

Opportunities to Improve Obesity Assessment and Treatment Through Measurement and Accountability



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Agenda

- **NCQA Obesity Initiative**
 - Importance of Measurement
 - Focus on Obesity
 - Development and Testing
 - Adults
 - Children/Adolescents
- **Health Plan Strategies to Combat Obesity**

NCQA: Committed to Measurement, Transparency, Accountability

Quality measurement means:

- Use of objective measures based on evidence
- Results that are comparable across organizations
- Impartial third-party evaluation and audit
- Public Reporting

NCQA's quality programs include:

- Accreditation of health plans using performance data
- HEDIS clinical measures
- CAHPS consumer survey
- Measurement of quality in provider groups
- Physician Recognition



NCQA Home About NCQA About Accreditation

Plan Performance: ★★★★★ best, ★★★★★ very good, ★★★ good, ★ fair, ○ poor

Here are the results of your search:

Plan	Product Line/Product	Access & Service	Qualified Providers	Staying Healthy	Getting Better	Living with Illness	Overall Accreditation
Plan Alpha	Commercial/HMO	★★★★	★★	★★★★	★★	★★	EXCELLENT
Plan Beta	Commercial/POS	★★	★	★	★★★★	★	ACCREDITED
Plan Delta	Commercial/POS	★★	○	★★	★	★	PROVISIONAL
Plan Gamma	Commercial/HMO	★★★	★★	★★	★★	★★★★	COMMENDABLE



What is HEDIS®?

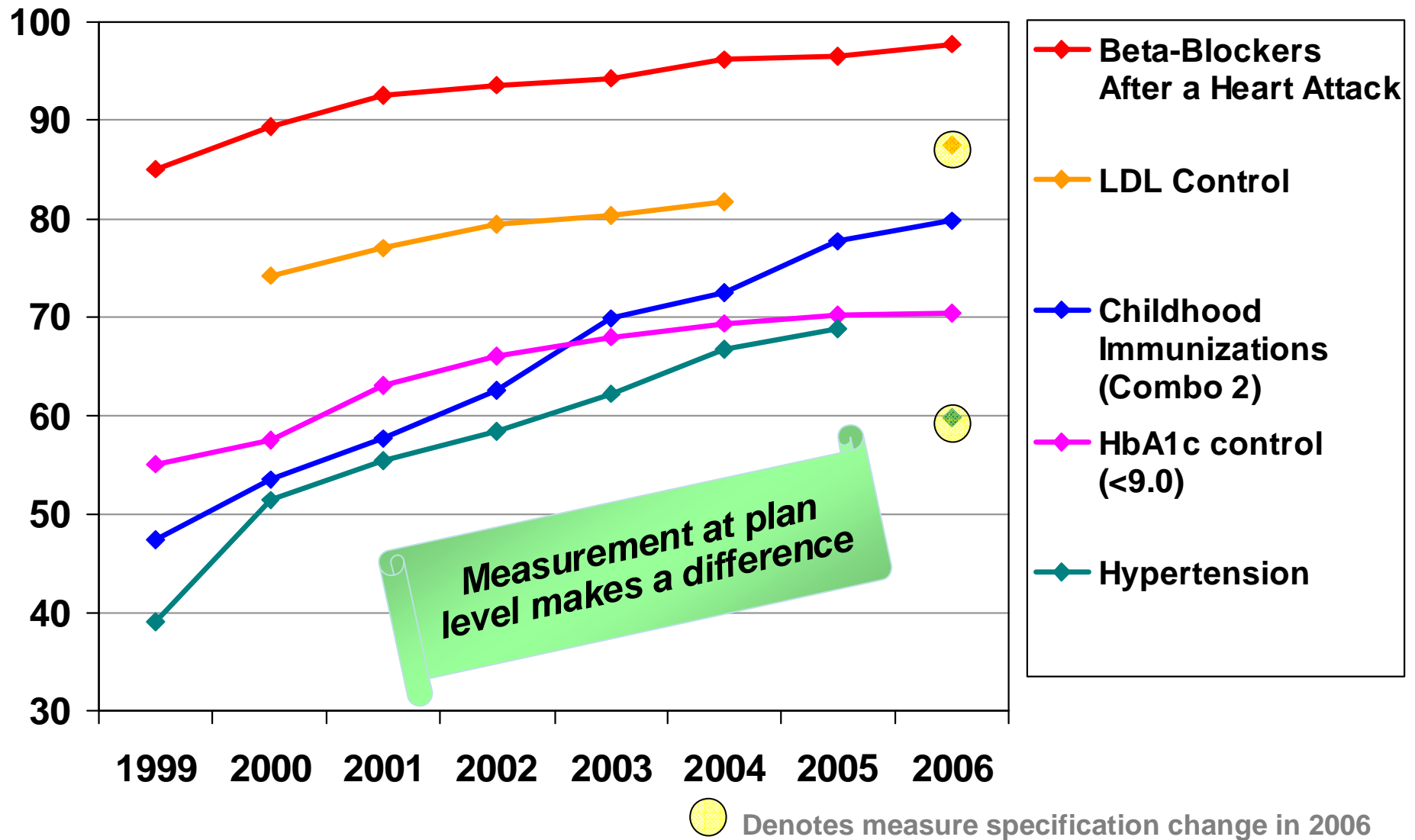
The Health Care Effectiveness Data and Information Set:

- Over 70 process and outcomes measures
- Standardized member satisfaction survey
- Used by Commercial, Medicare, and Medicaid plans alike

Key Design Features of Measures

- Relevance
 - **meaningfulness, clinical importance, financial importance, cost effectiveness, controllability, variance among plans, potential for improvement**
- Scientific Soundness
 - **reproducibility, validity, accuracy, risk adjustable, comparability of data sources**
- Feasibility
 - **data sources, collection, and reporting methods specified, reasonable cost, assures confidentiality, (auditable)**

Measurement Leads to Improvement



Research Objectives

Explore the validity and feasibility of performance measures assessing if health plan members have their BMI assessed and documented by a clinician

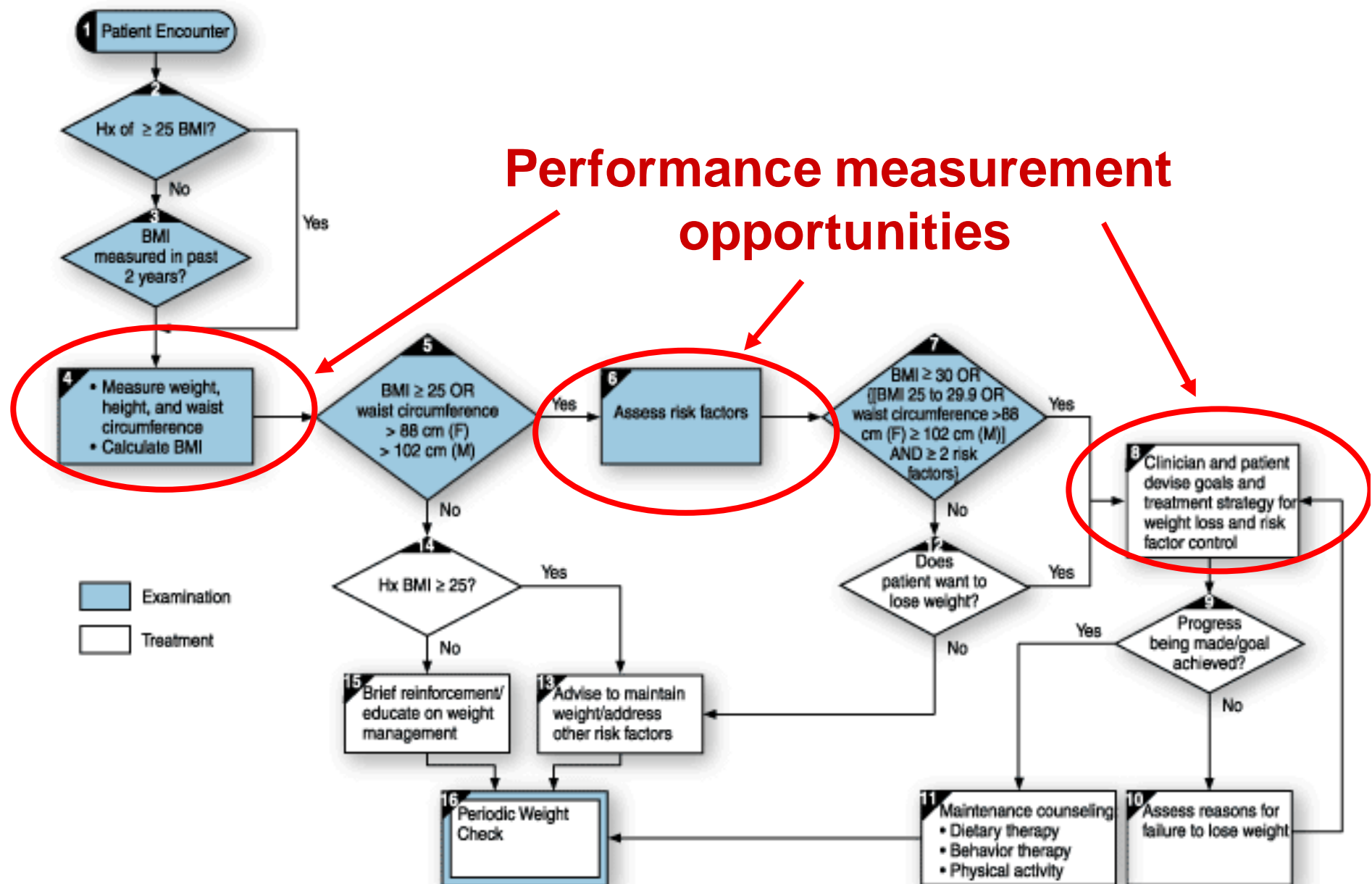
Adults: BMI documentation over a 2-year period

Children/Adolescents: BMI percentile and counseling for physical activity and nutrition documented annually

