

NWX-HHS-AOA-1

Moderator: Lauren Solkowski
April 02, 2014
1:00 pm CT

Coordinator: Welcome and thank you for standing by. At this time, all participants are in a listen only mode. During the question answer session of today's call, you may press Star 1 to ask a question. Today's conference is being recorded. At this time, we'll turn the call over to Lauren Solkowski. You may begin.

Lauren Solkowski: Great. Thank you, (Shirley) and good afternoon everyone. And thank you for joining us today for the Administration for Community Living's Targeted Technical Assistance Webinar, CBO Impact on Health System Quality and Performance Measures. I am Lauren Solkowski with ACL and I will be facilitating the Webinar.

On today's Webinar, we will be hearing from - we will be hearing two perspectives on quality and performance measures. One from the health plan side and then one from the community-based organization side in terms of helping plans and other organizations to meet those measures.

So before we begin with our speakers, I have a few housekeeping announcements that I'd like to go through. First of which, if you've not done so, please use the link included in your calendar appointment to get on to

WebEx so that you can not only follow along with the slides as we go through them, but also ask your question when you have them through the chat function.

If you don't have access to the link that we emailed you, you can also go to www.webex.com, click on the "Attend a Meeting" button at the top of the page and then enter the meeting number, which is 665324137. That's 665324137. If you have any problems getting into WebEx, please call WebEx tech support at 1-866-569-3239. That's 1-866-569-3239.

As our operator mentioned, all of our participants are in a listen only mode. However, we do welcome your questions throughout the course of our Webinar.

And there are two ways that you can ask questions. The first using the web - or actually through the web using the chat function in WebEx. You can enter your question here. I will sort through them and then answer as best we can when we take breaks for questions after each speaker presents.

In addition, after the speakers wrap up, we will offer you a chance to ask your questions through the audio line. And when that time comes, (Shirley) will give us instructions as to how to queue up to ask your question. If there are any questions that we do not get to during the course of the Webinar, we will follow up to be sure that we get them answered.

If you have any questions you think of after the Webinar, you can email them to me at lauren.solkowski@acl.hhs.gov. And I'll actually place my email address in the chat box in a moment so you can find it there so you don't have to scribble it down.

And then also as (Shirley) mentioned, we are recording the Webinar. We will be posting the recording, the slides and a transcript of the Webinar on the ACL web site as well as n4a's mltsnetwork.org web site. And I will also enter ACL's web site and the n4a web address in the chat box for your reference.

So with that, I would like to introduce our first speaker, Sharon Williams. Sharon Williams, now a consultant, comes with executive leadership experience in both the community-based services setting, including serving as the chief operating officer within the Detroit-area agency on aging, as well as the traditional healthcare arena, serving in executive roles at CareSource Michigan, Coventry, Amerigroup, as well as Omnicare.

So with that, Sharon, I'll turn it over to you.

Sharon Williams: Thank you, Lauren. Can everyone hear me?

Lauren Solkowski: Yes, yes.

Sharon Williams: I presume you all can because you're all in silent mode. Okay. Well, I'd like to thank Lauren and (Melissa) for this opportunity today. I've long been an advocate for the integration of medical, mental health and community-based services. It's a more coordinated and seamless system. And that's more optimal for the users, the consumers, the providers, the health plans, et cetera.

As you all probably know, the cornerstone of the dual demonstrations and other ACA initiatives is the increase in access to quality care as well as improved quality outcomes.

Quality however, is in the eye of the beholder. Consumers judge it based on a different set of factors than you'd expect from a health plan or from regulators.

Health plans are looking at quality from the perspective of market competitiveness, financial PML implications and as well, consumer satisfaction. Today we'll focus on some of the many quality standards that impact health plans, their providers and their consumers.

Healthcare - please go to the next slide. Healthcare is among the most heavily regulated and monitored U.S. industries, at the federal, the state and the industry level. And there's a high focus on quality of care and health outcomes.

This quality continuum involves significant data mining, analytics, reporting, screening, audit takes and in many cases, there's a redundancy. For example, Medicaid, Medicare, NCQA and all the dual demonstration will require tedious reporting.

There's heavy pressure on plans and their providers for data integrity in this process. Dual demonstrations in particular are under significant scrutiny not just to lower costs, but also to improve health outcomes for participants in the dual projects.

Quality assurance, you know, is again in the eye of the beholder. A couple of concepts that have become standardized from the healthcare perspective nationally, quality-management goals need to include excellent care, strong coordination, consumer satisfaction and consumer health outcomes.

The Institute of Medicine defines quality assurance, which is the foundation of health plan and care delivery and the degree to which health services for individuals and populations increase the likelihood of outcomes in a consistent with profession knowledge.

So from a health plan perspective, it's not Blue Cross of - Blue Cross HMO in Pennsylvania using one set of standards and Blue Cross in California using a different set versus what a PPO in Atlanta or a PPO in New York would use.

Most health plans are using some of the standardized tools that are out there so that allows for some cross review and evaluation and comparison in health plans.

So what you hear a lot when you talk about quality assurance is evidence-based services, tried and true methodology and unfortunately a lot of it is very clinical-based when you're talking about some of the healthcare-specific outcomes.

And then again there are performance outcomes and we'll talk more about that, that are not necessarily clinical but have implications for health plan operations and financial (unintelligible).

And the quality improvement as defined by AHRQ is doing the right thing at the right time for the right individual. That's a very simplistic overview, but it's the underscore of everything that's related to quality services. Next slide please.

There are a number of components, no matter where you are. And I do want to emphasize that from a perspective of what health plans are looking for, you will generally find that health plans will have a quality improvement plan.

There's probably not a health plan on the planet that does not have what is known as their quality bible or their quality improvement plan, quality-management plan.

And it details exactly how are they going to deliver the services - the healthcare services to their consumers? Any many times it is population-based, a number of states require in their Medicaid contract that the quality improvement plans first identify what are some of the key significant health care indicators in the community and if that quality plan has to be built around that.

The components of a quality-management program generally include the adoption of a medical quality-management standard of care. And again, most standards of care are driven by nationally recognized, evidenced-based standards.

The establishment of a quality improvement committee. In fact, many states require that HMOs and health plans - PPOs - must have an established quality improvement committee as does NCQA. And that both committees have to have a direct reporting relationship to the board.

There's a utilization of views from the consistent evaluation of what kinds of services are being delivered. Is there consistency in the delivery of this kind of treatment for somebody who's post-hospitalized for COPD, et cetera, et cetera?

There are quality management studies when you're evaluated. All right. We've got a high population of asthmatics, childhood asthmatics, in our health plan.

What kinds of things - what kinds of medical practices, preventative care, well care, post-hospitalization, services that support an intervention can we provide for this population and what's impact of the services we're providing around the network credentialing and oversight is a critical, critical aspect because most of the quality of delivery of care comes not from the health plan itself but from its provider network which certainly the community-based organizations like the AAA will become an integral part of those provider networks.

