How to Measure Health Improvement for On-Site Employee Health Clinics

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Objectives

- Understand how patient-centered medical home (PCMH) and culture drive health outcomes
- Identify where you are in establishing baseline data
- Leverage the use of electronic medical record (EMR) and health risk assessment (HRA)
- Identify keys to successful reporting over time

Huntington Ingalls Industries

- Nearly 40,000 employees
- America's largest military shipbuilding company
- Exclusive supplier of nuclear powered aircraft carriers for the U.S. Navy
- Largest employer in MS and largest industrial employer in VA

"Hard Stuff, Done Right"

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Onsite Family Health Centers

- Why?
  - Self-insured
  - Rising healthcare costs
  - High emergency department (ED) utilization
  - “It’s the right thing to do!”
- Two locations
  - Excludes occupational health
- Open six days a week
  - 7 a.m. – 6 p.m. Monday through Friday
  - 8 a.m. – 12 p.m. Saturday
- Appointment-based system
- Onsite lab, X-ray, pharmacy, physical therapy, dental and vision
- Eligibility
  - Employees, retirees and dependents on company health plan

Creating a Culture of Wellbeing

- Executive support
- Making the connection between wellbeing and employee safety
- Constantly assessing data to identify needs
  - Health care needs
  - Financial well-being
  - Wellness coaches
- Full-time EAP provider
- Focus and outreach:
  - Medically homeless
  - Chronic disease management
    - Diabetes
    - Hypertension
    - Substance abuse
  - High ED utilizers

Patient-Centered Medical Home (PCMH)

- Choosing a vendor
  - Ownership
  - Expertise
- Aligning the PCMH between company and vendor
  - Outreach and patient engagement
  - Outcome focused
  - Understanding opportunity for impact
- Evolving
  - Developing resources and initiatives

PCMH + Culture of Well-being

YEAR 1	YEAR 2	YEAR 3

Focus on patient satisfaction, utilization and engagement.

- The primary focus for the first year is to engage employees in the health and wellness center services and offerings. In the first year, the best way to measure immediate impact is through patient satisfaction.