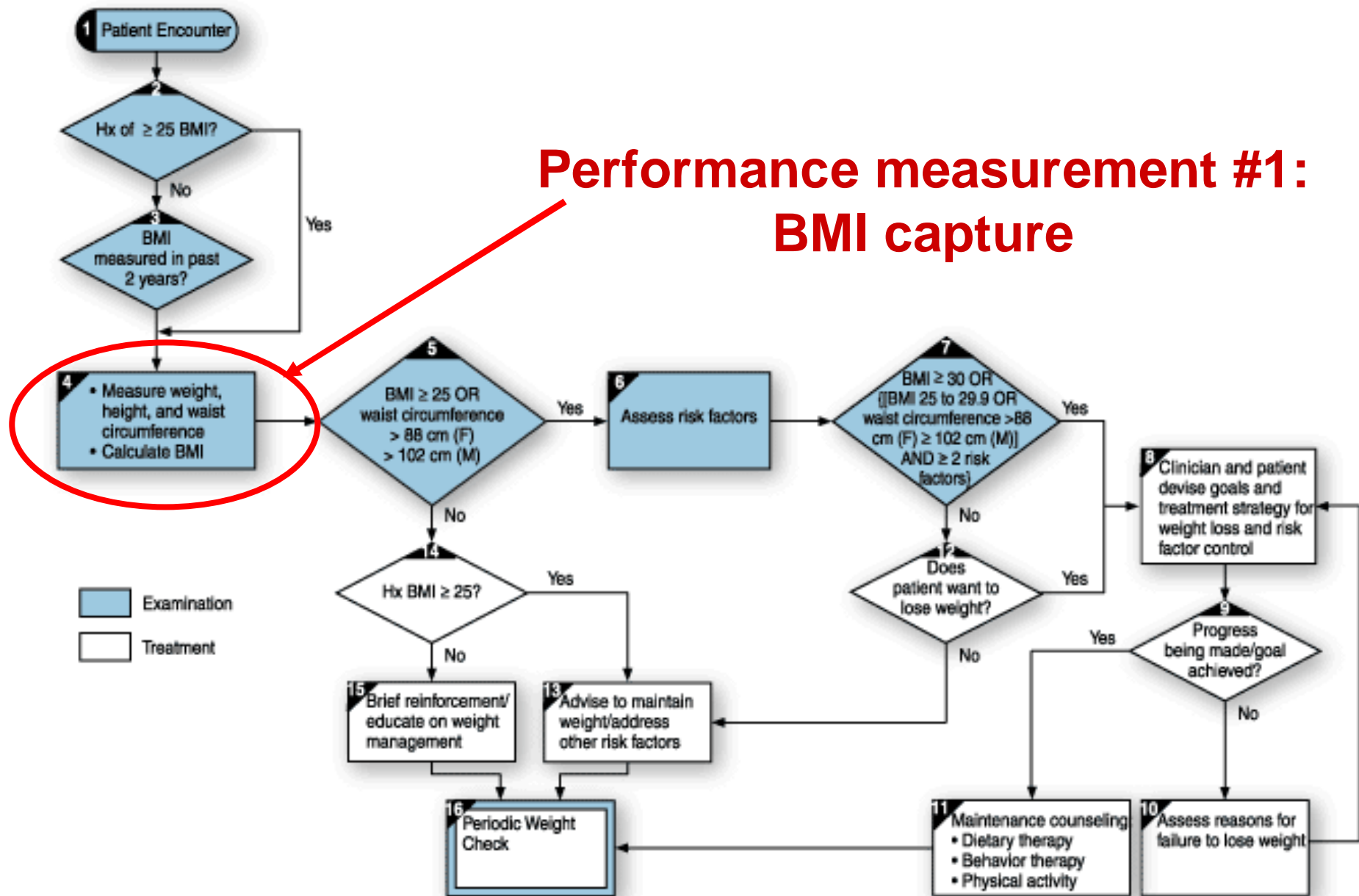
Importance

- Nearly two thirds of US adults are overweight (BMI ≥ 25), and over 30% are obese (BMI ≥ 30).
- Nearly 18% of American children are overweight or obese (BMI $\geq 95^{\text{th}}$ percentile for age and gender).
- Increased deaths per year due to poor diet/inactivity.

NIH Obesity Treatment Algorithm



NIH Obesity Treatment Algorithm



Adults: BMI Assessment

- **Measure Description:**
 - The percentage of members 18 – 74 years of age who had an outpatient office visit and who had their body mass index (BMI) documented in the measurement year or year prior.
- **Commercial, Medicaid and Medicare product lines**
- **Constructed as a hybrid measure**
 - ICD-9 codes exist for BMI Assessment, however, rarely used