So how do you credential? How do you evaluate the qualifications of the provider to participate in your health plan? Do you follow those credentialing standards consistently across the board?

How are you providing oversight and monitoring of the data of the quality of care, member satisfaction and complaints? The greatest appeal and review is a significant portion of engaging that consumer perspective.

So if you've got a particular provider, you've got a high number of complaints about cleanliness of the office, quality of care, high hospital utilization, both - high ER visits.

Those are some of the things that customers are taking into consideration to determine the quality of care that is being delivered. Again member satisfaction cannot be underrated.

It's a significant part as dictated by (unintelligible) by accrediting organizations. How well do the members feel about the services they're receiving and the quality of care?

And then there is consistently constant program evaluation reported and process improvements but it's not enough just to have these quality studies published. You have to take something from those quality studies to identify ways to improve the delivery of care in the system.

Next. This is my attempt to kind of pull together how the quality impact of these various (unintelligible) did in an organization and (unintelligible) in many aspects of the healthcare organizations operations.

From a compliance perspective there are significant state and federal regulations and industry-standards and a number of, at the state level, legislative initiatives.

For instance in Michigan for the Medicaid program because we have a significant incidences of blood lead poisoning in young children the Michigan legislature mandated that subcontracted Medicaid HMOs had to do special studies, following management studies, for blood lead screening and preventative services and engagements they were doing to manage blood lead screening and to raise awareness among your consumers.

Accreditation is a heavy and significant portion. You can't be a Medicare Part D provider contracted health plan if you're not accredited. There are a number of employer groups who (unintelligible) contract (unintelligible) health plans who are not accredited.

So the accreditation piece which 50 to 70% of the whole accreditation evaluation process is based on quality review announcements. The financial implications for quality are significant.

The whole P&L for a health plan could be positively or significantly negatively impacted by the quality outcome. And just a couple of examples. You can't qualify for certain contracts, as I mentioned, if you don't meet certain quality benchmarks.

There are contractual incentives built into Medicaid and Medicare and in some cases commercial contracts where if you meet certain benchmarks you get a bonus and if you don't meet certain benchmarks then there is a quality (unintelligible) if you will.

And I'll talk about that more as we get to the Ohio the (unintelligible) of understanding. So your health plan's financial health is impacted significantly by your quality outcome.

And then again the whole consumer satisfaction. Not just from the perspective of what are the state and the feds looking at in terms of your health (unintelligible) and your satisfaction but consumer satisfaction is a driver.

Consumers vote with their feet. If they're not happy with the health plan, their access to care, how easy it is to use the health plan, are you responsive to my inquiries, my (unintelligible), I'm going to walk with my feet next open enrollment.

The Medicaid program ties their enrollment - for many states ties their enrollment to (unintelligible) health plan to quality outcomes. So the higher your quality scores the more opportunity you have to enroll people in your health plan. And that's also a factor with Medicare Part B programs as well. It's the ease of use again, the plan services, et cetera.

And then finally a number of health plans have been founded on the mission of providing quality outcomes - higher quality outcomes particularly for those health plans who are focused on serving public (unintelligible). Next slide please.

The genesis of the quality management again is driven from several state regulations with a heavy emphasis from a perspective of federal HMO Act, Medicare/Medicaid standards.

There are contractual obligations under Medicare/Medicaid. A number of consumer or commercial employers require certain quality outcomes in their contracts.

Accreditation as I mentioned is 50 to 70% based on quality outcomes. And then the healthcare organization itself, its specific mission around quality improvement. Next slide please.

Some of the federal and state drivers for quality - the dual demonstrations. Heavy emphasis on quality outcomes. If you look at your various state MOUs if they become public you'll see that probably 2/3 or half of the MOU requirements are around (unintelligible) quality outcomes and the kinds of tools and initiatives that the feds and the state will use for audit. They'll follow the outcomes.

Almost all Medicaid waivers, 1115 waivers in particular, have some kind of quality component in them. And the states have to demonstrate they're going to meet some of these quality components in order to get authorization for the waivers.

The model of care which is the quality improvement plan, if you will, for Medicare part C specifically the special needs plans or those plans that are designated for bi - for dual eligible and as well all dual demonstrations have a model of care.

And that model of care has a number of components in it around quality indicators that health plans must meet. The Accountable Care Organizations established under the Affordable Care Act are systems that are hospital-based.

And their primary target is to again improve health outcomes, reduce readmission rates, reduce unnecessary hospitalization and reduce unnecessary ER visits. And there are a number of quality standards that are inherent in those ACO contracts around the country. I mention the ACA and the federal HMO Act.

State health insurers' regulations - again HMOs (unintelligible) are licensed at the state level. And there are number of specific quality indicators that are inherent in that legislated mandate.

And then one of the major consumer-driven quality indicators is of course the CAHPS. The Consumer Assessment of Healthcare Providers and Systems. And those are surveys that are administered at the health plan (unintelligible) that gauge what their level of satisfaction is around a myriad of domains that help evaluate whether the plan has been effectively serving the members. Next slide please.

This is a snapshot of one of the regulations from the state of Michigan HMO licensure under the insurance code. And this insurance code specifies (unintelligible) what some of the quality assessments or quality improvement, quality management systems are required for an HMO.

And I won't go into reading all of that. You can look at that at your leisure. But it's just an example of how state insurance codes incorporate the kind of quality standards that they're looking at. Accreditation guidelines et cetera. Next slide please.

(Unintelligible) contractual (unintelligible). Once you have a Medicare contract you have a lot quality reporting that you have to meet. You also have to report out on the model of care that the health plan has developed in response to the Medicare guidelines.

There are the state contracts, (unintelligible) Medicaid, HMO contracts and a number of other issues. The underscore here is to understand that from a contractual perspective, the feds, the states and a number of commercial employers have introduced a (unintelligible) that impacts rate setting in normal priority and bonuses that are directly tied to quality performance. Next slide please.

Accreditation is a huge industry for health plans. A huge industry for accrediting bodies as well. It's almost impossible to get a contract as a health plan or PPO unless you have gone through the accreditation process.

And this definition here is from URAC and a couple of AAA (unintelligible) participators who have recently in the last several years become your URAC-accredited.

But these are the primary accrediting bodies. JCO is almost solely focused on hospital accreditation. At one time they did do HMO accreditation but haven't done it in about ten years.

URAC which originally started out at monitoring and accrediting using (unintelligible) review process which has become a full-blown accrediting body for a number of different kinds of organizations.

And then NCQA which is for the HMO industry kind of the gold standard for accreditation is a huge portion. And as NCQA actually owns the HEDIS measure that is so heavily used by (unintelligible). Next slide please.

And then there - these are a couple of examples of mission and vision statements from health plans around the country where they actually have incorporated into their particular mission or vision statement the opportunity to provide high quality outcomes. And if you look at the second one AmeriHealth this is focused on some of their publicly-funded services and health plans. Next slide.