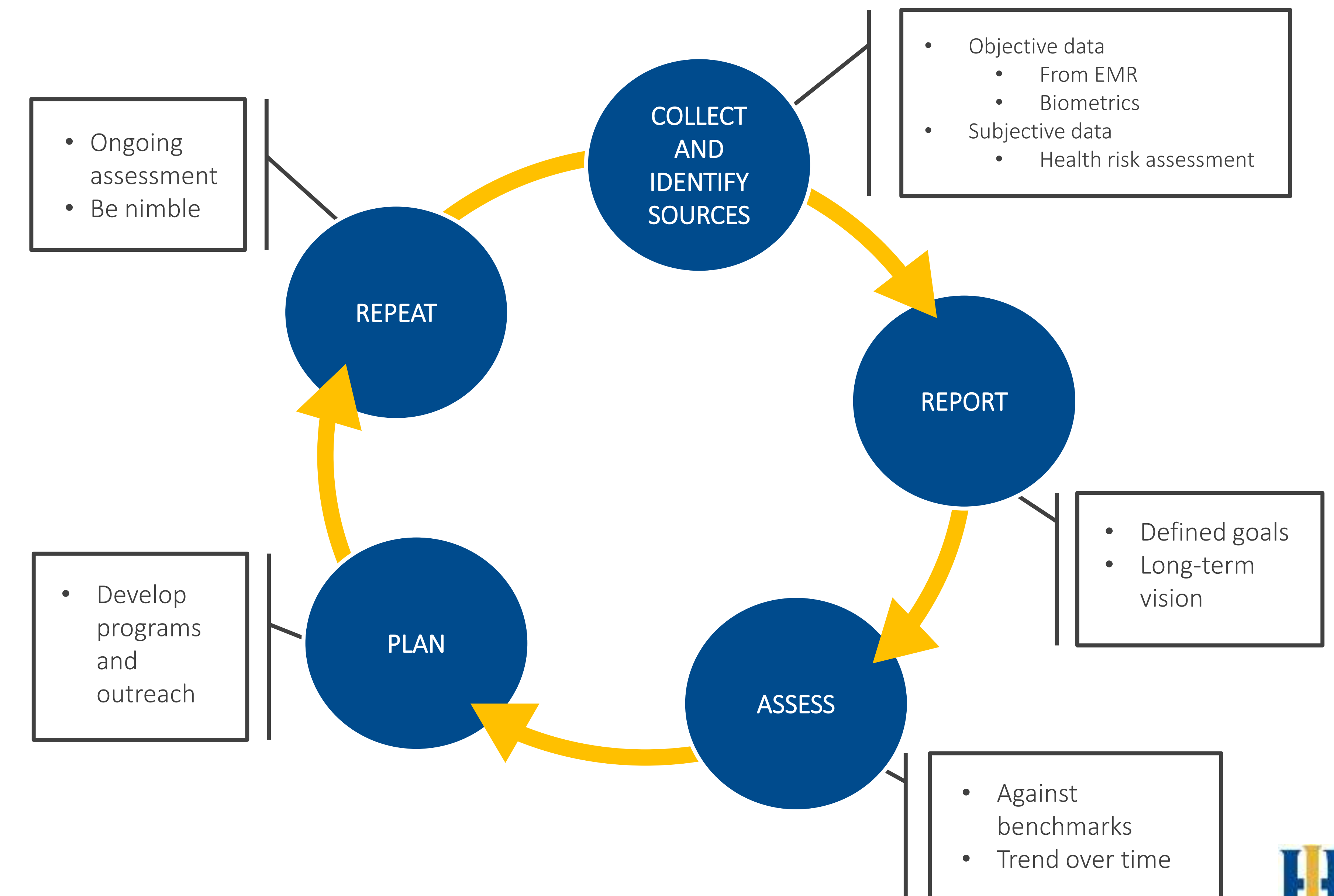
Measuring health outcomes.

- Longitudinal claims data and benchmarking data are available to measure the impact and report on population health improvements via cohort analysis, reductions in downstream utilization, etc.

Outcomes and utilization.

- By year three, the best measures of impact is utilization and health outcomes.

Collect, Report, Assess, Plan, Repeat



Step 1: Establish Goals

** Information provided by QuadMed*

	2017 Plan	Actual	Achieved	2018 Goal
A1c over 9% *n=283*	<15%	10%	✓	12%
Eye Exam *n=283*	19.25%	47.5%	✓	60%*
Foot Exam *n=283*	47.3%	86.5%	✓	90%

- Eye exam goal is dependent on the onboarding of the onsite vision centers.

Step 2: Establish Benchmarks

** Information provided by QuadMed*

Diabetic Risk Reduction		Newport News				Pascagoula			
	National Benchmark	Members	2016	2017	2018 Goal	Members	2016	2017	2018 Goal
Blood Pressure Control	80%	108	76%	81%	86%	175	62%	71%	86%
A1c Control	68%	108	27%	51%	50%	175	26%	34%	50%
Statin Therapy	79%	92	66%	78%	80%	161	70%	78%	80%
Renal Screening	36%	105	74%	90%	90%	171	78%	95%	90%
Eye Exam	60%	108	16%	53%	60%	175	23%	42%	60%
Foot Exam	80%	108	34%	88%	90%	175	52%	82%	90%
Tobacco Free Status	93%	108	86%	94%	93%	175	82%	79%	93%

Higher percentages are better

1. PCP patients with Diabetes will have blood pressure in control. This measure assesses the percentage of PCP adult patients whose most recent blood pressure reading within the measurement period is controlled to a rate of less than 140/90 mmHg.
2. Patients with Diabetes will have A1c in good control. Good Control is an A1c level less than 8.0%
3. Patients with Diabetes will be on statin therapy, unless contraindicated
4. PCP patients with a diagnosis of diabetes who were screened and/or monitored for kidney disease in the measurement year.
5. PCP patients with a diagnosis of diabetes who were screened for diabetic Retinopathy
6. PCP patients with a diagnosis of diabetes will have a foot exam at least once annually
7. PCP patients with a diagnosis of diabetes will be tobacco free

National Benchmark based off of National Committee of Quality Assurance (NCQA) HEDIS Metric and it is reflective of the 90th percentile.
[1]National Benchmark based off of HealthyPeople 2020 Projected Goal.

