Care Management

QUALITY MEASUREMENTS AND OUTCOMES

UDS Care Management strives for excellence in providing quality care management. We have developed a variety of measures to ensure quality outcomes and identify areas that can be improved.

We study our data at least monthly and year-over-year. We report our data to our payors quarterly for full transparency. Our quality measures are recognized by the National Committee for Quality Assurance (NCQA) who has given us their highest quality rating. We provide our data to NCQA every three years.

DEVELOPMENT OF MEASURES

CMS uses outcome measures to calculate overall hospital and nursing home quality. There is a star rating for each. We looked at the 7 star ratings for the hospital and the 5 star ratings for Long Term Supports and Services (LTSS) and from there we advanced our quality measures in areas that we felt we could impact categories.

Given the rapid changes that occur within healthcare, making sure best practice care guidelines are current is critical for achieving the best care outcomes. We assessed and developed processes to yield quality outcome measures based upon the Deming Cycle (also known as PDSA: Plan-Do-Study-Act).

National Committee for Quality Assurance (NCQA Accredited)

UDS was one of the first service coordination agencies in Pennsylvania to receive NCQA accreditation. This addresses how case management services are delivered (not just the organization's internal administrative process) to get to the heart of care coordination and quality of care. NCQA case management accreditation signals a commitment to the highest degree of quality improvement.

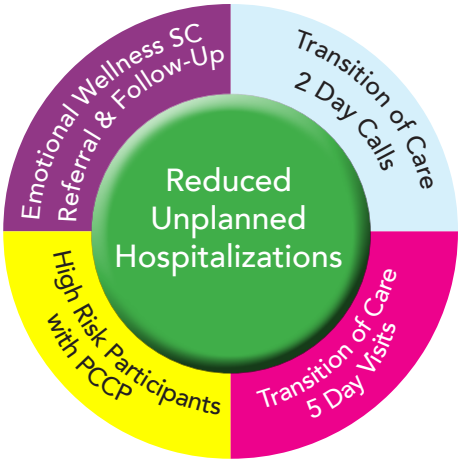
COMPLAINTS AND GRIEVANCES

We also understand that UDS is in a position to facilitate positive experiences for our participants beyond our program and giving participants a voice to be heard is an important part of providing services. We have a system in place to address any concerns related to those providers that work with our participants, such as Personal Assistance Agencies. We call this an Agency Related Concern (ARC).

Overall our participants seem to be well pleased with their services and we have registered very few grievances. We have documented an average grievance rate of only .04% over the past 33 months.

We continue to provide training and tools to our Supports Coordinators to ensure that they are speaking with their clients about the quality of their services and reminders to document all grievances and concerns.

UNPLANNED HOSPITALIZATIONS AND READMISSIONS



One of our primary goals is focused on reducing unplanned hospitalizations and readmissions which can help ensure the participant remains in their home and community. Knowing that readmission following hospitalization is a common measure, we set-up several smaller sub-goals (as detailed in the graph on the right) to help accomplish lower readmission rates.

Readmission is costly (and often preventable). In fact, researchers estimate that in one year, $25 - $45 billion is spent on avoidable complications and unnecessary hospital readmissions. (https://www.cdc.gov)

In order to better manage our participants conditions, we have developed programs to help educate participants and better manage their outcomes:

Transition of Care process was developed and implemented to meet NCQA guidelines.

Managing Chronic Conditions prevents avoidable Emergency Department visits and hospitalizations. We instituted four Chronic Condition Measures:

- Wound Care/Skin Breakdown - This happens when pressure decreases blood flow to the skin. Patients with pressure injuries are at a higher risk of infection. Patient risk scores go up if they are diabetic, for example, because their circulation is poor putting them at risk for diabetic ulcers.
- Diabetic Risk Assessment and Education - This plan was developed in a pilot.
- Fall Risk Assessment/Prevention - Falls among adults age 65 and older are very costly. Each year about $50 billion is spent on medical costs related to non-fatal fall injuries and $754 million is spent related to fatal falls. (Jul 9, 2020; https://www.cdc.gov > falls > data > fall cost). Performing a fall risk assessment on a participant at the initial assessment, post hospitalization and annually (process measure) can reduce fall rates (outcome measure).
- High Risk Assessment and Care Planning (stratification of participants) - Any participant discharged from an unplanned hospitalization is placed automatically on high risk for 30 days and specific protocols are followed. The same occurs with significant changes in conditions.

PARTICIPANT EXPERIENCE

According to the Agency for Clinical Innovation (ACI), Patient-reported outcome measures (PROMs) "assess the patient's experience and perception of their healthcare. This information can provide a more realistic gauge of patient satisfaction as well as real-time information for local service improvement and to enable a more rapid response to identified issues."

UDS does service recovery for any participant that renders a less than satisfactory experience in the survey. This engages the Care Managers (Service Coordinators) supervisor in providing follow-up and follow-through until there is a positive outcome. Over the past 33 months, UDS has achieved an outstanding participant satisfaction rating of 95%.