Measure Applications Partnership

Dual Eligible Beneficiaries Workgroup In-Person Meeting

April 19-20, 2016

NATIONAL QUALITY FORUM

Welcome

Meeting Objectives

- Complete annual update to the Family of Measures for Dual Eligible Beneficiaries and review the Starter Set of measures
- Identify priority issues and measures for Dual Beneficiaries with Multiple Chronic Conditions
- Explore healthcare linkages to community and related NQF projects

Day 1 Agenda

- Welcome
- Thoughts from CMS Colleagues
- Exploring Multiple Chronic Conditions
  - Context and Emerging Policy
  - Overcoming Barriers to Measure Development
- Maintaining the Family of Measures
  - Considering Measures with Changed Endorsement Status
  - Prioritizing Measures for the Starter Set
- Summary of Day and Adjourn

Dual Eligible Beneficiaries Workgroup Membership

Workgroup Chairs: Jennie Chin Hansen, RN, MS, FAAN and Nancy Hanrahan, PhD, PN, FAAN

Organizational Members

AARP Public Policy Institute	Susan Reinhard, RN, PhD, FAAN
American Geriatrics Society	Gregg Warshaw, MD
American Medical Directors Association	Gwendolen Buhr, MD, MHS, MEd, CMD
Association for Community Affiliated Health Plans	Christine Aguiar
Centene Corporation	Michael Monson
Consortium for Citizens with Disabilities	E. Clarke Ross, DPA
Easter Seals	Cheryl Irmiter, PhD
Homewatch CareGivers	Jette Hogenmiller, PhD, MN, APN, CDE, TNCC
Humana, Inc.	George Andrews, MD, MBA, CPE
iCare	Thomas H. Lutzow, PhD, MBA
National Association of Medicaid Directors	Alice Lind, BSN, MPH
National Association of Social Workers	Joan Levy Zlotnik, PhD, ACSW
New Jersey Hospital Association	Aline Holmes, DNP, MSN, RN

Dual Eligible Beneficiaries Workgroup Membership

Subject Matter Experts

Mady Chalk, MSW, PhD
James Dunford, MD
K. Charlie Lakin, PhD
Ruth Perry, MD
Kimberly Rask, MD, PhD
Gail Stuart, PhD, RN

Federal Government Members

Administration for Community Living	Eliza Bangit
CMS Medicare Medicaid Coordination Office	Venesa Day
Office of the Assistant Secretary for Planning and Evaluation	DEB Potter, MS

Thoughts from CMS Colleagues

MAP at 5 Years: Impact and Future Direction

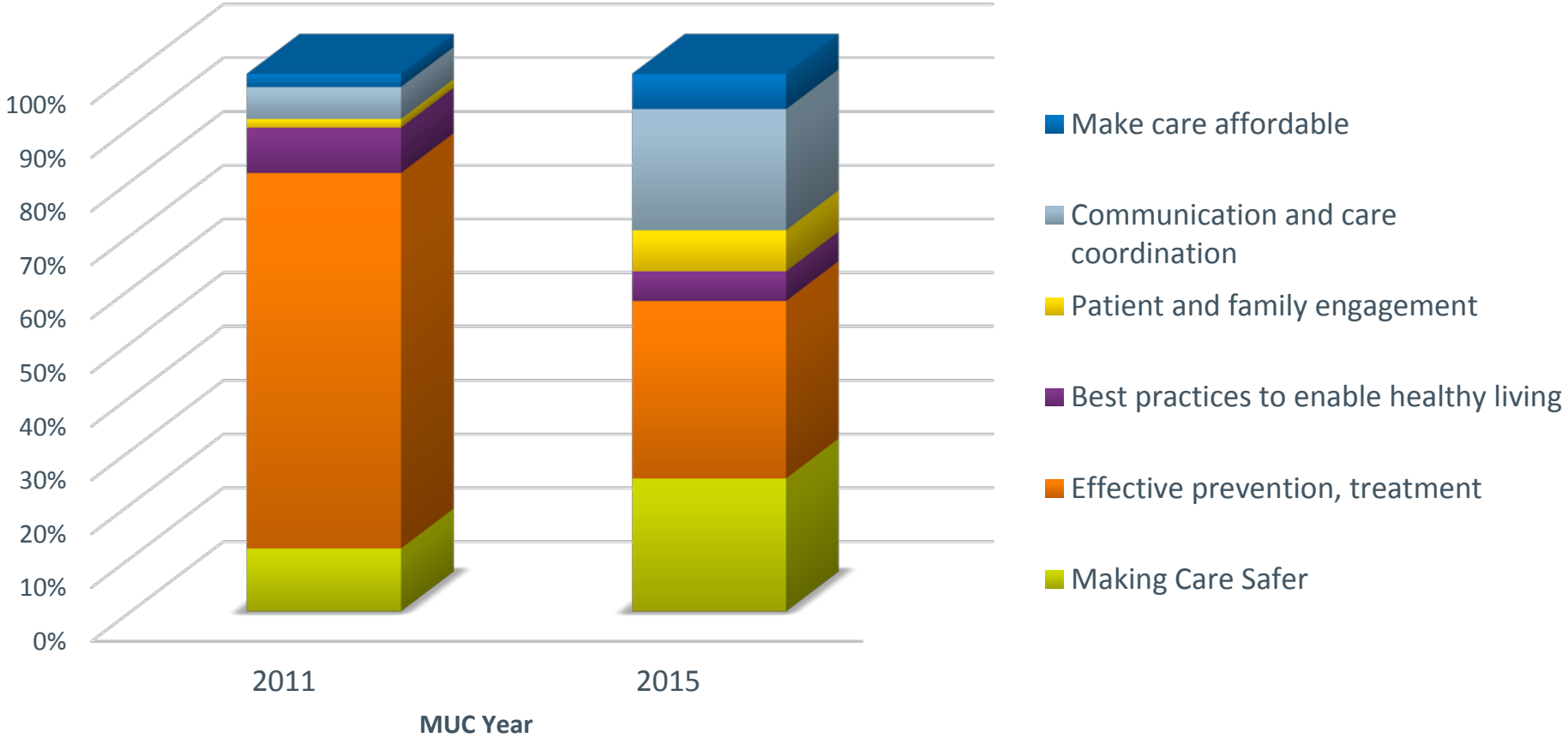
The Role of MAP and the Dual Eligible Beneficiaries Workgroup