Step 3: Trend over time

** Information provided by QuadMed*

Diabetic Risk Reduction		Newport News				Pascagoula			
	National Benchmark	Members	2016	2017	2018 Goal	Members	2016	2017	2018 Goal
A1c over 9%	15%	108	10%	8%	12%	175	13%	12%	12%

Lower percentages are better

PCP patients with uncontrolled Diabetes will be less than 15%

National Benchmark based off of National Committee of Quality Assurance (NCQA) HEDIS Metric and it is reflective of the 90th percentile.

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Establish Goal

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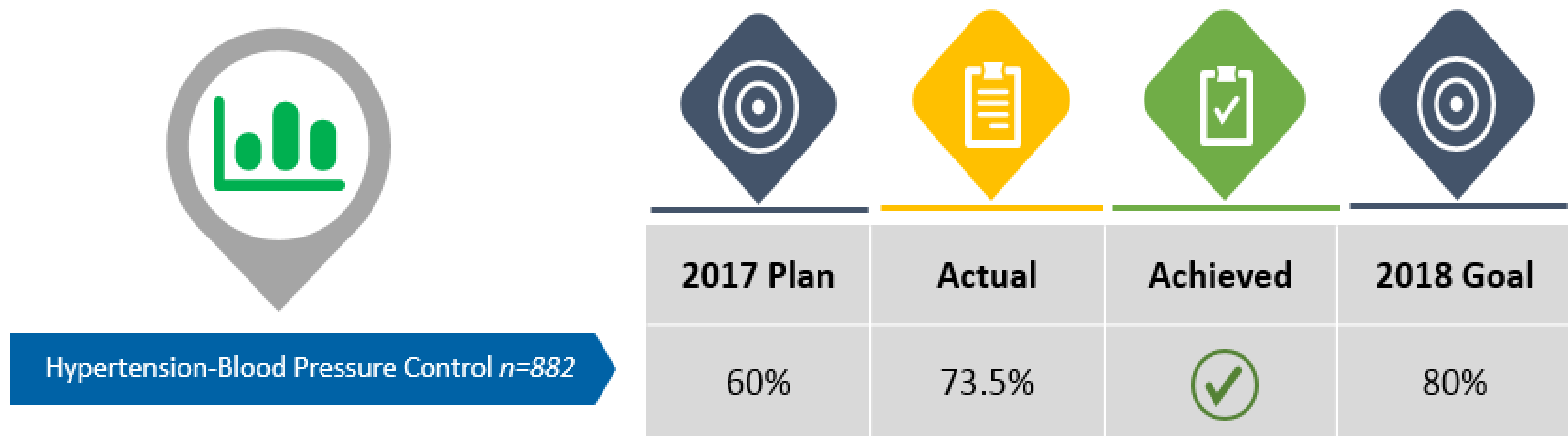

2017 Plan	Actual	Achieved	2018 Goal
60%	73.5%	✓	80%

- The American College of Cardiology (ACC) and the American Heart Association (AHA) recommend that blood pressure is measured at every routine visit and that the systolic blood pressure is less than 140 mmHg and the diastolic blood pressure is less than 90 mmHg.
- This measure shows the percentage of adult PCP patients with a diagnosis of hypertension whose most recent blood pressure reading within the measurement period is controlled to a rate of less than 140/90 mmHg.