Some of the common clinical and nonclinical performance indicators and you hear, you see quality performance, quality indicators. Most of them are clinical but there are a number of them that are non-clinical that still constitute quality management. Provider network, adequacy, the (unintelligible), data reporting, consumer satisfaction, timely-placed payment, et cetera.

On the clinical side depending on what kind of health services you're providing you'll see a lot of emphasis on preventative health around things like childhood immunizations, pre-and postnatal care, chronic disease management, asthma, COP, diabetes, et cetera, having emphasis in the last ten years for post-hospitalization care particularly around that 30-day readmission issue that has been incorporated into some of the Medicare contracting, child and adolescent well care and significant adult measures - adult BMI measuring body weight as a factor.

As obesity in America has become a significant issue you'll start to see some of these adult quality indicators as more significant. And then (unintelligible) gratitude I know on the community (unintelligible). A lot more emphasis particularly from NCQA via HEDIS for an older adult quality indicator. Next slide please.

Some of the conventional healthcare quality indices are around accreditation and accreditation (unintelligible). Your program, your program structure and operation.

HEDIS accounts for almost 50% of the entire of the NCQA accreditation review. And then the CAHPS survey whether it's HEDIS, URAC or (unintelligible) those are very significant issues for health plans in terms of consumer satisfaction.

From the Medicare perspective as I mentioned the model of care is a huge piece of the quality indicator. There the star ratings which I'll talk about a little bit more.

And then also some Medicare (MCO) standards and quality initiatives that have to be met every quarter (unintelligible). From a dual demonstration (unintelligible) perspective, there is the (unintelligible) of understanding.

And those will include both the Medicare and the state Medicaid quality initiatives. As well you'll find some state-specific additions to that beyond what may be inherent in the existing Medicaid contracts.

And then you'll see a lot of long-term care a specific indices included in the model here. So we'll highlight a couple of these quality drivers in the next couple of slides.

And I would say to you that I just discovered on my review just before the session started that Slides 13 and 14 are quick. So I'm going to start with Slide 14.

Thank you. HEDIS. You'll hear a lot of discussion about this especially your quality management team, your care management team. They're going to hear HEDIS until it is coming out of their - you fill in the blank.

It stands for the Healthcare Effectiveness Data and Information Set. And it's a set of measures used to evaluate the quality of outcomes from a particular healthcare management. I mentioned earlier chronic care, diabetes management, prenatal and postnatal care et cetera.

For the most part HEDIS is used by 90% of America's health plans. That is very significant. That is how much it has become institutionalized as a quality measure in this country.

It measures performance on important dimensions of care and service. There are about 75 measures across eight domains of care involved in HEDIS. And traditionally what the healthcares are trying to achieve is for their specific population, let's say, for - if you've got 300 people who are listed in your system as asthmatics, that becomes your denominator.

And then your numerator are the number of people who are listed as asthmatics in your system who have met things like reduced hospitalization, have had prescriptions for appropriate asthma meds, who have been tracking that they're utilizing the asthma medication, they're recording better health outcomes, fewer asthma attacks, et cetera, et cetera.

So what you're trying to achieve is at least a 50% of your 300 asthmatics have met the HEDIS indicators. And that 50th percentile to 90th percentile is where you get higher quality ratings and outcomes.

Anything below the 50th percentile basically puts a health plan quality measure - that's a (unintelligible) quality measure - at risk. Again HEDIS is required reporting for almost everything (unintelligible) Medicare Part B plans, most Medicaid programs.

It's certainly for the dual demonstrations. And it's based on - they draw information from health plan and counter and claims data. Health plans spend a ton of money, millions of dollars every year, chasing HEDIS data.

If it's not in their claims data it may be in provider office medical records. And that's another opportunity for the community-based organization to help beef up that whole HEDIS data search by assuring that you're reporting information as accurately and as timely as possible.

Okay you can go to 13 now. As I mentioned some of the domains preventative and well care, older Americans, over the belt measures, fall risk management, osteoporosis testing (unintelligible) and a chronic disease management comprehensive diabetes care or all your diabetics who are listed as diabetics getting the annual eye exam, the foot exam and the blood level screening.

So those are critical factors that plans - and again each one of these might have 30 or 40 different sub-index measures that have to be evaluated in order to meet these criteria.

Okay? Slide 15 please? Thank you. The model of care is the Medicare requirement for health plans who are applying for special needs plans (unintelligible).

Those are the plans that are solely focused on the delivery of Medicare services - Medicare and Medicaid services - for folks who are dually eligible. This is outside of the dual demonstration.

But the dual demonstration at MOUs (unintelligible). That health plans meet the qualification that the model of care. Basically it's your roadmap for how you're going to provide services to the population that will be enrolled in a special needs plan on a dual demonstration.

And you have to - it takes into account about 11 elements. The MOC is reviewed by NCQA on behalf of (unintelligible). The NCQA has to approve a planned model of care.

And that model of care is submitted annually with the Medicaid application unless you score at a certain level on your model of care and you don't have to renew it until the third year.

But most new health plans have to renew that model of care annually. There are 11 elements. First and foremost is your definition and evaluation of the needs of the target population.

And this is a very valuable point. Again for CBLs because who your annual plan is program analysis and the development of your roadmap for the year. You collect a lot of very valuable data about what's going on from a public health perspective for seniors and persons with disabilities in your community

and your ability to share that data with health plans is very vital for their development of the MOC.

The MOC also defines a number of other issues, case management protocol, the interdisciplinary care team which again, CBOs in their role and capacity support. Effectively that integrated peer delivery team is important.

And then the MOC also just provides kind of the overview of the quality improvement program or quality management program. It identifies the quality improvement project, the quality improvement studies, a chronic care management program which is a unique aspect for Medicare Part C where you're identifying some specific disease states where you're going to have a particular focus or initiative around some of those disease states. Next slide please.

The model of - the model - the memorandum of understanding is the precursor to the contract that will eventually be developed in the states where the dual demonstrations will be improved.

And the Memorandum of Understanding or MOU is a joint development between (FEMA) and the state. It's predominantly driven by some of the Medicare and the Medicaid federal rules around waivers et cetera.

But it also has a heavy emphasis where some of the initiatives are critical to the dual demonstration and its mission and mantra. (Unintelligible) the details, the principles under which the state, the (CMF) and the contract, the health plans will (unintelligible) and operate the dual demonstration. It'll eventually become the blueprint for what will be the three-way contract for the dual demonstration.

And some of this information - the Ohio MOU for those of you who have had access to that, I think, maybe 20 pages of some of the quality measures. And some of them include, again, consumer satisfaction so you can (tap) over and over again as you walk this health plan quality road.

It includes the number of enrollees with an initial assessment completed within 90 days of enrollment. So again, (CBOs) have a critical opportunity to participate in helping health plans meet that particular quality measure.

