Achieving NCQA accreditation

In an increasingly competitive health care marketplace, more MCOs aim to distinguish themselves by achieving health plan accreditation from the National Committee for Quality Assurance (NCQA). If your MCO is pursuing NCQA accreditation, asthma home visiting services can help.

Specifically, asthma home visiting services can enhance several different components of NCQA's population health management (PHM) requirements. Below are some key excerpts from the *2018 HP Standards and Guidelines for the Accreditation of Health Plans* (the Standards).

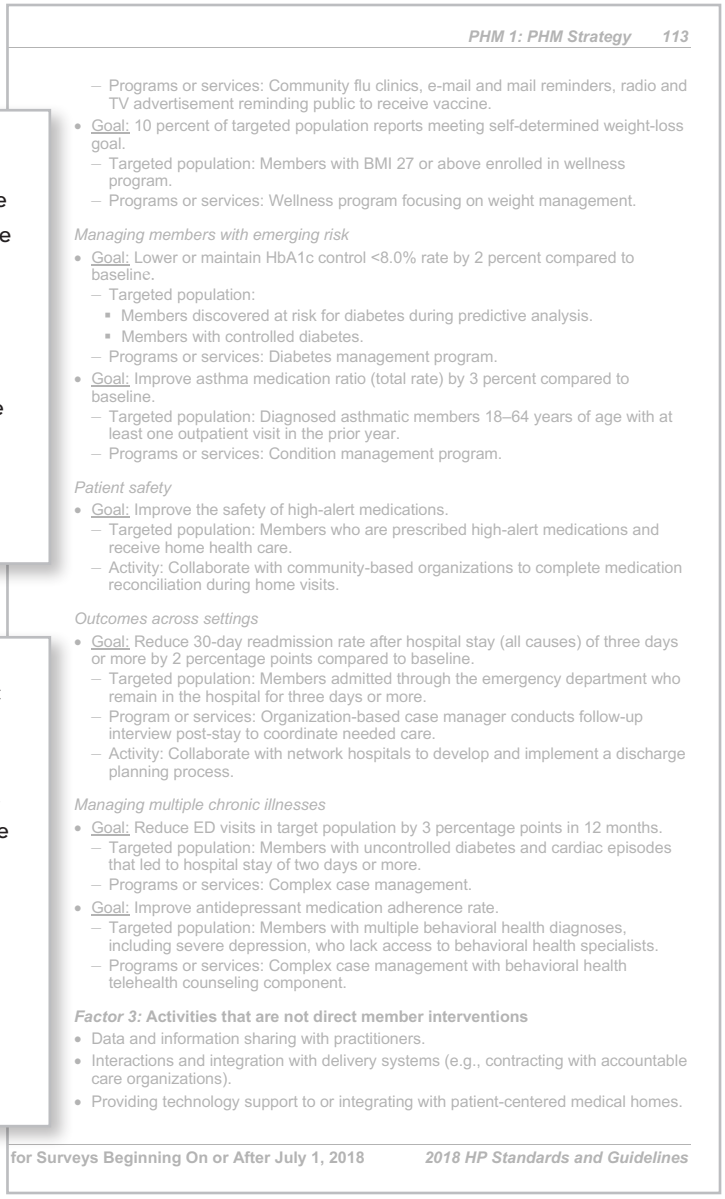
PHM 1: PHM Strategy

As part of an MCO's comprehensive strategy for meeting the needs of its members, in Factor 1 of Element A: Strategy Description, there are four areas of focus. Asthma home visiting services can help address two of them (right).

For both areas of focus, asthma home visiting services can help demonstrate an MCO's comprehensive PHM strategy.

Managing members with emerging risk: Among those diagnosed with asthma, there are different levels of risk; home visiting services are typically offered to those with the highest risk. Within the Standards, asthma is one of the examples provided for managing members with emerging risk.

Managing multiple chronic illnesses: Asthma can present with a variety of comorbidities. For example, in California adults who have respiratory co-morbidities, such as COPD, are also significantly less likely to have well controlled asthma (35.5%) than those who do not have respiratory co-morbidities (60.6%).