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Establish Benchmarks

** Information provided by QuadMed*

Cardiac Risk Reduction		Newport News				Pascagoula			
	National Benchmark	Members	2016	2017	2018 Goal	Members	2016	2017	2018 Goal
HTN Blood Pressure Control	75%	418	-	75%	80%	464	-	72%	80%
Blood Pressure Control	68%	1660	79%	83%	85%	1008	62%	80%	85%
Statin Therapy	64%	242	54%	60%	65%	331	55%	59%	65%
Tobacco Free Status	90%	1660	87%	90%	90%	1008	73%	83%	90%

Higher percentages are better

1. Patients with a diagnosis of hypertension
2. Patients at risk for coronary and other atherosclerotic vascular disease
3. Patients with coronary and other atherosclerotic vascular disease will be on statin therapy, unless contraindicated
4. Patients with coronary and other atherosclerotic vascular disease will be tobacco free

National Benchmark based off of National Committee of Quality Assurance (NCQA) HEDIS Metric and it is reflective of the 90th percentile
[1]National Benchmark based off of HealthyPeople 2020 Projected Goal

Preventive Care is Important Too!

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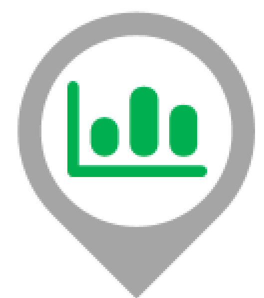


	2017 Plan	Actual	Achieved	2018 Goal
Depression Screening *n=2,306*	82.5%	88%	✓	90%
Colon Cancer Screening *n=947*	17%	58%	✓	72%
Cervical Cancer Screening *n=877*	20%	53%	✓	73%
Breast Cancer Screening *n=424*	27%	63.5%	✓	70%

Preventive Services Over Time

** Information provided by QuadMed*

Preventive Services		Newport News				Pascagoula			
	National Benchmark	Members	2016	2017	2018 Goal	Members	2016	2017	2018 Goal
Depression Screening	30%	1488	87%	83%	90%	818	60%	93%	90%
Colon Cancer Screening	48%	536	18%	68%	72%	411	12%	48%	72%
Cervical Cancer Screening	45%	559	20%	64%	73%	318	19%	42%	73%
Breast Cancer Screening	80%	228	21%	69%	70%	196	30%	58%	70%

Higher percentages are better

1. Adolescents (12-18 years)and Adults 18 and older will be screened for depression annually
2. Men and women, at age 50 and older should have had a colorectal cancer screening (colonoscopy)
3. Women who should have had one or more cervical cancer screening tests during the previous 36 months or one cervical cancer screening test and a human papillomavirus test within the last 5 years.
4. Women who should have had at least one mammogram within the previous 24 months

[1]National Benchmark based off of Center for Medicare and Medicaid Services (CMS) goal

National Benchmark based off of National Committee of Quality Assurance (NCQA) HEDIS Metric and it is reflective of the 90th percentile

Screening metrics follow United States Preventive Task Force Guidelines

The Patient Perspective

** Information provided by QuadMed*

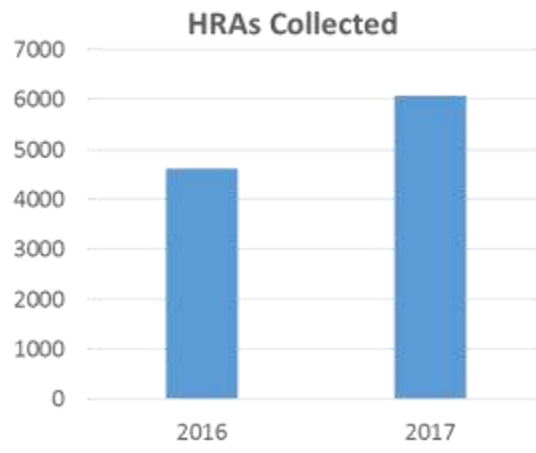
Health Risk Assessment (HRA)