And you've got the boots on the ground, you're out in the community, you're touching these people, seeing these people every day. You can help facilitate meeting that particular indicator.

I'm very pleased to see this in a couple of (unintelligible) in a couple of the MOUs. And that's to follow up after hospitalization for mental illness. The whole mental illness/mental health piece has not always been fully integrated into health plan quality initiatives.

Particularly because at some level a number of health plans and states carve those services out of the Medicaid contract. And it is a Medicare perspective. It's been done via fee for service.

So the dual demonstrations kind of force that whole integration. So there's going to be a lot more emphasis with these dual demonstrations around some of the services provided for preventative and follow up care for mental health.

Re-admission rate - there's a huge emphasis through the dual demonstrations and through the ACL to reduce re-admission rates. Reduce risk of falling - another of the older adult measures that you'll see quite frequently throughout.

And then another huge aspect of the dual demonstration is around deinstitutionalizing some of the consumers.

So the opportunity to have a larger portion of those enrollees receiving care and living effectively and efficiently, as they define it and as defined by these quality measures, is going to be a critical aspect. Next slide please.

The star rating system is used by Medicare health - Medicare to do a report card on Medicare health plans. It's used for both the commercial Part C plans and as well for the special needs plans.

It's Medicare-specific. It's scored 1 to 5, 5 being the highest rating. And with the star program, the bonus program for Medicare rate setting is tied to your star rating.

So plans with a 3-5 rating actually get to reintroduce some bonus payments they would have received from Medicare for achieving that star bonus status by adding that money back into their overall rates.

And their rates tend to fall. So if it would have originally been \$35 for a vision screening, the bonus payment applies. Now the out-of-pocket cost for the consumer for that vision screening may be \$10 or may be zero depending on what the bonus looks like.

So it's an opportunity. If I'm looking at the star rating as a consumer and I see three plans have a 2, and five plans have a 5, I'm going to assume that the plans with the 5 have a better rating.

But additionally as I look more into those plan options, I will see that the plans with the 5 may actually be less expensive for me out-of-pocket as the consumer.

The plans that are rated 2 or below could be subject to termination from the Medicare (unintelligible). It takes you a long time to get back in Medicare's good graces once you've been dismissed. The star rating program uses, again, the reputation and (unintelligible) of HEDIS CAHPS and other.

They're about nine domains. Fifty-two measures across those nine domains. But again, emphasis on preventative and wellness, managing chronic conditions, self-care with confidence around consumer perspective and then number of complaints and appeal. Next slide please.

The opportunities, again, through the dual demonstrations or other contracts outside. I know a number of community-based organizations are working with some of their local (HVOs).

There's opportunities to work with some of the federally-qualified health centers in support of some of their initiatives around quality improvement in their Medicare and Medicaid dollar.

So one of the things that I think you can look at are around how do the (CBOs) align themselves around some of the health plan quality initiatives? Again, the utilization review.

Do you currently have a strong utilization review of the services you provide? Were you looking at appropriateness of care? Are you tiering levels so you've got folks who have high needs, have a higher focus and intervention level? Folks with moderate needs - you've adjusted the care at that level.

Are the services you're providing appropriate and consistent with what the needs are? And do you have evidenced-based programming for standards that you're utilizing to evaluate that?

What are your own internal plans? And how well do you have data to support which says what you're doing for the utilization review is appropriate, consistent and leading to quality outcomes?

Helping your outcomes as dictated to you from the Older Americans Act, your state waiver. How much do those align with - and there's a lot alignment from my perspective between what NCQA is looking for, what CAHPS is looking for, what URAC and some of those other organizations are looking for.

And there's a lot of alignment for the opportunity for you to say, we can support your NCQA accreditation, we can support your dual-demonstration contracting because we're already doing six of these domains. And here is the data we have to support that.

Consumer satisfaction is heavily driven by the engagement with the consumer. So for the most part health plans very rarely ever see or touch their enrollees.

Ninety nine percent of the delivery of healthcare from the health plan perspective is done by their provider network. You become a vital part of that provider network in influencing how consumers perceive a health plan.

Population base followed an improvement. Again the (MLC) is heavy emphasis in that on determining what kinds of issues - public health issues - are out there for the folks in the service area that the health plans will enroll.

You're collecting that information. You can provide that. It's valuable information for the health plan particularly around some of the non-clinical issues that impact overall quality and health outcomes.

Data analysis, evaluations of process improvement, health information technology is a critical factor. How quickly, how easily, how comprehensive is your database? Not just do you have the data but do you have ongoing, analytical evaluation that gets (rolled) into quality improvement projects and processes?

And then finally the financial incentives. As I mentioned several times, there is a huge stake for health plans' P&L around quality initiatives. Health plans partner with providers to help them meet and recover all their money.

For instance, in the Ohio MOU around the quality withhold, the first year of the agreement the health plans will reach the - will have a 1% withhold of their payment that they have to earn back through meeting those quality metrics. The second year that increases to 2%. And then in the third year - because by the third year they should have worked out all the kinks - it's a 3% withhold.

So imagine you've got an \$8 million or a \$20 million dual demonstration contract and 3% of your money is being withheld until you meet those quality and performance indicators. You want providers on your side who can help you get all of that money back.

The other side of that is, if health plans are going to be looking for providers who are prepared to help assume a share of some of that risk and so you may

very well be looking at your performance is going to determine what your financial - what your P&L is going to look like as well. Next slide. Thank you.

Just underscoring some of the critical resources for CVOs to start looking at in terms of how you can more closely align your quality management systems to your potential new customers.

Definitely you have to take a look at the end-run view and the dual demonstration contract. That's the roadmap if you've got a dual demonstration going on.

The Medicare Manual, particularly the quality management chapter, which is where the (MLC) fee is listed, but a number of the other managed Medicare quality initiatives for other contracting outside of the dual demonstrations are inherent in that document.

Familiarize yourself. Have (team) on board. Send folks to NCQA conferences. NCQA and HEDIS, as I mentioned, the granddaddy, the gold standard, the good housekeeping seal of approval and other accrediting institute standards.

The CAHPS surveys. Look at those consumer surveys and identify opportunities for your staff to help support consumers, A, responding to those surveys and influencing positive outcomes through their interactions with your organizations on behalf of the health plan.

The ACL contract has significant factors in it around what are the quality outcomes that the hospitals who have these ACL standards and ACL contracts - what do they have to meet? How do they meet them?

If you are a subcontractor for those hospital ACLs you want to know what the feds are looking at so you can align your services with their support to help them maximize those outcomes.

State Medicaid contracts. I said this before. I know a number of you have heard this from me before. There's a population outside of the duals that are kind of headed into dual eligibility. The age one disabled population, they're the Social Security disability income population. High health needs. Multiple chronic conditions.

Health plans could use some of the same help with them as will be provided for duals in terms of outside services. They may not be compelled to do it by state edict but a number of health plans are becoming savvy.