BMI Percentile Assessment, Counseling for Nutrition and Physical Activity

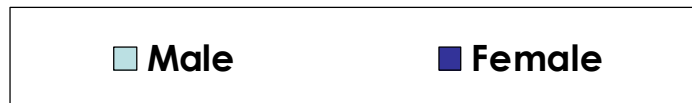
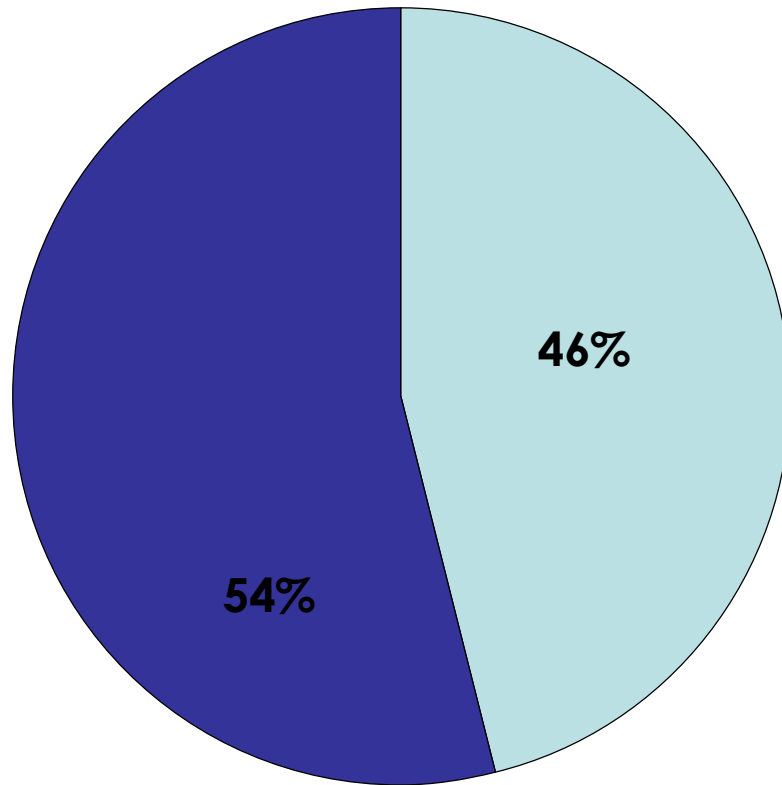
- **Measure Description:**
 - The percentage of members, ages 2 – 17 years of age who had an outpatient visit with a PCP or OB/GYN and evidence of the following during the measurement year:
 - BMI Percentile Assessment
 - Counseling for Nutrition
 - Counseling for Physical Activity
- **Commercial and Medicaid product lines**
- **Constructed as a hybrid measure**
 - ICD-9 codes exist for BMI Assessment, however, rarely used

Adult Field-Test Data Characteristics

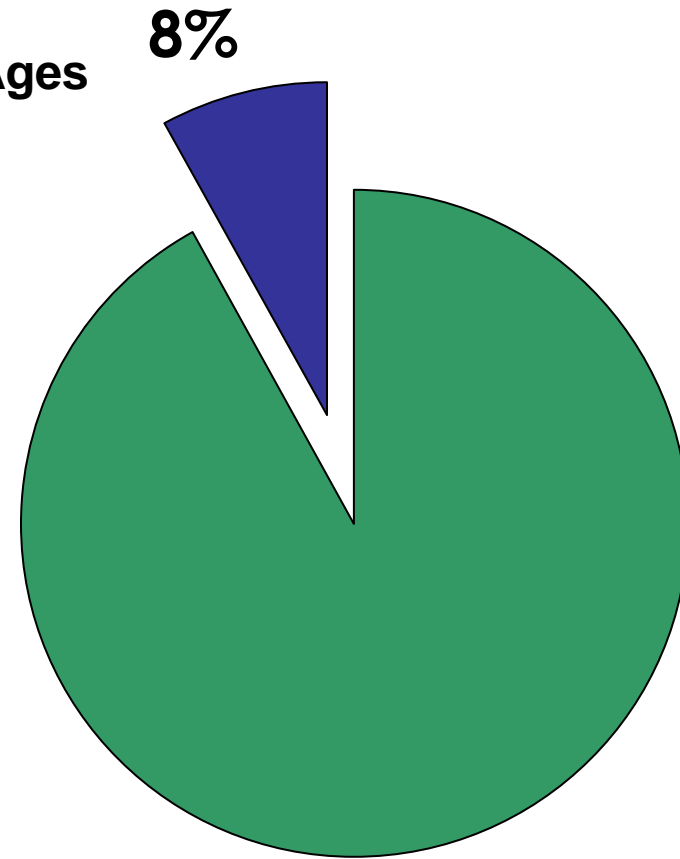
Number of Records Submitted by Plans			
Plan/Product	Admin Records	Medical Records	Percent EMR
A	9,575	150	100%
B	196,631	330	18.5%
C	337,287	124	50.8%
Commercial	502,563	345	46.4%
Medicaid	3,434	54	100%
Medicare	37,496	205	29.7%
Total	543,493	604	-