- In pursuit of the National Quality Strategy, MAP provides input to HHS on the use of performance measures to achieve the goals of improvement, transparency, and value
- MAP also helps identify gaps in measure development, testing, and endorsement
- MAP encourages measure alignment across public and private programs, settings, levels of analysis, and populations

Measure Applications Partnership Impact

- Over the past five years, MAP has made significant strides in strengthening the use of measures within federal programs
- To date, over 1,543 measures have been submitted for consideration by the MAP for use in over 20 federal programs
- Of these, nearly 50% have been process measures, and just over one-third have been outcome measures
- DHHS has increasingly looked to the MAP to provide upfront guidance prior to investments in measure testing
  - In 2015, more than 60% of measures submitted for consideration were under development not fully tested
  - Less than 30% of measure submitted to MAP have been endorsed by NQF, likely due to their stage of development

CMS Measures Under Consideration Profile: NQS Priority



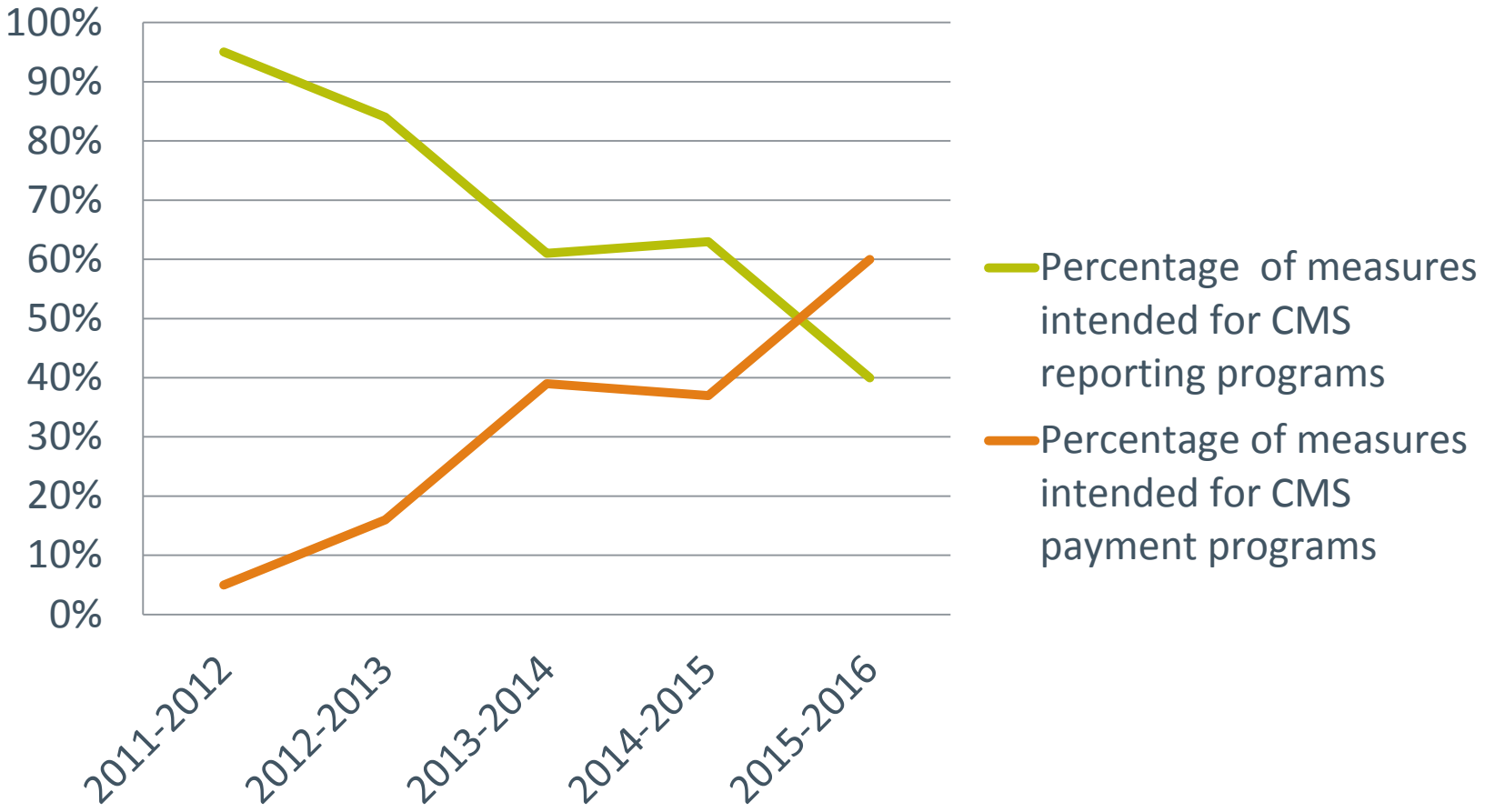
Changes in CMS Quality Programs

- In addition to changes in the performance measures, there have been strategic shifts in the nature of the quality initiative programs.