And I know we worked with a health plan in Detroit, when I was at the AAA, to look at how can we help support management of that population? A lot of those dictates are adherent in that contract with the state.

The standard health organization provider agreements. There are a lot of the quality initiatives that you'll be required to meet that will be documented in those contracts either in the base of the contract and in many cases a number of those, particularly on the dual demonstrations, in the addenda.

Look at the health plan's quality improvement program. Ask for a copy of it. Read it. Identify what are some of their hot spots? What are some of the issues? And also ask them where they've been dinged by the state, by Medicare, by employers and where are they looking to provide improvement?

And then the health plan report card. NCQA publishes annually, as do several other reporting entities, a health clinic quality report card. I'm pleased to say

that the health plan that I ran here in Michigan - (unintelligible), Michigan, was consistently ranked among the top 100 Medicaid health plans in the country. And a lot of that was driven by what our HEDIS outcomes and our consumer satisfaction surveys looked like. Next slide please.

These are just a number of the references that I utilized. And boy does that look good the way you guys (unintelligible). And that's the end of my presentation. Lauren, I'll turn it back over to you.

Lauren Solkowski: Great. Thanks so much Sharon. I think I'm going to check through our questions in the chat before we go to our next presenter. And we did have a question come in.

And this is actually in reference to Slide 16 so I'm going to go back to that. And so they're asking, are the plan expectations specific to Ohio? And if so, were these measures recommended by CMS, developed by the state or negotiated between the two? She says she's trying to determine whether the same or similar issues may be included in other states' MOUs.

Sharon Williams: That's a very good question. Let me say this, that first the MOUs' quality measures are going to start with a base of Medicare and Medicaid standardized issues.

So there's going to be what you would traditionally see in a Medicare contract, that's going to be the basis for the MOU quality indicators. Then CMS and the state negotiate on what may be some state Medicaid-specific and/or some state long-term care specific measures that need to be included.

So your - the first part of your question, is this going to be what we see in almost all MOUs? For the most, part, yes.

The second part of your question, will there be variations based on the states? That question is also, yes. But each MOU is going to be specific and unique in some part to the state that it's been designed for.

Lauren Solkowski: Okay. Actually somebody wanted to - I'm going to put back your last slide to get your e-mail address up. I had clicked away too quickly. So here is Sharon's e-mail address.

And I'm just checking for chat. I don't see any additional questions. So I think what we'll do is we'll go ahead and move to our second speaker. And then we'll take questions on the phone and chat once she's finished.

So now I would like to introduce and welcome our second speaker who is Sandy Atkins. Sandy is the Vice President, Institute for Change at Partner in Care Foundation. Thank you, Sandy. You are welcome to begin. And I'm going to pull up - your slide should be up now and you're welcome to start.

All right, Sandy, you might be on mute.

Sandy Atkins: Oh yes, sorry. Thanks so much. Nice to be with you. Sharon Williams, that was incredible. It's - my presentation is a little bit more in the weeds with some examples of specific measures and specific programs and things that we tend to do that can help just to kind of create an orientation toward, you know, what are we discussing with health plans when we talk about how we can help with the quality measures. So next slide.

That's just how CVOs can impact quality. Next slide.

Here we go. So I'd like to start with the Triple Aim. And hopefully you've all heard of it but the Institute for Health Care Improvement basically started this and then adopted it and called it the Three-part Aim. But in general it tends to be the same thing. And the reason for doing this is just to keep a kind of a balanced perspective.

So health care contracting and activities are motivated in all three areas. And to me this is sort of a mantra. I just keep reminding myself, better population health, better patient experience of care, lower per capita costs.

So in general we look for a balance of these things. Both population health and patient experience of care are in the quality domain. And I think actually some - there are some quality measures that relate to costs and particularly efficiency of care.

But also in addition to the Triple Aim I think a couple of things that - I'm talking more specifically about health plans, ACOs, that kind of thing. Member retention is a primary metric and it's sort of the ultimate expression of satisfaction. But they want - they will - we will be measured on helping them with member retention.

And another thing to think about is, everybody in healthcare wants physicians to be happy. And when we help keep their patients healthy and well-managed that makes physicians more satisfied themselves. Oh, I'm trying to scroll through myself. Next slide.

So when we talk about the first part of the Triple Aim better population health, so what do we do? What's related to better population health? First of all better care coordination.

So here's some of the things that we do that relate to better population health. That's our care transitions programs, the CCTP. We very often have service coordination, navigation either at the waiver level or at lower levels depending on what our funding sources are. And also improved access to care.

So we've got transportation, helping people schedule their appointments, sending a companion along. So those are all things that relate to better care coordination and the first part of the Triple Aim.

In addition, better population health - what we particularly influence is improved functioning and behavioral health. In some cases also, you know, health in terms of diagnoses but in particular we address - so Enhance Fitness, Fit & Strong, Healthy Moves, Tai Chi. Those are all improved functioning, better strength, better balance. Those sorts of things.

And our Pearls and healthy IDEAS evidence-based programs address the behavioral health domain and the Stanford programs kind of go across all of it in improving self-management which drives better behaviors, better symptom control, lower utilization. All of those things. Next slide.

So in better patient experience - and another way to think of it is satisfaction - one of the things that we've learned is what's very important to health plans when we're contracting with them is that we represent them.

We're not representing ourselves, not our agency, not our network. We're representing the plan, the provider group, that sort of thing which may even mean wearing name tags that represent them.

But because we do these things we improve the patient's experience by visiting them in the hospitals and following up. Visiting them at home.

Obviously you'll recognize care transitions coaching. We have - they will have a relationship with us as care coordinators.

We provide them things they need that they may have been having problems getting, like transportation. We do the benefits checkups. So they're - a great way to make a health plan member more satisfied with the health plan is that we help them have better lives in general.

You know, access food, access benefits, access income supplements. Those kinds of things that they may not even know about. And help them find free and discounted services of course. That's going to make people happy and it's what we do. Next slide.

And finally lower per capita costs. I think in general our quality enhancements that we work on need to be at least cost-neutral. We can't always do a positive return on investment. But of course that's the best possible outcome. That we improve quality, we improve patient satisfaction, we improve health and we save money.

Other ways to improve lower per capita costs would be to reduce falls which are very costly in terms of emergency skilled nursing care for rehabilitation. So we have a number of programs like Matter of Balance, Healthy Moves, Home Meds that are directly aimed at reducing falls. The exercise ones are a little bit one step back from that but obviously will also have an effect on fall reduction.

Reducing ED visits. So again our fall prevention symptom management. So if you've got - you know, in care transitions you have those red flags. If you teach people what they are we can present ourselves as an alternative to 911 by keeping a call center or telling people how to get that care from their health

plan. So the health plan may have a call center. And our job would be to connect them with that.

And of course self-management, understanding, following your diet orders, following your - maintaining your meds is going to keep you out of the ED - Emergency Department.