Wellness Online Members/Logins

6,646/13,490

HRAs Collected

6,080 ➡ 62% of *all eligible



*Eligibility is patients 18 years of age that have a provider visits one in the given time period

Wellness Score, Cohort

569 PCP patients who had at least two visits to the health center

43% **showed health behavior improvements** (average 12 point increase)

Wellness Score, All

Notable Health Improvements:

- **Employee 1, 49 points:** 40 y/o; male; engaged with Health Center PCP and Diabetes Educator; A1C from 15.3 to 6.6, blood pressure from 144/98 to 128/78; walking 15,000 steps a day.
- **Employee 2, 45 points:** 52 y/o; female; engaged with Health Center PCP; Diabetes Educator and Physical Therapy, cholesterol down 28 points; quit smoking.
- **Employee 3, 39 points:** 43 y/o; male; engaged with Health Center PCP; Diabetes Educator and Wellness Coach; 10lb weight loss; blood pressure from 144/90 to 112/78.

Risk Review

** Information provided by QuadMed*

Health Risk Assessment (HRA)

In general, my health is...

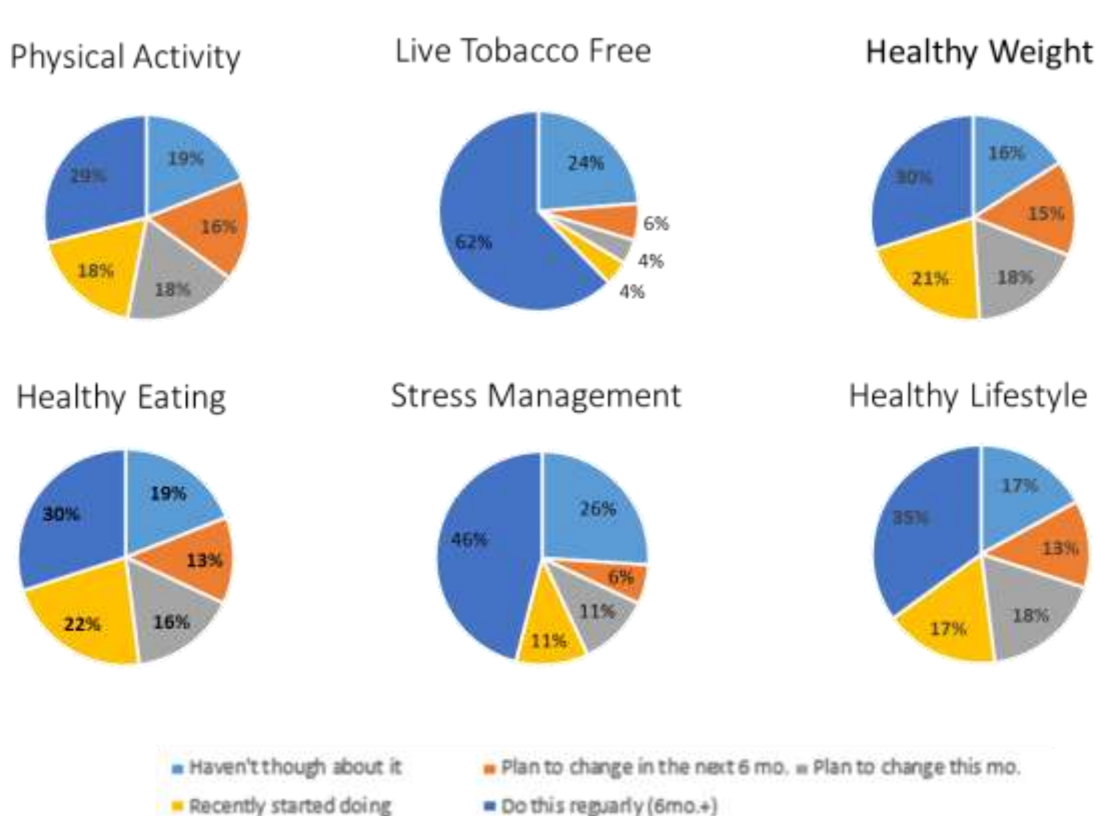
	Excellent	Very Good	Good	Fair	Poor
2016	13	38	39	9	1
2017	12	37	48	2	1