- Affordable Care Act, which created MAP, ushered in the era of value-based purchasing, creating a number of the pay-for-performance initiatives, particularly for hospitals
  - Financial Alignment Demonstrations authorized by ACA are partnerships between States and CMS to explore methods of integrating care, to save resources without reducing quality
- DHHS continues to show commitment to value-based purchasing
  - January 2015 announcement: DHHS goal of 90% of all traditional Medicare payments to quality or value by 2018 through its quality initiative programs

Changes in CMS Quality Programs

- Medicare Access and CHIP Reauthorization Act (MACRA) legislation
  - Demonstrates a changing environment as it repeals the Sustainable Growth Rate in an attempt to continue to tie physician payment to value rather than volume.
  - Consolidation of clinician quality improvement initiatives into Merit-Based Incentive Payment System (MIPS).
- Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014
  - Seeks to improve care for Medicare beneficiaries by implementing and standardizing quality measurement and resource utilization for post-acute care providers.
  - Increased attention is needed on ensuring consistent performance measurement across the various post-acute settings.

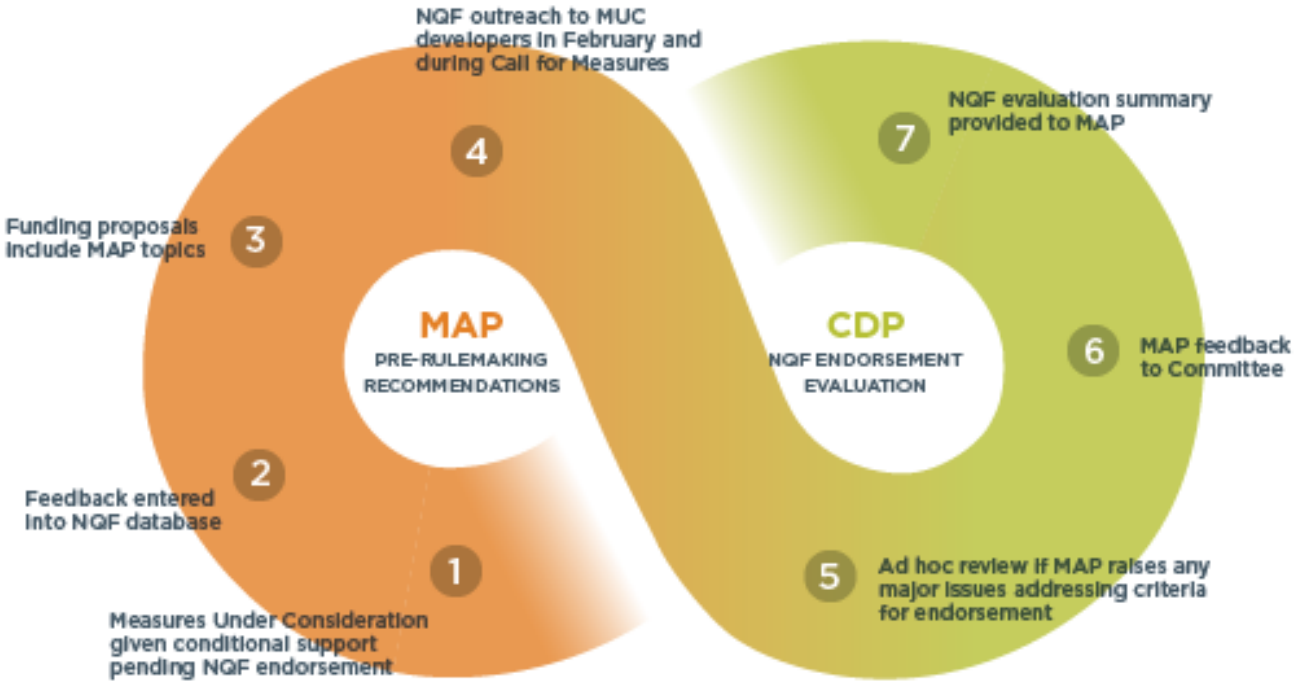
Shift in the Intended Use of Measures Submitted to MAP Over its 5 Years