PHM 1: PHM Strategy 113

– Programs or services: Community flu clinics, e-mail and mail reminders, radio and TV advertisement reminding public to receive vaccine.
- Goal: 10 percent of targeted population reports meeting self-determined weight-loss goal.
  – Targeted population: Members with BMI 27 or above enrolled in wellness program.
  – Programs or services: Wellness program focusing on weight management.

Managing members with emerging risk
- Goal: Lower or maintain HbA1c control <8.0% rate by 2 percent compared to baseline.
  – Targeted population:
    ▪ Members discovered at risk for diabetes during predictive analysis.
    ▪ Members with controlled diabetes.
  – Programs or services: Diabetes management program.
- Goal: Improve asthma medication ratio (total rate) by 3 percent compared to baseline.
  – Targeted population: Diagnosed asthmatic members 18–64 years of age with at least one outpatient visit in the prior year.
  – Programs or services: Condition management program.

Patient safety
- Goal: Improve the safety of high-alert medications.
  – Targeted population: Members who are prescribed high-alert medications and receive home health care.
  – Activity: Collaborate with community-based organizations to complete medication reconciliation during home visits.

Outcomes across settings
- Goal: Reduce 30-day readmission rate after hospital stay (all causes) of three days or more by 2 percentage points compared to baseline.
  – Targeted population: Members admitted through the emergency department who remain in the hospital for three days or more.
  – Program or services: Organization-based case manager conducts follow-up interview post-stay to coordinate needed care.
  – Activity: Collaborate with network hospitals to develop and implement a discharge planning process.

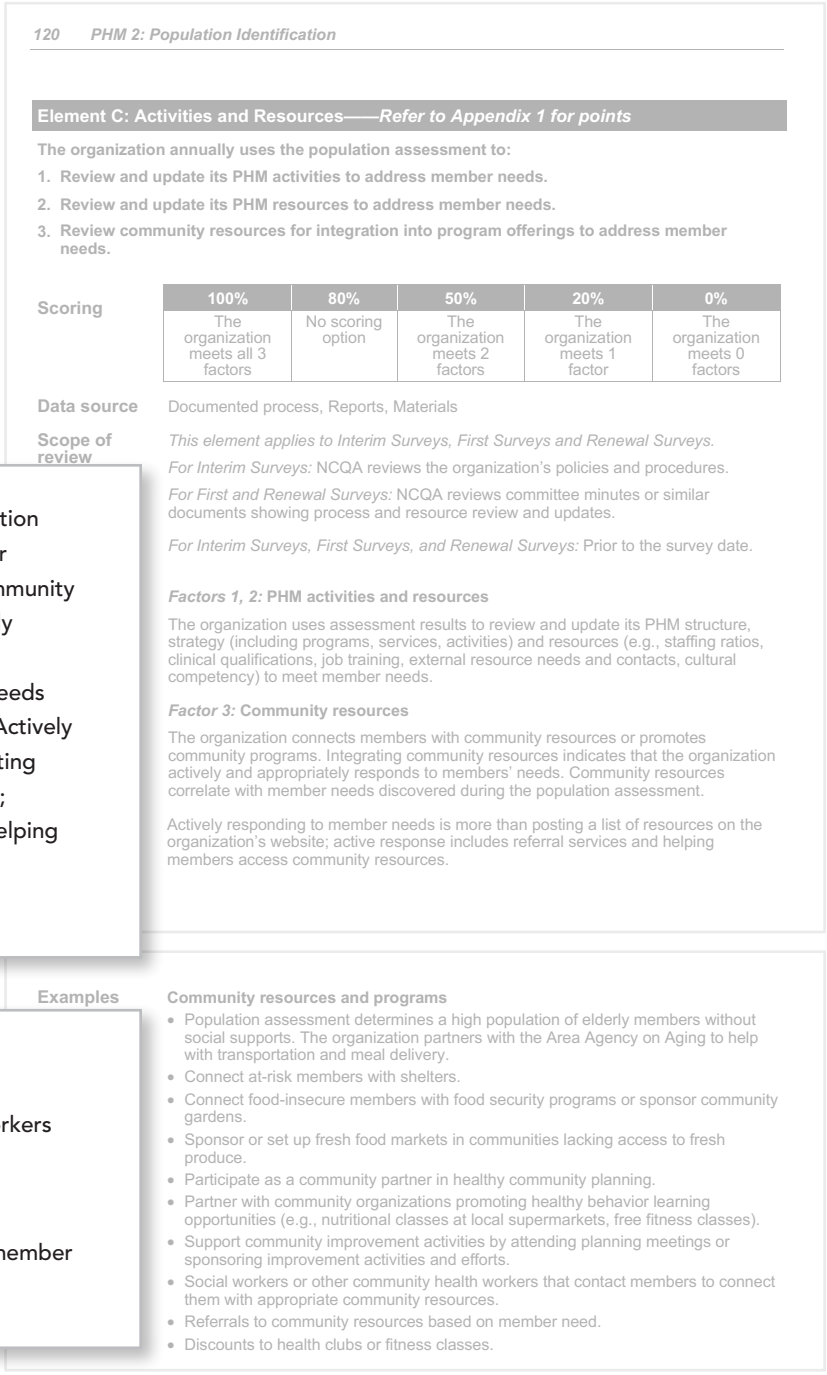
Managing multiple chronic illnesses
- Goal: Reduce ED visits in target population by 3 percentage points in 12 months.
  – Targeted population: Members with uncontrolled diabetes and cardiac episodes that led to hospital stay of two days or more.
  – Programs or services: Complex case management.
- Goal: Improve antidepressant medication adherence rate.
  – Targeted population: Members with multiple behavioral health diagnoses, including severe depression, who lack access to behavioral health specialists.
  – Programs or services: Complex case management with behavioral health telehealth counseling component.