	High	Moderate	Low
NUTRITION 2016	21	4	75
NUTRITION 2017	28	53	19
PHYSICAL ACTIVITY 2016	13	17	70
PHYSICAL ACTIVITY 2017	31	53	16
ALCOHOL USE 2016	21	16	62
ALCOHOL USE 2017	13	17	70
STRESS AND COPING 2016	10	19	71
STRESS AND COPING 2017	8	20	72
TOBACCO USE 2016	21	2	77
TOBACCO USE 2017	17	5	78
SEAT BELT USE 2016	4	6	90
SEAT BELT USE 2017	5	11	84

Readiness to Change

** Information provided by QuadMed*

Health Risk Assessment (HRA)



Next Steps:

- Meet people where they're at
- Offer options for high, moderate and low risk groups
  - Target and outreach to individuals based on readiness to change
- Collaborate with communications to target specific health behaviors and market available wellness services
  - Fitness Program Design—NEW service
- Continue to administer HRA and pre- and post-program surveys to assess behavior change
- Collaborate with other health vendors to offer optimal programming offerings

Patient Success Story

October 2016 – October 2017

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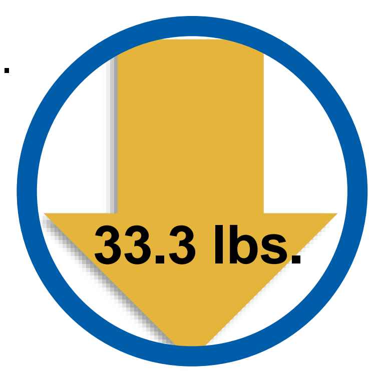
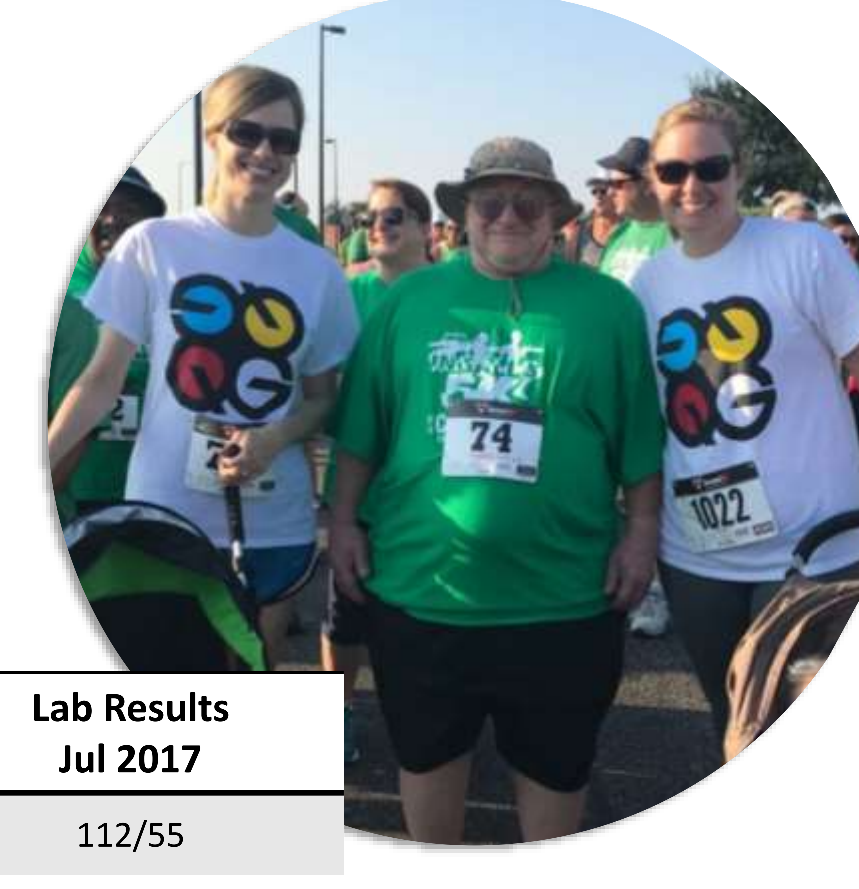


Starting weight: 231.5 lbs.