Vision for the Future
MAP/CDP Alignment

- MAP depends on the NQF Consensus Development Process (CDP) measure endorsement process to ensure that there is sound testing and robust evidence to support the measure focus.
- As MAP continues to review measures earlier in their lifecycle, there is also a need to ensure that MAP's recommendations are known to the Standing Committees and Consensus Standards Approval Committee (CSAC) as they make their endorsement decisions.

MAP – CDP Integration Information Flow



Review of Workgroup Charge and Work to Date

Dual Eligible Beneficiaries Workgroup Charge

Dual Eligible Beneficiaries Workgroup:

- Identifies performance measures for use in dual beneficiary and sub-populations (family of measures)
- Prioritizes measurement gap areas
- Provides strategic input for maximizing quality of life for Medicare-Medicaid enrollees
  - Focus this year on measurement topics for individuals with multiple chronic conditions
  - Explore topics of community integration and connection to resources

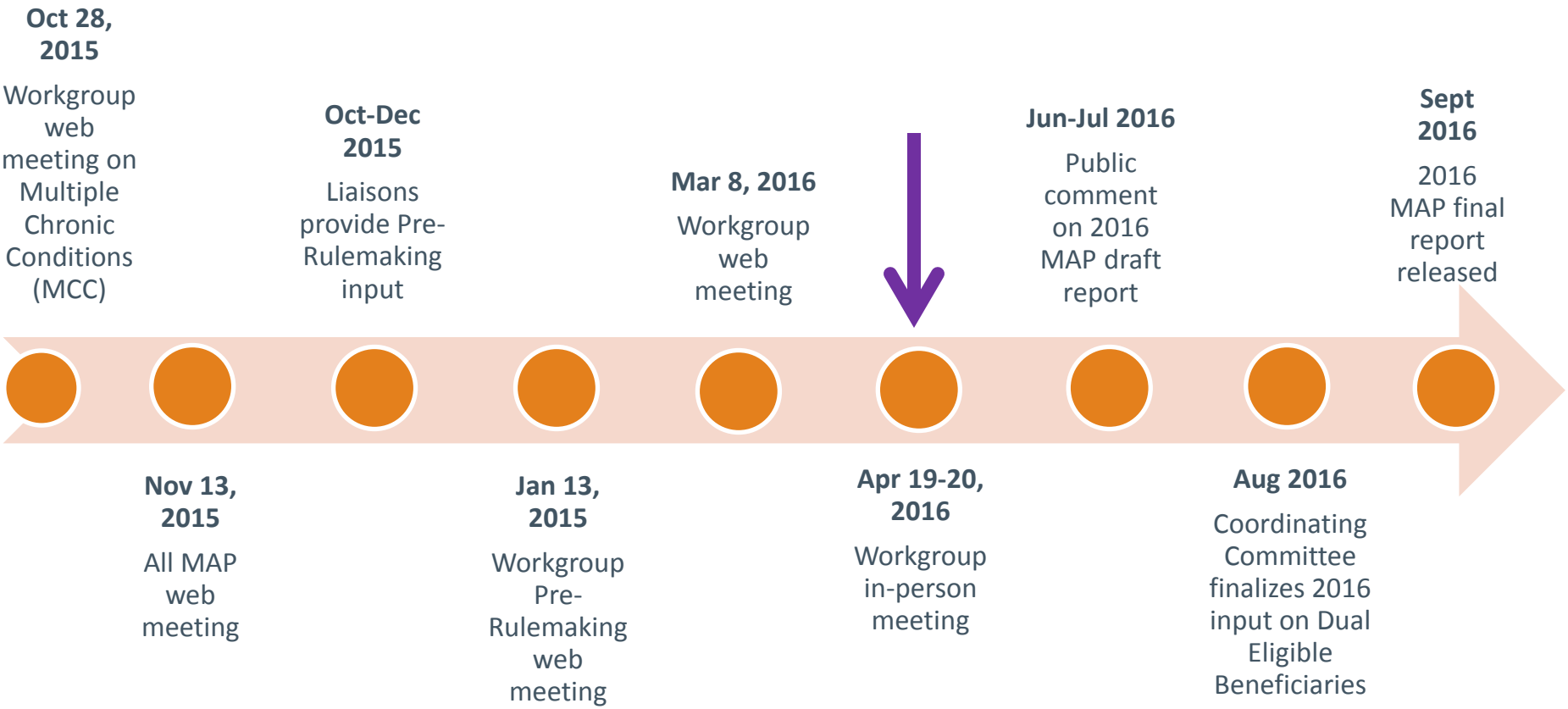
MAP Recommendations To Date

2011

2016

- Vision for high-quality care and guiding principles for measurement
- Five high-leverage opportunities for improvement through measurement
- First 'core' measure set + lengthy list of measure gaps
- Began annual updates to recommended Family of Measures
- Explored unique needs of sub-populations
- Surveys and other activities that could fill prioritized gaps
- Strategies to support improved quality of life outcomes
- Gathering stakeholder experience with measure use and assessed alignment of current measures
- *Pursue measures to support the needs of individuals with MCCs and connections to community resources and community integration*

2015-2016 Dual Eligible Beneficiaries Workgroup: General Timeline



Multiple Chronic Conditions: Context and Emerging Policy

Who are Dual Eligible Beneficiaries?

- Individuals who are dually-eligible for Medicare and Medicaid benefits
  - Usually have a combination of complex clinical and behavioral conditions compounded by social disadvantages; all are low-income
  - Typically considered “vulnerable” or “high need”
  - Highly diverse with most social, ethnic, and geographical groups represented
- Spending for dual beneficiaries is disproportionately high. Annually:
  - 20% of Medicare beneficiaries and 1/3 of spending = $498.9 billion
  - 14% of Medicaid beneficiaries and 1/3 of spending = $340.5 billion