***Factor 3:* Activities that are not direct member interventions**
- Data and information sharing with practitioners.
- Interactions and integration with delivery systems (e.g., contracting with accountable care organizations).
- Providing technology support to or integrating with patient-centered medical homes.

for Surveys Beginning On or After July 1, 2018 *2018 HP Standards and Guidelines*

PHM 2: Population Identification

Asthma home visiting services can also help MCOs to assess the needs of its population and determine actionable categories for appropriate interventions. Specifically, these services can help MCOs review community resources for integration into program offerings to address member needs. From Element C: Activities and Resources:



120 PHM 2: Population Identification

Element C: Activities and Resources——*Refer to Appendix 1 for points*

The organization annually uses the population assessment to:

1. **Review and update its PHM activities to address member needs.**
2. **Review and update its PHM resources to address member needs.**
3. **Review community resources for integration into program offerings to address member needs.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 3 factors	No scoring option	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Reports, Materials

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

For Interim Surveys: NCQA reviews the organization's policies and procedures.

For First and Renewal Surveys: NCQA reviews committee minutes or similar documents showing process and resource review and updates.

For Interim Surveys, First Surveys, and Renewal Surveys: Prior to the survey date.

***Factors 1, 2:* PHM activities and resources**

The organization uses assessment results to review and update its PHM structure, strategy (including programs, services, activities) and resources (e.g., staffing ratios, clinical qualifications, job training, external resource needs and contacts, cultural competency) to meet member needs.

***Factor 3:* Community resources**

The organization connects members with community resources or promotes community programs. Integrating community resources indicates that the organization actively and appropriately responds to members' needs. Community resources correlate with member needs discovered during the population assessment.

Actively responding to member needs is more than posting a list of resources on the organization's website; active response includes referral services and helping members access community resources.

Examples

Community resources and programs

- Population assessment determines a high population of elderly members without social supports. The organization partners with the Area Agency on Aging to help with transportation and meal delivery.
- Connect at-risk members with shelters.
- Connect food-insecure members with food security programs or sponsor community gardens.
- Sponsor or set up fresh food markets in communities lacking access to fresh produce.
- Participate as a community partner in healthy community planning.
- Partner with community organizations promoting healthy behavior learning opportunities (e.g., nutritional classes at local supermarkets, free fitness classes).
- Support community improvement activities by attending planning meetings or sponsoring improvement activities and efforts.
- Social workers or other community health workers that contact members to connect them with appropriate community resources.
- Referrals to community resources based on member need.
- Discounts to health clubs or fitness classes.

Factor 3: Community resources: The organization connects members with community resources or promotes community programs. Integrating community resources indicates that the organization actively and appropriately responds to members' needs. Community resources correlate with member needs discovered during the population assessment. Actively responding to member needs is more than posting a list of resources on the organization's website; active response includes referral services and helping members access community resources.