Current weight: 198.2 lbs.



	Lab Results Sep 2016	Lab Results Jul 2017
Blood Pressure	190/102	112/55
Total Cholesterol	240	213
LDL	151.6	137
Triglyceride	232	210
A1C	6.6	6.2

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Value On Investment (VOI)

"Crossing the finish line at the 5K was an exhilarating experience for me! I have gone on to complete two more 5K events in less than a year. I owe my success to the wonderful staff at QuadMed for inspiring me to achieve these goals and more!"

- HII employee

- Realized sooner than ROI
- Has longer lasting results than impact on health plan and spend

Hitting the Objectives….

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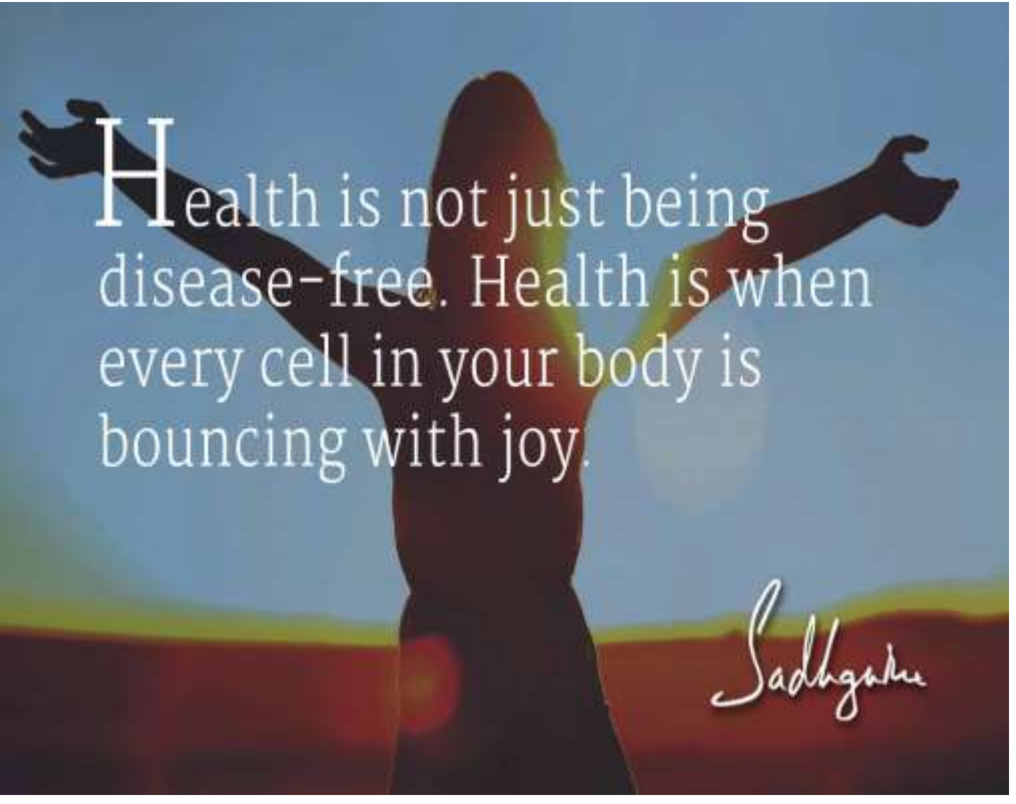
Questions and Comments



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