Finally reducing admissions and re-admissions. We have care transitions intervention. Here in California we're doing the Bridge Program out of the Rush University Medical Center in Chicago. And we have Enhance Fitness and Stanford's Self-Management Program.

So the idea is that we have a whole array of services or if you're a doctor you would call that your armamentarium of services to help with the Triple Aim. Next slide.

So here we get into some of the specific measures that Sharon Williams was talking about. So the older adult measures. During the year the person - each older adult should receive advance care planning which is help with advanced directives, medication review, functional status assessment and pain assessment.

And these are all things that we do or can help with. These are all typical waiver or care management services. And with one home visit for us we would meet of all of these HEDIS older adult measures for a plan or a provider group. Next slide.

And then as Sharon Williams mentioned, for Medicare Advantage plans they have the star ratings. And here we have a yearly review of all medications and supplements being taken.

I wouldn't be doing my job if I didn't always plug home meds. So that's part of what we do there. A yearly pain screening or pain management plan. Again, you know, when you're doing a full assessment for somebody you're talking about their pain. And then creating a care plan to help them manage that. Or working on a care plan - maybe not creating it in a context of a health plan.

Controlling blood pressure. It's something that we work on. And I'll talk a little bit later about how we do some of these things.

Reducing risk of falling.

Re-admission within 30 days of discharge.

They get dinged on plan members over age 65 who are on high-risk medications when there may be safer drug choices. And high risk is usually defined by something called the Beers Criteria and that's - the American Geriatric Society issues those criteria.

And then medication adherence for hypertension.

So these are all things that we can help with. And not only is it just the flat quality measure but as Sharon Williams mentioned the 4- and 5-star plans are getting bonuses and those bonuses are increasing. Next slide.

Physicians have their own HEDIS measures so large provider groups. We have a contract to do some post-acute interventions with patients of a large provider group. And for some reason HEDIS measures talk about age 66 plus whereas star ratings talk about age 65 plus. Who knows why?

So HEDIS for physicians - they would have a goal of not prescribing high-risk medications. And those include things that affect your balance, things that can cause confusion, increased risk of falls, gastric bleeding. There are a number of reasons for calling certain medications high risk in older adults.

Fall management is another. So they're supposed to have a discussion and a management plan for falls. And in addition HEDIS measures for physicians include potentially harmful drug disease interactions.

So they've got to - when they're prescribing something the idea is you prescribe in the context of the whole patient and not just, oh, today your symptom is this so I'm going to prescribe X.

And then, you know, when you look at the whole picture what you just prescribed could cause an exacerbation of something else that the patient has. Next slide. I was going to say, next measure.

So taking a little deeper dive into those physician standards, so all of those - the high-risk medications are all associated with higher hospitalization in community-dwelling elders which goes back to the lower per capita cost part of the Triple Aim.

So any time you're talking hospitalization you're talking about high cost. And also high suffering. So that's why, you know, you talk about it in a quality - and that quality goes from the person themselves. And it ripples out to the whole healthcare system and society. And of course those high-risk medications have adverse drug reactions and costs.

Again, the potentially harmful drug disease interactions. These are just some interesting things to look at. So people will give you something to manage your bladder.

And those are in the drug class called anti-cholinergic. So if you've got urge incontinence and they give you that but then it decreases - it increases your dementia. That's not a good combination.

Or if you're falling and you're taking certain medications you might be depressed. But you then - you're going to be in a hospital and you'll be even more depressed. So the whole idea of this is again to look at the whole patient. Next slide.

So when you're talking to health plans about their quality measures, fall prevention is one of the door openers as I call them. So it's the - here's the actual standard.

Fall risk management. Percent of Medicare members - this is a star rating measure by the way - who had a fall or had problems with balance or walking who received fall risk intervention.

And below is just a little example of something that one of a - the AAA in Tarrant County, Texas is doing. So they joined a local fall prevention collaborative with the hospital's public health.

Partnered with the fire department who mapped their 911 calls for falls. And then they target those people for Matter of Balance and Home Meds for frequent fallers.

That's such a win-win. It's a partnership - the programs that we have in our portfolio and the results in reduced falls, reduced cost and better quality measures. Next slide.

Medication management is another door opener. We find that - you know, obviously this is our own program so it would be logical for us to use this - but we find that you can just literally see people start sitting up straighter and leaning forward when you start talking about what we can do about medications because they know that they have no idea what's in the home.

There's just - we've done Home Meds on people who have just had a so-called medication reconciliation in the home. And 66% of them came up with problems that a pharmacist thought the prescriber needed to know about.

So we're addressing fall risk. We're addressing those high risk medications. We're addressing hypertension control with the Home Meds protocols and the pain control and assessment as well as the potentially dangerous side effects of many pain medications.

And in care transitions, this serves as a medication reconciliation which is a requirement from NCQA for health plans. So you know it all comes back into the programs that we can offer people. Next slide.

So what else can we do? A lot of the quality measures are specific to screening and access to care. So what can we do to help with those getting people to their mammogram or they are glaucoma test?

Well we can provide transportation or transportation assistance. Help them with their scheduling for, you know, certain of the clients that need that extra help or encouragement. They may just keep putting it off. But if you give

them a call and say, you know, can I help you make the appointment, they're more likely to say yes.

We can also help with clinical outcomes. So medication adherence. If you've got a care management program you're in the home. Then you can help them with their typical waivers.

You can do things like medication dispensers as well as discussions reminders, some of the apps that you can get on a cell phone that ring a reminder.

You know, there's all kinds of things now to help with blood pressure and hypertension control. And of course, exercise and diet also affects those which we take care of too.

Cholesterol we've got our meals, dietary counseling, medication adherence, diabetes. We might have a fund for purchasing monitoring supplies beyond those that the person can afford.

Helping them with meals, dietary counseling, diabetes self-management program, counseling the family. So you know, if you've got a family that eats traditional high-carb food and the person is supposed to be following a low-carb diet then you can help the whole family figure out how to do these. There are low-carb tortillas. We could have those instead. Things like that.

So there's some very creative ways that we can help with the clinical outcomes and the screenings that are part of the clinical side of quality measures. Next slide.

Another domain of quality of population health is in the Healthy People 2020. Pretty soon it's going to be 2030 I'm sure. And they've recently added an older adult measures in Healthy People 2020.

And the measures in Healthy People are goals of, you know, a percent of people who have confidence managing their chronic conditions. Well, obviously if you've ever done chronic disease self-management and the other Stanford programs you know that that's one of the things - the great results of those programs.

Receipt of the diabetes self-management benefits. Well, we've been working on getting our provider numbers so that we can provide the diabetes self-management program in the context of the diabetes self-management education benefit. So that gives us a value in that quality measure.

Leisure time physical activities among older adults. Of course, we have all our evidence-based programs like Enhanced Fitness, Fit and Strong and caregivers support.

We've got savvy, powerful tools. ED visits to the falls. We've got Home Meds, Matter of Balance, Healthy Moves, all of which have positive effects on falls. Next slide.

