Care Coordination Committee

NATIONAL QUALITY FORUM

Off-Cycle Webinar
March 7th
2-4 PM ET

Meeting Objectives

- Introduce the Standing Committee to Off-Cycle activities
- Gain an understanding of ONC's current activities in the area of care coordination measurement
- Provide ONC with an overview of NQF's work in care coordination measurement in terms of lessons learned
- Facilitate a discussion between NQF and ONC about care coordination measurement and the use of health IT in capturing care coordination

Agenda

- Off-Cycle Activities: Introduction and Overview
- Office of the National Coordinator for Health Information Technology
  - Overview of activities around healthIT and care coordination
- Care Coordination Committee
  - Lessons Learned and Directions Moving Forward
- Facilitated Discussion

Off-Cycle Activities

Off-Cycle Activities

- What is considered “off-cycle”?
  - During the periods in which no measures are being reviewed, or the “off cycle”, these are Standing Committee activities that may occur outside a funded project’s scope.
  - In order to enable ongoing engagement of committee members throughout their two (or three) year terms, NQF will host quarterly, two-hour web meetings or conference calls for each Standing Committee during the off cycle timeframe.

Off-Cycle Activities

Potential Activities:

- Ongoing updates on NQF policy/process
- Addressing and setting measurement priorities for topic area
- Reviewing current measurement landscape
- Follow–up from the Consensus Development Process
  - Deferred decisions
  - Directives from CSAC or Board of Directors
  - Related and competing measures/harmonization
- Ad hoc reviews
- Topic area consultation to other Committees
- Collaborative opportunities with developers, specialty societies, and implementers

The Office of the National Coordinator for Health Information Technology

NQF Care Coordination Committee Meeting

Kelly Cronin
Director, Office of Care Transformation
ONC/HHS

March, 2016

Putting the I in HealthIT
www.HealthIT.gov

Delivery System Reform Focus Areas

"Improving the way providers are incentivized, the way care is delivered, and the way information is distributed will help provide better care at lower cost across the health care system…"

Pay Providers

- Promote value-based payment systems
  - Test new alternative payment models
  - Increase linkage of Medicaid, Medicare FFS, and other payments to value
- Bring proven payment models to scale

Deliver Care

- Encourage the integration and coordination of clinical care services
- Improve population health
- Promote patient engagement through shared decision making

Distribute Information

- Create transparency on cost and quality information
- Bring electronic health information to the point of care for meaningful use

Source: Burwell SM. Setting Value-Based Payment Goals – HHS Efforts to Improve U.S. Health Care. NEJM 2015 Jan 26; published online first.

Through MACRA HHS aims to:

- Offer **multiple pathways** with varying levels of risk and reward for providers to tie more of their payments to value.
- Over time, **expand the opportunities** for a broad range of providers to participate in APMs.
- **Minimize additional reporting burdens** for APM participants.
- **Promote understanding** of each physician's or practitioner's status with respect to MIPS and/or APMs.
- Support **multi-payer initiatives** and the development of APMs in Medicaid, Medicare Advantage, and other payer arrangements.
- Advance use of **interoperable health IT** to enable providers to succeed in value based payment arrangements

APMs & MIPS

Paying for Performance

Alternative Payment Model (APM)

Clinicians who receive a substantial portion of their revenues (at least 25% of Medicare revenue in 2018-2019 but threshold will increase over time) from ***eligible*** alternative payment entities will not be subject to MIPS.

MACRA outlines criteria for Alternative Payment Models which includes but is not limited to:

Quality Measures	*Use of certified EHR technology*
Risk-sharing	

Merit-Based Incentive Payment System (MIPS)

Adjustments based on the **composite performance score** of each eligible physician or other health professional on a 0-100 point scale based on the following performance measures. CMS has some flexibility to vary the weighting of these categories in the initial program years. Additional positive adjustment is available for exceptional performance.