- Little is known about the quality of care for these beneficiaries, as distinct from other groups of consumers

Multiple Chronic Conditions in Dual Eligible Beneficiaries

- MCCs are common among Medicare-Medicaid beneficiaries:
  - 77% of beneficiaries have documented diagnoses across two or more condition groups of physical or mental illness
  - 41% have diagnoses across four or more condition groups
  - 25% have diagnoses across five or more condition groups
- FFS per member per month costs are higher in beneficiaries with MCCs than those without documented conditions:
  - Expenditures were found to be about twice as high for beneficiaries with 2 or more co-morbid conditions
  - Expenditures were over four times as high for those with 5 or more comorbid conditions

Centers for Medicare & Medicaid Services. Physical and Mental Health Condition Prevalence and Comorbidity among Fee-for-Service Medicare-Medicaid Enrollees. Baltimore, MD: CMS. September 2014.
Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission. *Data book: Beneficiaries dually eligible for Medicare and Medicaid. January 2015*

Multiple Chronic Conditions in Dual Eligible Beneficiaries

- The five most common co-occurring condition groups include: **heart conditions, mental health conditions, anemia, musculoskeletal disorders, and diabetes**
  - 2/3 of individuals with any condition also have a heart condition
  - Mental health conditions are the 2nd most common co-occurring disease

Centers for Medicare & Medicaid Services. Physical and Mental Health Condition Prevalence and Comorbidity among Fee-for-Service Medicare-Medicaid Enrollees. Baltimore, MD: CMS. September 2014.

Social and Demographic Status in Beneficiaries with MCCs

- Women have a higher prevalence of chronic conditions
  - Also have higher rates of 3 or more conditions
- White non-Hispanic, African Americans, and Hispanic groups have the highest rates of 4 or more condition categories
- Population under age 40 consistently has the highest proportion of mental health conditions and the lowest proportion of physical health conditions

Centers for Medicare & Medicaid Services. Physical and Mental Health Condition Prevalence and Comorbidity among Fee-for-Service Medicare-Medicaid Enrollees. Baltimore, MD: CMS. September 2014.
Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission. *Data book: Beneficiaries dually eligible for Medicare and Medicaid. January 2015*

NATIONAL QUALITY FORUM

Medicare and Medicaid Dual Eligible Populations and Evolving Federal Policy

Dual Eligible Population Meeting
Washington, D.C.