Member Demographics

Gender

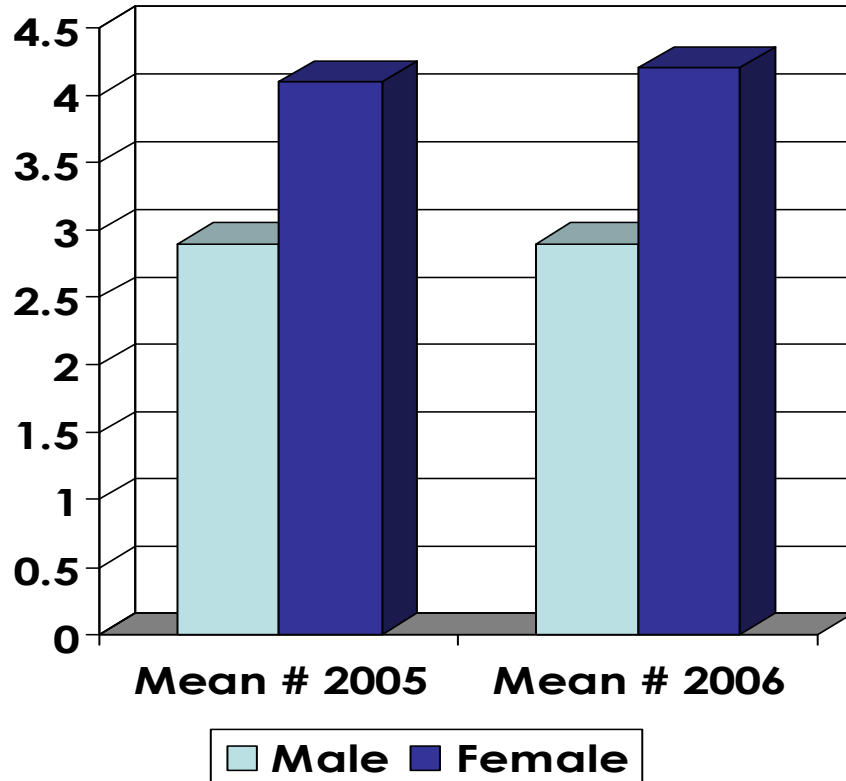


Ages

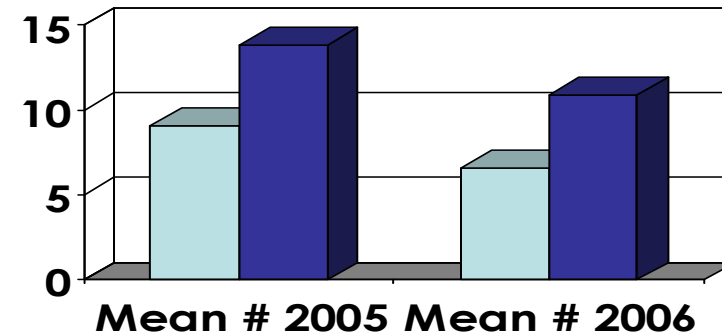


Office Visit Characteristics

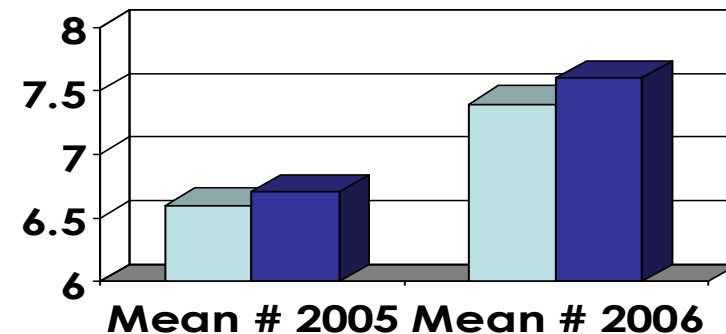
Commercial Plans



Medicaid Plans



Medicare Plans



86% of health plan members had at least one outpatient visit in 2005 or 2006 (Commercial = 85.4%; Medicaid = 84.4%; Medicare = 94.5%)

Plan Performance

- **Prevalence of BMI documentation**
 - Ages 18-74 years
 - Outpatient visit in either 2005 or 2006

	A*	B	C	Total
BMI Documented (n)	98	24	10	132
Office Visit in 2005 or 2006 (n)	105	133	93	431
% with BMI documented	93.3	10.3	10.8	30.6

	Commercial	Medicaid*	Medicare
BMI Documented (n)	80	34	18
Office Visit in 2005 or 2006 (n)	308	37	86
% with BMI documented	25.9	91.9	20.9

*Plan A – submitted utilizing EMR, all Medicaid

BMI vs. Height/Weight Documentation

	# Medical Records	Eligible members with BMI doc.		Eligible members with both height and weight		Eligible members with either BMI or both height and weight	
		BMI (n)	% MR	Both	% MR	Either	% MR
A	150	112	74.7	114	76.0	114	76.0
B	330	32	9.7	137	41.5	139	42.1
C	124	12	9.7	59	47.6	60	48.4
Commercial	345	65	18.8	110	31.9	111	32.2
Medicaid	54	39	72.2	40	74.1	40	74.1
Medicare	205	20	9.8	23	11.2	23	11.2
Total	605	124	20.5	173	28.6	174	28.8