Examples:

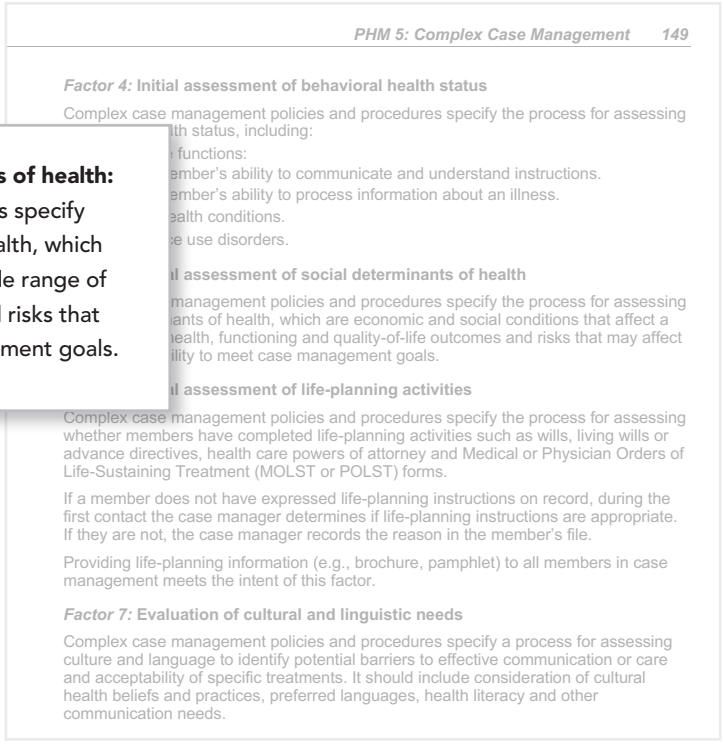
- Social workers or other community health workers that contact members to connect them with appropriate community resources.
- Referrals to community resources based on member need.

Local public health departments or community-based organizations offering asthma home visiting services would likely jump at the chance to create connections with MCOs to increase access to these services. For those cases where MCOs already offer asthma home visiting services in-house, you can still identify and refer to additional community resources. For example, staff with Contra Costa Health Plan's home visiting program provide referrals to the County's weatherization program.

PHM 5: Complex Case Management

One factor in Element C of the Complex Case Management Standard requires MCOs to assess and respond to a members' social determinants of health — those social, environmental and economic conditions that affect health, well-being, and capacity to follow a care plan. Typically, asthma home visiting services identify and help remediate any environmental triggers contributing to a member's poorly controlled asthma. Home visitors also connect the member to other community-based resources — such as legal aid services to help tenants correct housing code problems caused by landlords — that can affect health.

Factor 5: Initial assessment of social determinants of health: Complex case management policies and procedures specify the process for assessing social determinants of health, which are economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes and risks that may affect a member's ability to meet case management goals.



PHM 5: Complex Case Management 149

Factor 4: **Initial assessment of behavioral health status**

Complex case management policies and procedures specify the process for assessing
lth status, including:
functions:
ember's ability to communicate and understand instructions.
ember's ability to process information about an illness.
alth conditions.
e use disorders.

l assessment of social determinants of health

management policies and procedures specify the process for assessing
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ealth, functioning and quality-of-life outcomes and risks that may affect
ility to meet case management goals.

l assessment of life-planning activities

Complex case management policies and procedures specify the process for assessing whether members have completed life-planning activities such as wills, living wills or advance directives, health care powers of attorney and Medical or Physician Orders of Life-Sustaining Treatment (MOLST or POLST) forms.

If a member does not have expressed life-planning instructions on record, during the first contact the case manager determines if life-planning instructions are appropriate. If they are not, the case manager records the reason in the member's file.

Providing life-planning information (e.g., brochure, pamphlet) to all members in case management meets the intent of this factor.

Factor 7: **Evaluation of cultural and linguistic needs**

Complex case management policies and procedures specify a process for assessing culture and language to identify potential barriers to effective communication or care and acceptability of specific treatments. It should include consideration of cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

Leading the Way to Better Breathing: Managed Care Organizations and Asthma Home Visiting Services in California Produced by Regional Asthma Management and Prevention, a project of the Public Health Institute. For the full document, including references, please visit **www.rampasthma.org**.

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