Ann Greiner, VP of Public Affairs

April 19, 2016

Distinct Pathways for Medicare and Medicaid

1965 **Medicare and Medicaid Enacted as Separate Programs**

- **Different benefits, financing, payment rates, enrollment**
- **Separate program administration and Hill staff**

1972 **Social Security Amendments**

- **Medicare extended to those < 65 with long term disabilities and ESRD**
- **Establishes SSI & allows linkage to Medicaid for the elderly**

Modest Convergence Between Medicare and Medicaid

1990 PACE Program

2009 Affordable Care Act Enacted

- Medicare-Medicaid Coordination Office (MMCO) created
- CMMI demos

Drivers for Integration and Focus

Complexity of Care

- Uncoordinated and duplicative = ineffective and costly

Budget Pressures – Federal and State

- Medicare: 20% of beneficiaries but 34% of spending; $500 B
- Medicaid: 14% of beneficiaries but 34% of spending; $340 B

Vulnerability of the Population

- More than 60% have mental or cognitive impairment
- > 20% need assistance with 2or more ADLs
- 1/5 have 3 or more chronic conditions (CBO 2009)

Current Policies

Evolution of Pace Program, 2015

Financial Alignment Demonstration, 2011

- Currently 13 states; recommend extending 2 years
- GAO report – “Homegrown” measures so comparability is not possible. Recommend development/alignment of standardized measures to better monitor care coordination
- No evaluation yet

New Policies Under Development

- Senate Finance Chronic Care Working Group
  - Provision of services in the home -- Independence at Home demo, home hemodialysis therapy
  - Advancing team-based care
  - Empowering individuals and caregivers
- Leveraging new technologies
  - Telehealth, Remote patient monitoring
- Mental Health Bills
  - Integration of mental & physical health (S.2680, H.R.2569)
  - State models
- SES bills

More Integration and Coordination Needed

Multiple Chronic Conditions: Overcoming Barriers to Measure Development

Overcoming Barriers to Measure Development for MCCs

Building on the Workgroup's Prior Input

- Measure gaps persist, while progress has been made
  - Workgroup has been monitoring progress on measures across topics of person-centered care planning, connection to community resources, and other gaps
- Review of literature in 2012 uncovered dearth of foundational research on dual beneficiaries and high-need subgroups on which to build quality measures
  - Frustration across stakeholders with the lack of progress towards priority measurement development
  - Challenge to overcome barriers to understanding and improving care needs for these populations

Overcoming Barriers to Measure Development for MCCs

Building on the Workgroup's Prior Input

- Workgroup has previously highlighted the difficulties experienced by beneficiaries with complex conditions and social situations
- Challenges amplified for beneficiaries seeing multiple providers with complex health conditions
- Significant portions of dual beneficiaries see multiple providers, including providers for both physical and mental or behavioral healthcare
- Dual beneficiaries often use or are eligible for additional services, particularly those based on income and need, often related to psychosocial issues

Overcoming Barriers to Measure Development for MCCs

IOM Psychosocial Interventions for Substance Use Disorders

- Workgroup considered adopting a definition to discuss Psychosocial issues

  Psychosocial interventions are defined as *interpersonal or informational activities, techniques, or strategies that target biological, behavioral, cognitive, emotional, interpersonal, social, or environmental factors with the aim of improving health functioning and well-being.*
- Workgroup emphasized the importance of the person-centered goals, community resources, and systems to support providers

IOM (Institute of Medicine). 2015.*Psychosocial interventions for mental and substance use disorders: A framework for establishing evidence-based standards.* Washington, DC: The National Academies Press.

Overcoming Barriers to Measure Development for MCCs

IOM Psychosocial Interventions for Substance Use Disorders: A framework for establishing evidence-based standard