Public Comment Issues

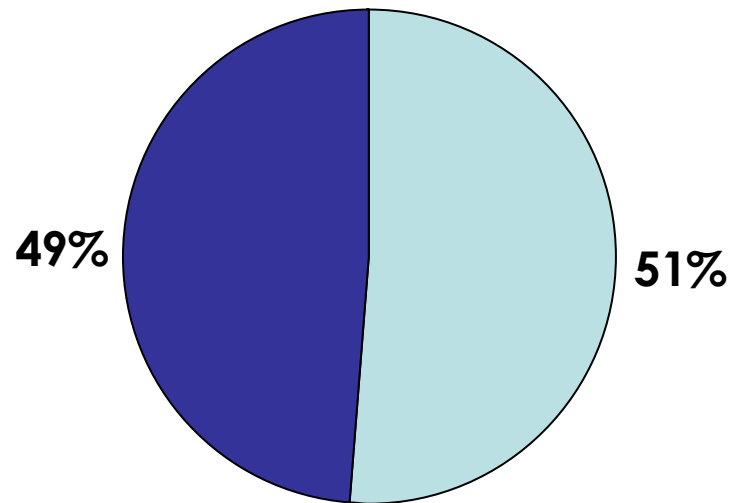
- **Majority of comments were supportive of the measures. Several themes emerged...**
 - **Burden**
 - **Incorporate measure components into existing HEDIS measures**
 - **Expansion of the measure**
 - **Restrict counseling components to children/adolescents identified as overweight or obese**

Child: Field-Test Data Characteristics

Number of Records Submitted by Plans			
Plan/Product	Admin Records	Medical Records	Percent EMR
A	227,971	150	16%
B	267,248	150	0.7%
C	65,535	179	-
Commercial	267,248	150	0.7%
Medicaid	293,506	329	7.3%
Total	560,754	479	-