So just to give you one idea of what a health plan has to do to become accredited. Case management is one of the areas where they become accredited.

And look at the assessment that they're supposed to do. Clinical history, medications, ADLs, cognitive, psychosocial, health behaviors, life planning,

linguistic, culture, vision, caregiver resources, available benefits, community resources.

And what was in my head was, sound familiar? But they tend to do this only by telephone but for their high-risk members, the folks that we're used to seeing, we know that a phone call isn't going to do all of this. So that home visit, when you have trouble connecting with the person, is going to help the health plan meet this accreditation metric. Next slide.

In our recent discussions we're working with a health plan in California. Actually their exchange population. But they raised an issue of, are you licensed? Are you accredited?

And they actually reached out NCQA and are asking for permission to use our services and have it not affect their NCQA accreditation. So I put, how can we heard quality measures?

Well, if they are held to certain standards and we don't meet their standards we could potentially hurt the health plans --- our partners that we so much need and want to have relationships with.

So they have rules about to whom they can delegate different services and why. And so in order for us to accept delegation from them there are certain things we can't do.

So they have to do a care plan. We can only make recommendations. We can't refer patients. They have to refer patients. So there are things that they cannot delegate.

So we have to first know that, you know, don't be offended if they say they've got to make all the referrals. It's because of the - their accreditation standards. But we have to - you know, our information systems have to meet their standards.

All of our documentation has to meet their standards. We have to have quality assurance programs in place. And we have to have the metrics to prove to them and to NCQA because then by delegation we could be audited as well as they could.

In addition we could possibly adversely affect their customer service in certain ways. For example, you know, typically in a waiver you've got a couple of weeks to, you know, do things.

And then a couple more weeks to do something else and - but, you know, we're not going to be on that kind of timeline anymore. Those of you who have experience with care transitions know that it's a real culture change to start now to - tomorrow I've got to be in that home.

Not next week or the week after. Also we have to be very careful at representing ourselves in that relationship with the health plan because if they think the health plan is sending a lot of strangers and they sense uncoordinated care that could actually adversely affect their quality ratings. Next slide.

So I was thinking about this. And it's like everything we're talking about here is our usual business but it's the way we do it. We can't be doing it in a business as usual way.

So all of what I've talked about is stuff we're ready doing for somebody either through Older Americans Act funding or grants. Or if we're lucky and on the

cutting edge already, through some contracts with health plans, hospitals, ACOs et cetera.

But now we're going to have to do it better and faster. And we've heard comments from health plans saying, you know, talking to CBOs saying, well, we don't do it that way. We can't do that.

And really to succeed it's got to be a new culture. And it basically - it's how high. You know, it's not yes - it's not - no is not an answer. And we have to come up to this new standard.

And also we have to really get used to measuring ourselves, being measured from outside sources, keeping data. And one lesson learned that we have at Partners in Care, is that when you have a contract you need to make sure that they are going to give you data about your performance as well as you giving them data about your performance because we've had some struggles trying to prove our impact.

And we can't do that without some of their claims data, their clinical data and things like that, that we just will never have access to. So we're writing that into some of our contracts.

Not only do we have to meet your standards but you kind of have to meet ours too. And you have to share this performance data so that together we can continuously improve quality. Next slide.

I think this is the end. There we go.

Lauren Solkowski: Excellent. Thank you, Sandy. Let's see. I think what we'll do now is I will ask (Shirley) if we could open up for Q and A. If you could please provide instructions for asking a question through the audio line that would be great.

Coordinator: Certainly. If you'd like to ask a question on the phone lines just press Star 1 and record your name clearly. Again press Star 1 to ask a question. And one moment please for our first question.

Lauren Solkowski: Sure. So all right. While we're waiting for questions to come in on the phone we'll run through some that have come in over the chat. And this first question I think is for you Sandy. It says can you explain how you conduct pain assessments? What tool do you use and what are staff credentials?

Sandy Atkins: Okay. Pain assessments in our context is the ten point pain scale which you can do, you know, either with the frowny faces and the smiley faces or just on a scale of 1 to 10 with 10 being the worst pain imaginable.

So there are evidence-based pain questions that pretty much anybody can administer. So we're typically doing that either with a social worker - in California our waiver program has nurses.

So in the initial assessment they may be doing that but not required that it be administered by a nurse. So it's a very simple evidence-based - I believe it's been certified for kind of anybody that asks the question correctly.

Lauren Solkowski: Okay. And here's another question. It says, MCOs require licensed personnel for most programs. A Matter of Balance and other evidence-based programs are lay-leader models. How do you - or how to frame this with the MCOs?

Sandy Atkins: Typically - are you asking me?

Lauren Solkowski: Yes.

Sandy Atkins: What we've found in our endeavors is that they don't have to be provided by licensed personnel. They have to be supervised by licensed personnel. So, you know, if we've got social workers they're what we in California call a LCSW - it seems to be a Licensed Clinical Social Worker or whatever your state equivalent of that is. The diabetes health management can be a registered dietitian.

So we haven't found that they are requiring that programs be delivered by licensed personnel but rather that they be supervised by health - by personnel. But that - there are also state-managed care requirements.

So generally, I think they're primarily related to NCQA which from what I've seen doesn't require certain services to be delivered by licensed personnel. So that - it may be a state-managed care regulation that they have. Or it may be kind of their fear of delegating to unqualified people.

And it may be their lawyers rather than any regulation. So it's a matter of negotiation. And try to find out - ask them specifically what rule, you know, to quote you a chapter and verse. Sharon might have something else to say about that. The issues come from the other side of the world.

Sharon Williams: I would echo what you've just shared Sandy. In some cases it is going to be driven by a state regulation. I know Illinois for example has some very specific restrictions about someone delivering some of those community-based services even driven down to the level it has to be performed by people that are part of a certain contracted union.

In many other cases where it's not a state mandate or a Medicare - because sometimes it's payer-driven. Medicare or Medicaid only allow for a particular service to be delivered in this kind of facility, by this kind of licensed personnel.

So going back to Sandy, if it's chapter and verse from Medicare or Medicaid or one of those kinds of payers I would look to have that documented in the contract.

And then the other option is that sometimes health plans put those specific provisions in place as a means of defensive management. You know, again driven in sense by the lawyers.

Or sometimes that's just a proclivity of their medical director and their quality improvement team. In that case it may not be a regulatory or legislative mandate but it's the plan's prerogative. And if it's what they've documented in their quality improvement or quality management plan I don't know that you have a lot of wiggle room around it.

Sandy Atkins: Yes. Just yesterday we were on a call with a health plan at the contract negotiation stage. And we're talking about an in-home assessment care transitions.

And they accepted the wording that it could be delivered by a social worker, a community health worker, medical assistant, you know. So they were willing to have all kinds of non-licensed personnel deliver the service as long as it's supervised...

Sharon Williams: Right.