Quality (30%)	*Clinical Practice Improvement Activities* (15%)
Resource Use (30%)	*Meaningful Use of certified HER* (25%)

MACRA Merit-Based Incentive Payment System

- **MIPS- Clinical Practice Improvement Activities:** Secretary shall solicit suggestions from stakeholders to identify activities. Sec. retains discretion.

Expanded Practice Access	Population Management	Care Coordination	Beneficiary Engagement
• Same day appointments for urgent needs • After hours clinician advice	• Monitoring health conditions & providing timely intervention • Participation in a qualified clinical data registry	• Timely communication of test results • Timely exchange of clinical information with patients AND providers • Use of remote monitoring • Use of telehealth	• Establishing care plans for complex patients • Beneficiary self-management assessment & training • Employing shared decision making

HIT Capabilities for APMs

- Based on a literature review, interviews, and input from Technical Expert Panel participants, the following health IT capabilities emerged as the most important for successful participation in APMs by 2019:
  1. Enrolling patients in programs and empaneling them in care teams, particularly with non-billing, ancillary professionals;
  2. Managing referrals across clinical and non-clinical settings;
  3. Provision of patient risk stratification information across care team;
  4. Documenting and sharing the care plan;
  5. Applying clinical decision support;
  6. Tracking patient use of services in a timely manner;
  7. Access to and integration of patient's claims data in a timely manner; and
  8. Ability to organize quality measures at the practice and panel levels and aggregate scores across settings.

ONC efforts to support health IT enabled care coordination

- Enhanced oversight of health IT vendors through certification program
- Improvement in technical standards that support summary record exchange
- New optional certification criterion for care plan exchange supported by a cCDA care plan template standard
- HIE grants to states to extend existing HIE reach to behavioral health, long-term care, EMS and other providers
- Recent State Medicaid Director letter with an updated policy on 90% federal match to support HIE services to Medicaid providers not eligible for EHR Incentives, i.e., behavioral health and long-term care providers.
- Moving forward, will continue to support evolution of standards needed for referral management, shared care plan and other aspects of care coordination that are essential for APMs and patient centered care
  - New standards and certification criteria will enable new care coordination measures, new measures will create demand and consistent uptake of the standards

Care Coordination: Lessons in Measurement

Ten Lessons in Care Coordination Measurement

1. Care coordination is about closing loops and completing connections.
2. Measures capturing only one segment of the process are insufficient and ultimately, invalid.
3. Our ability to recognize high quality care coordination exceeds our ability to measure it.
4. Preferred practices in care coordination are important and largely overlooked sources of insight into effective care coordination and potential performance measures.
5. General care coordination processes, like communication of information across settings and providers, are important and need to be measured for all recipients of health care regardless of diagnosis or setting.

Ten Lessons in Care Coordination Measurement

6. *General* care coordination processes should be distinguished from more *complex* care coordination processes targeted to the needs of high risk individuals and populations.
7. Care coordination, by definition, occurs between and across people and settings; capturing attribution in measures will likely be difficult and controversial.
8. Patient and family experience with care coordination is central to performance measurement.
9. Meaningful care coordination measurement requires strong process and outcome measures and rigorous research supporting their relationships.
10. Structural measures may be important for evaluating capacity to deliver the necessary dose of care coordination for achieving outcomes.

Discussion

Discussion Questions

- What are the major challenges in developing comprehensive measures for care coordination?
- How might the various health information technology (health IT) strategies be used more effectively to solve some of the challenges?
- How are you currently utilizing various health IT strategies to facilitate, track and/or measure current and future care coordination efforts in your work?

Discussion Questions

- Are you aware of any examples of healthIT being used effectively to facilitate, monitor and measure comprehensive care coordination between behavioral health and primary care providers?
- Is there any specific work that you are aware of that addresses more outcomes rather than process from an e-measurement perspective? For instance, there is support *and* concern about how CAHPs is utilized, so do you have any experience in this area that could be shared?
- Are there any other off-cycle activities related to working with the ONC or other potential collaborators?

Adjourn