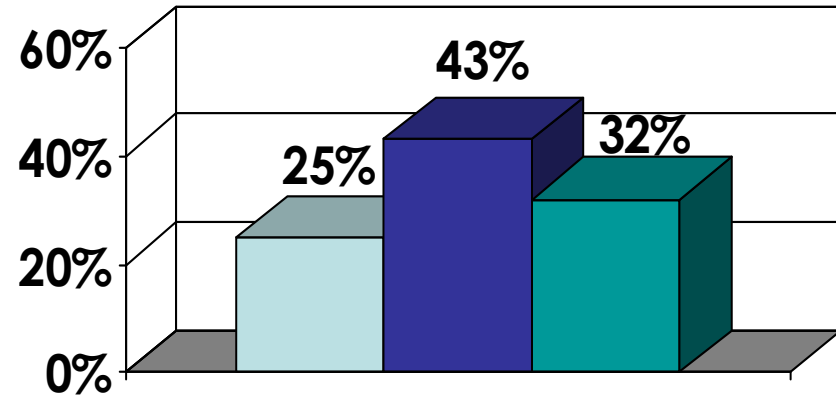
Member Demographics

Gender



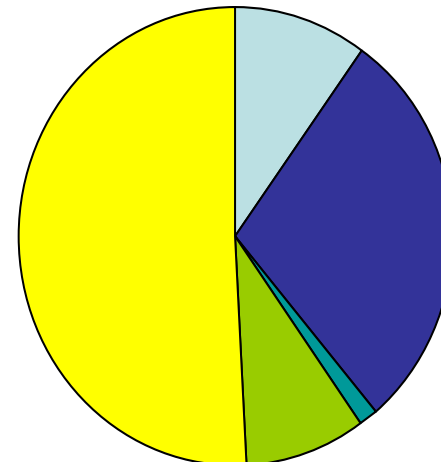
Male Female

Ages



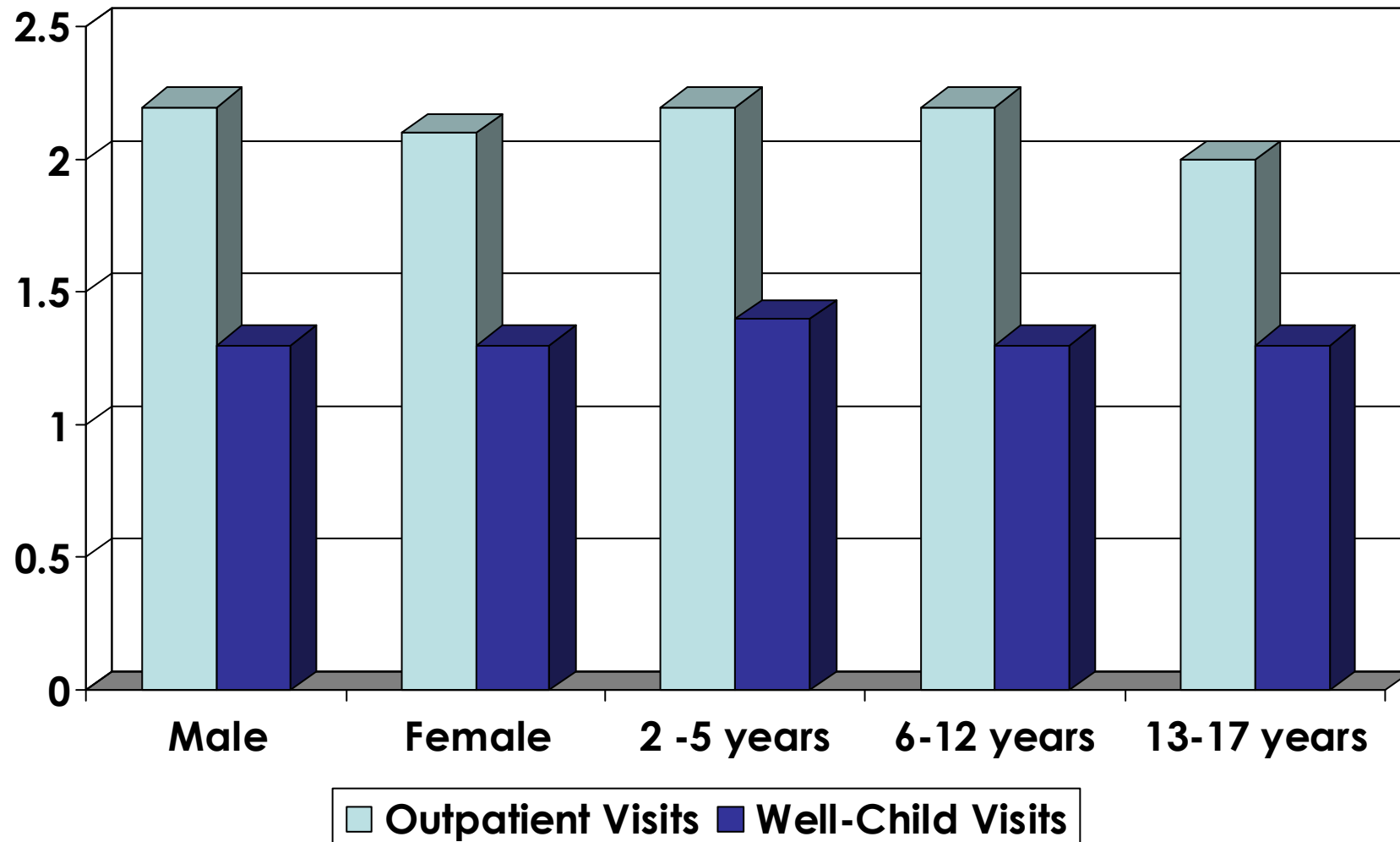
2-5 years 6-12 years 13-17 years

Race*



Black White Asian Other Not Documented

Office Visit Characteristics



72% of children included in field-test had at least one outpatient visit in 2006; 83% had at least one visit in 2005 or 2006

Plan Performance

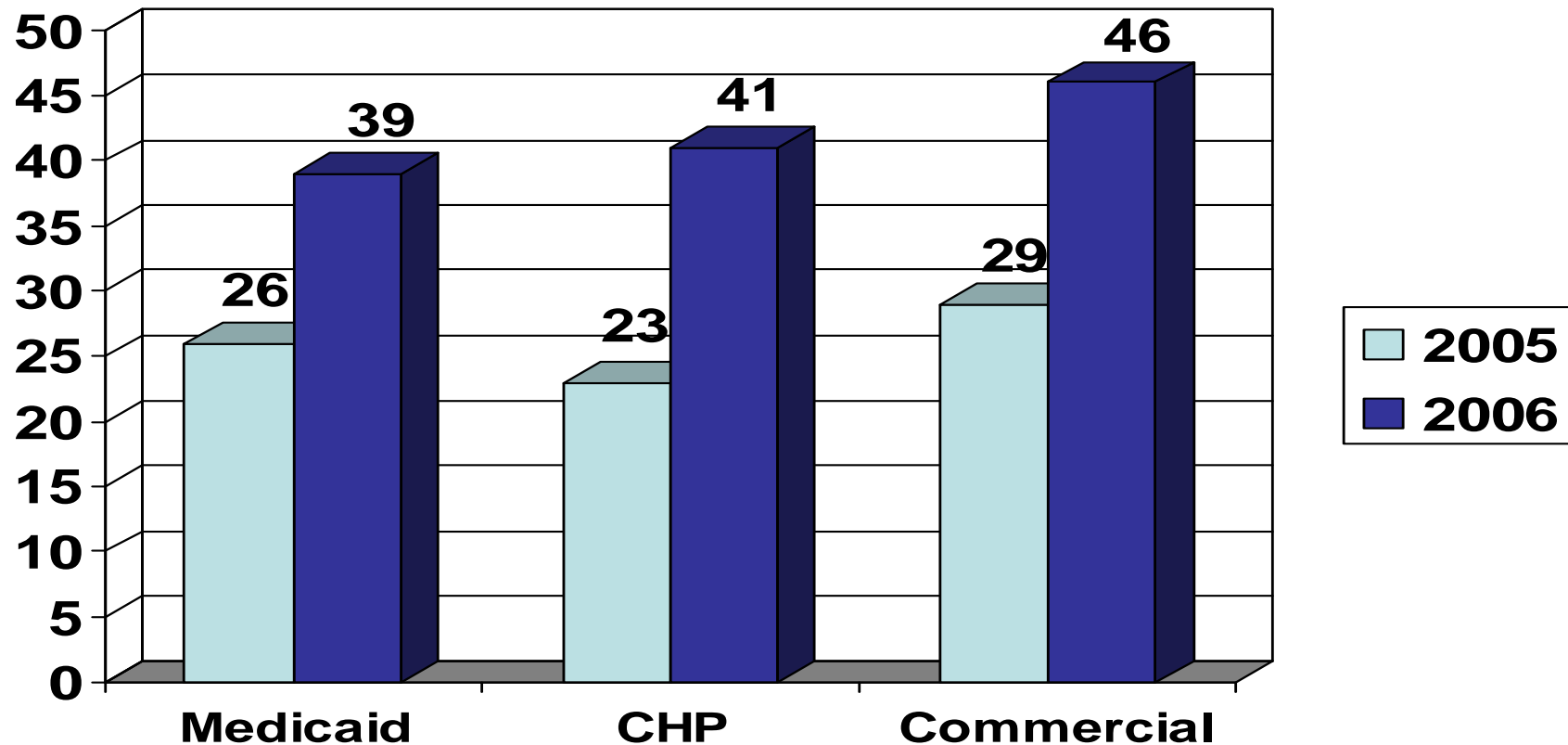
Percentage of child/adolescents with an outpatient visit and medical record documentation of...