Sandy Atkins: ...by a licensed person. And supervision does not mean they have to be in the same room or necessarily even in the same building.

Sharon Williams: Correct. Sometimes it's just the oversight in over - of review of the work that's been performed to ensure that it's meeting the standards and consistent with the evidence-based review process that's in place.

Lauren Solkowski: Okay. And before we check the phones another question for Sandy. Do you see any potential conflicts of - you represent the plan, so wearing their name badge and secure contracts with more than one plan in the area.

And this question comes from our - (Donnie Green) in our - from the Texas network. And so she writes saying, hi I'm (Donnie Green) and I'm with Molina or I mean Superior. I mean Amerigroup.

Sandy Atkins: One of the things that we've - there are phone systems that can actually - you know, certainly for incoming calls there are phone systems that can show you that it's a Blue Shield caller versus a Molina caller, that kind of thing. For outbound calls I guess it's a matter of training habits and get lots of sleep, you know.

Lauren Solkowski: Right.

Sandy Atkins: So I would say yes. Someday you're going to do - you're probably going to put your foot in it someday. And then that will help you learn.

Lauren Solkowski: Okay. So (Shirley) did we have any questions come in on the phone?

Coordinator: We do have one question. And again just press Star 1 to ask a question. Our first question comes from (Albert Travilian). You may ask your question.

(Albert Travilian): Yes. Hello. Thank you. First thank you very much for these presentations. I thought they were very helpful and very informative. I want to route back into something that Sandy Atkins had mentioned around the Triple Aim.

And I'm seeing in these presentations the chance to address the quality and the cost. I'm wondering if the presenters could talk about how both of these areas could work toward the population level and cover that third part of the Triple Aim.

Sharon Williams: Sandy do you want to go first?

Sandy Atkins: You know, I have a little trouble with population health as a picture in your mind that you're addressing the entire population. But to me it's more that you're looking - population health management comes from looking at data and finding portions of your population that are high-risk and then addressing those through systematic programs that look for high-risk people and take care of their needs.

So it's not, you know, an intervention at the population level but rather an approach to populations by in essence improving individual health on a targeted basis rather than sitting and waiting for people to ask you for things.

So that's where - and in the context of the health plans they have to make the referrals because they have the data on their membership. So they'll say we - and we present our, you know, risk criteria that we think are appropriate for our programs.

So it'll be, you know, they've been in the ED twice in six months, they're taking six or more medications, they've had a recent fall. Whatever the risk criteria is appropriate to the program we're offering.

And then they have to make the referrals based on the data in their system. Does that at all answer?

(Albert Travilian): You know, I think that's a helpful context and a good way to look at it. I'm wondering about how partnering with other types - other agencies that also work in that kind of data level of public health or some other agencies that really kind of section out the population by those pieces.

Sandy Atkins: Your turn Sharon.

Sharon Williams: You know, it's a good point that there are a million organizations and entities that are looking at some of these same kinds of interview population parenthetically.

So if you look from a health plan perspective though when you talk about population - or targeted population and quality management often you're talking in the context of kind of a HEDIS domain if you will.

But when you think of population as, okay, I have 100,000 members and 5,000 of them are listed in my system as asthmatic. So that's a targeted population where I'm going to apply some of the standard evidence-based asthma intervention monitoring programs to provide X, Y and Z service. And this is the outcome I'm trying to achieve.

So one of the quality outcomes is I want to reduce ED visits, I want to reduce inpatient stays, I want to reduce missed work, missed school, what have you, blah, blah, blah.

But what other entities are out there who are interested in that, if I understand your question. Well, certainly school districts have a vested interest in supporting reduced lost time at school.

Employer groups certainly have a vested interest in parents not having to miss work because of sick kids. Or their own employees who are asthmatic. And then certainly the health plans have a vested interest in keeping those asthmatic members as healthy as possible.

So I think you have to look from the perspective of are you talking about a health plan, are you talking about the public health institutions in your community. And then define kind of here's what my population management supports that we can do to help you.

So you might have to - like your resume, you're generic, or if you're applying for a specific job then you have to turn that very generic resume into a very pointed and specific job-oriented tool.

Sandy Atkins: And as far as the public health domain goes, the - one of the entry points for CBOs to become involved in those kind of partnerships is through the - the hospitals have their Community Health Needs Assessments. And they target healthy - typically healthy people, 20-20 kind of measures.

So that's where you can become involved. Sort of like Tarrant County did in a - for example, the community-wide Fall Prevention Initiative. And then bring the kinds of interventions you have to that.

Lauren Solkowski: Okay. Are there any other - do we have any other questions that have come in on the phone?

Coordinator: At this time I'm showing no questions on the phone lines.

Lauren Solkowski: Okay. And actually, (Albert Travilian) I think since we have - we still have two more minutes or so. I noticed that you had sent in another question earlier.

I think this was directed towards Sharon. And it says, how does the recognition of the Person-Centered Medical Home by the NCQA, the National Committee for Quality Assurance, vary from other means of recognizing Person-Centered Medical Homes related to how it will work with CBOs?

Sharon Williams: (Albert Travilian) do you ever ask any easy questions? There are going to be variations. NCQA created this primary care case management - or medical home certification process.

Blue Cross Blue Shield has their own primary care - primary home verification standard as well. And so what the NCQA has done is said, if a provider office meets this particular criteria it's the equivalent of saying you meet certain quality standards that have been established and benchmarked.

Much like the accreditation that NCQA provides to health plans. So there's a certain level of getting the good housekeeping seal of approval or standardized practices that you use, outcome measures, et cetera, et cetera.

How that's going to relate to community-based organizations? I know that NCQA is looking at it as well as URAC who is now accrediting AAAs and other community-based organizations.

I know that they're looking at establishing some standards for that kind of unique AAA/community-based organization benchmarks and accreditations if you will.

But I haven't seen any real detail about how that's going to play out. What I suspect will happen is once NCQA gives it its blessing then the rest of the industry will fall in line. And what you may find, as Sandy mentioned earlier, is it becomes one of the criteria that you have to meet in order to contract with the health plan.

Lauren Solkowski: Okay. Excellent. Thank you, Sharon. And I think we're right about - well, actually we're a little past our time. But before we go I did want to point out - and I'm going to pull it up on Sharon's slides here - that (Mary Kay Shack), (Mary Kay Shack) from (unintelligible), had referenced in our Q and A, the second bullet there, the report from the Commonwealth Fund, at the end of this article there is a nice summary of the quality measures included in the (unintelligible) MOUs by state. So I just wanted to point that out because we thought that would be helpful. And beyond that just thank you everyone for joining us.

Thank you so much to both of our speakers for such informative and comprehensive presentations. And enjoy the rest of your afternoon.

Sharon Williams: Thank you very much Lauren. Great job Sandy.

Sandy Atkins: It's been a pleasure. Thanks Sharon.

Coordinator: This does conclude today's conference. We thank you for your participation.
At this time you may disconnect your line.

END