	BMI Percentile Documentation							Counseling			
	N	2005		2006		No Date		Nutrition		Physical Activity	
		n	%	n	%	n	%	n	%	n	%
A	150	0	0	0	0	8	5.3	98	65.3	66	44.0
B	150	4	2.7	4	2.7	0	0	97	64.7	75	50.0
C	179	1	0.6	3	1.7	0	0	131	73.2	72	40.2
Commercial	150	4	2.7	4	2.7	0	0	97	64.7	75	50.0
Medicaid	329	1	0.3	3	0.8	8	2.4	229	69.6	138	42.0
Total	479	5	1.0	7	1.5	8	1.7	326	68.1	213	44.5

Plan Performance

- **Rates of documentation of BMI percentile are extremely low across field-test sites**
 - 0 – 2.7% for both 2005 and 2006
 - One plan would achieve a higher rate, but dates of BMI percentile documentation were not provided
 - Rates go up to approximately 15% if documentation of BMI (vs. BMI percentile) was counted toward the numerator and if eligible population is visit based

NYS Adolescent Preventive Care Measure: Rates for BMI Screening



Differences from proposed NCQA measure: only adolescents (14-18 years); eligible population requires well-care visit; greater span of BMI documentation allowable (BMI, BMI percentile etc.)

Conclusions

- Identification of potential measures is an important step in fostering benchmarking and quality improvement in the area of obesity assessment and management.
- Guideline and expert support for the implementation of performance measures
- Performance measures are feasible for implementation and medical records are the most reliable source of data.

HEDIS® 2009 Measure

- **NCQA BOD approval – June 2008**
- **Publication in HEDIS Volume 2 – July 2008**
- **Plan reporting (measurement year 2009) – June 2009**
- **1st year measure results (aggregate) – September 2009**
- **Determination of public reporting status for HEDIS 2010 – September 2009**

Child/Adolescent Obesity MAP

Joe Anarella, MPH	NY State Department of Health
Keith Bachman, MD	Kaiser Permanente, Weight Management Institute
Terry Bazzarre, PhD	Robert Wood Johnson Foundation
Chris Bolling, MD (Co-Chair)	Cincinnati Children's Hospital Medical Center
William Dietz, MD, PhD	Centers for Disease Control and Prevention
Molly Gee, M.Ed, LD, RD	Baylor College of Medicine
Sandra Hassink, MD	Alfred I. duPont Hospital for Children
Francine Kaufman, MD	Children's Hospital Los Angeles
Jonathan Klein, MD, MPH (Co-Chair)	University of Rochester
Nancy F. Krebs, MD	University of Colorado School of Medicine
Catherine MacLean, MD, PhD	WellPoint, Inc
Joe Thompson, MD, MPH	Arkansas Center for Health Improvement
Reginald L. Washington, MD	University of Colorado Medical Center

Adult Obesity MAP

David Arterburn, MD, MPH	Center for Health Studies, Group Health Cooperative
Lawrence Blonde, MD, FACP, FACE	Ochsner Clinic
David Brumley, MD	Blue Cross Blue Shield of Massachusetts
Marc Cornier, MD	University of Colorado Health Sciences Center
Morgan Downey, JD	The Obesity Society (NAASO)
Len Fromer, MD, FAAFP	UCLA School of Medicine
LuAnn Heinen, MPP	National Business Group on Health
Trina Histon, PhD	Kaiser Permanente, Weight Management Institute
Michael Jenson, MD	Mayo Clinic
Richard Kahn, PhD	American Diabetes Association
Jaan Sidorov, MD, MHSA	Independent Consultant
Thomas Stellato, MD	University Hospitals of Cleveland
Thomas Wadden, PhD	University of Pennsylvania School of Medicine, Center for Weight and Eating Disorders
Peter Wald, MD, MPH	USAA