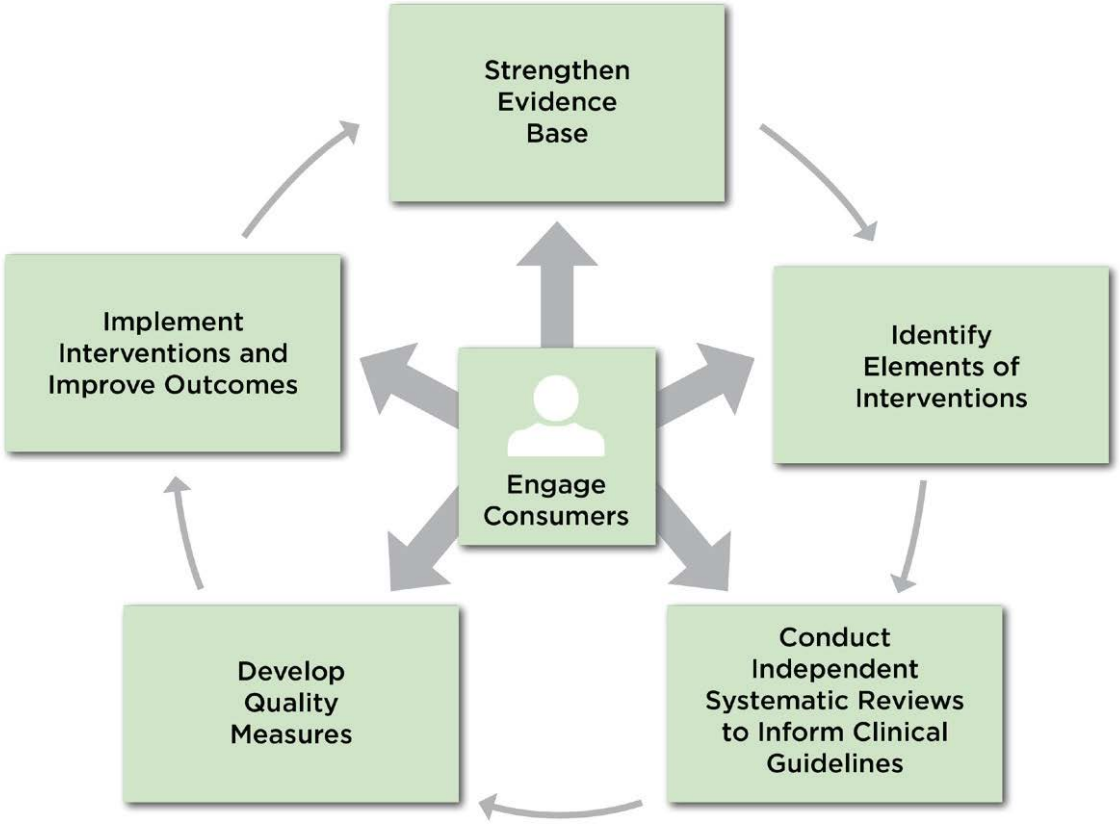
Recommendation from 2015 report:

1) Support research to strengthen the evidence base on the efficacy and effectiveness of psychosocial interventions;
2) Identify the key elements that lead to improved health outcomes;
3) Conduct systematic reviews to inform clinical guidelines that incorporate these key elements;
4) **Develop quality measures of the structures, process, and outcomes of interventions; and**
5) **Establish methods for successfully implementing, sustaining, and improving psychosocial interventions in regular practice.**

IOM (Institute of Medicine). 2015.*Psychosocial interventions for mental and substance use disorders: A framework for establishing evidence-based standards.* Washington, DC: The National Academies Press.

Overcoming Barriers to Measure Development for MCCs

IOM Psychosocial Interventions for Substance Use Disorders



IOM (Institute of Medicine). 2015.*Psychosocial interventions for mental and substance use disorders: A framework for establishing evidence-based standards.* Washington, DC: The National Academies Press.

Overcoming Barriers to Measure Development for MCCs

Workgroup Discussion

- The pervasive measure gaps for issues highly important for quality of care are a point of ongoing frustration
- Growing levels of resources are being devoted to bridge these gaps in the quality measures we have and those we need
- Barriers to measure development in complex populations are numerous

How do we overcome these measure development gaps and barriers?
What does ideal measurement for individuals with MCCs look like?

Workgroup Discussion

NQF Member and Public Comment

Maintaining the MAP Dual Eligible Beneficiaries Family of Measures and Gap Areas

Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

Overview of current Family of Measures

- Measures identified as best-available to address quality issues across the continuum of care for dual eligible beneficiaries and high-need subgroups
- Intended as a resource to assist the field in the selection of measures for programs, to promote alignment, and define high-priority gaps
- Workgroup periodically considers updates to the family
  - Consider changes to the measures
  - Identify relevant newly NQF-endorsed measures

Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

Current MAP Measure Selection Criteria

1. NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective
2. Program measure set adequately addresses each of the National Quality Strategy's three aims
3. Program measure set is responsive to specific program goals and requirements
4. Program measure set includes an appropriate mix of measure types
5. Program measure set enables measurement of person- and family-centered care and services
6. Program measure set includes considerations for healthcare disparities and cultural competency
7. Program measure set promotes parsimony and alignment

Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

National Quality Strategy Priorities 6 Priorities Established in 2011

- Making care safer by reducing harm caused in the delivery of care.
- Ensuring that each person and family is engaged as partners in their care.
- Promoting effective communication and coordination of care.
- Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
- Working with communities to promote wide use of best practices to enable healthy living.
- Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

Agency for Healthcare Research and Quality. (n.d).*Working for Quality: About the National Quality Strategy.* Last accessed April 2016. Retrieved from http://www.ahrq.gov/workingforquality/about.htm

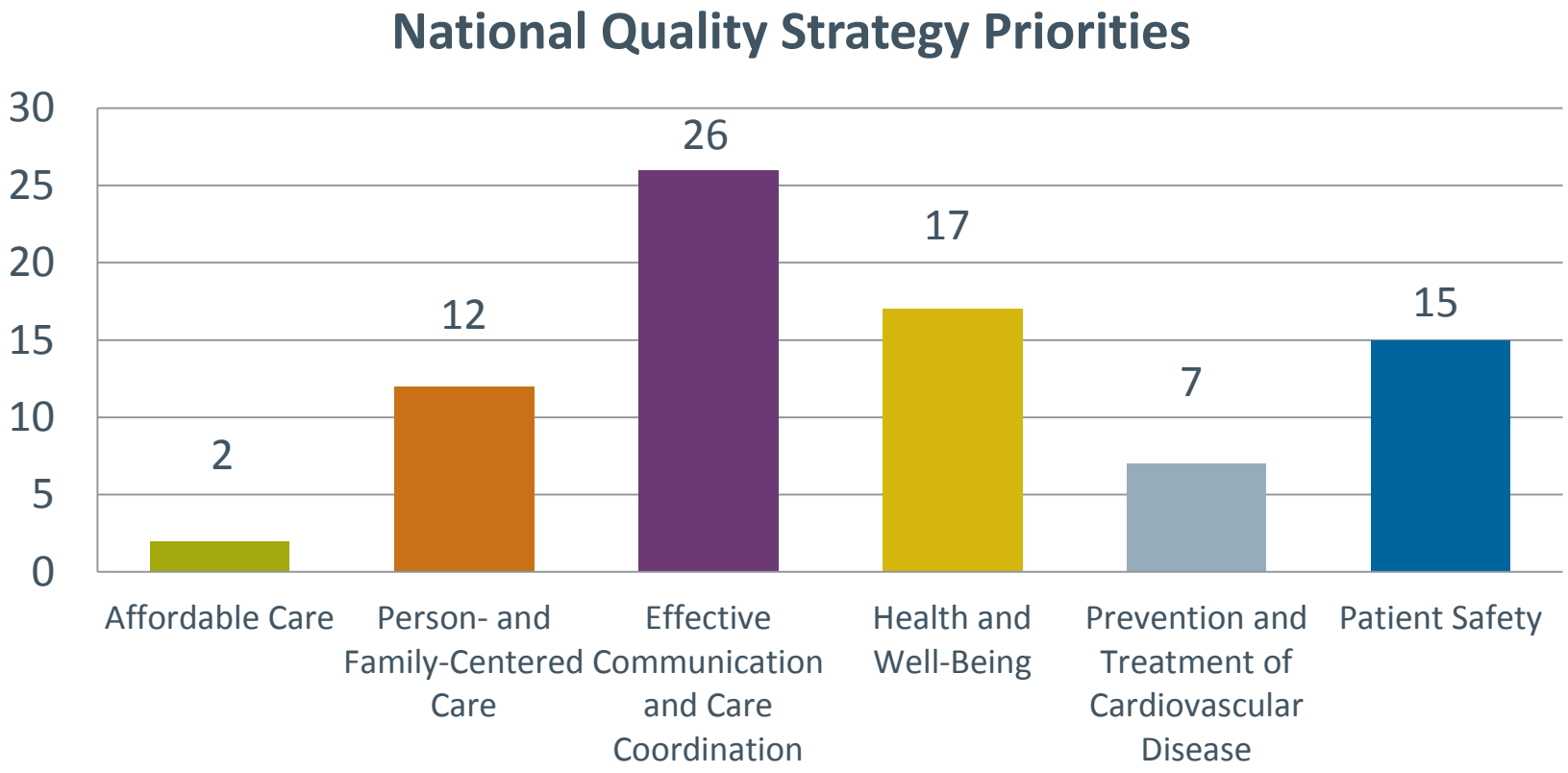
Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

Review of Workgroup Priorities for Measurement

- Established in 2012 and implemented to identify and refine selection of best available measures for dual beneficiaries:
  - Quality of Life
  - Care Coordination
  - Screening and Assessment
  - Mental Health and Substance Use
  - Structural Measures

Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

Key Characteristics of the Measures in the Family



Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

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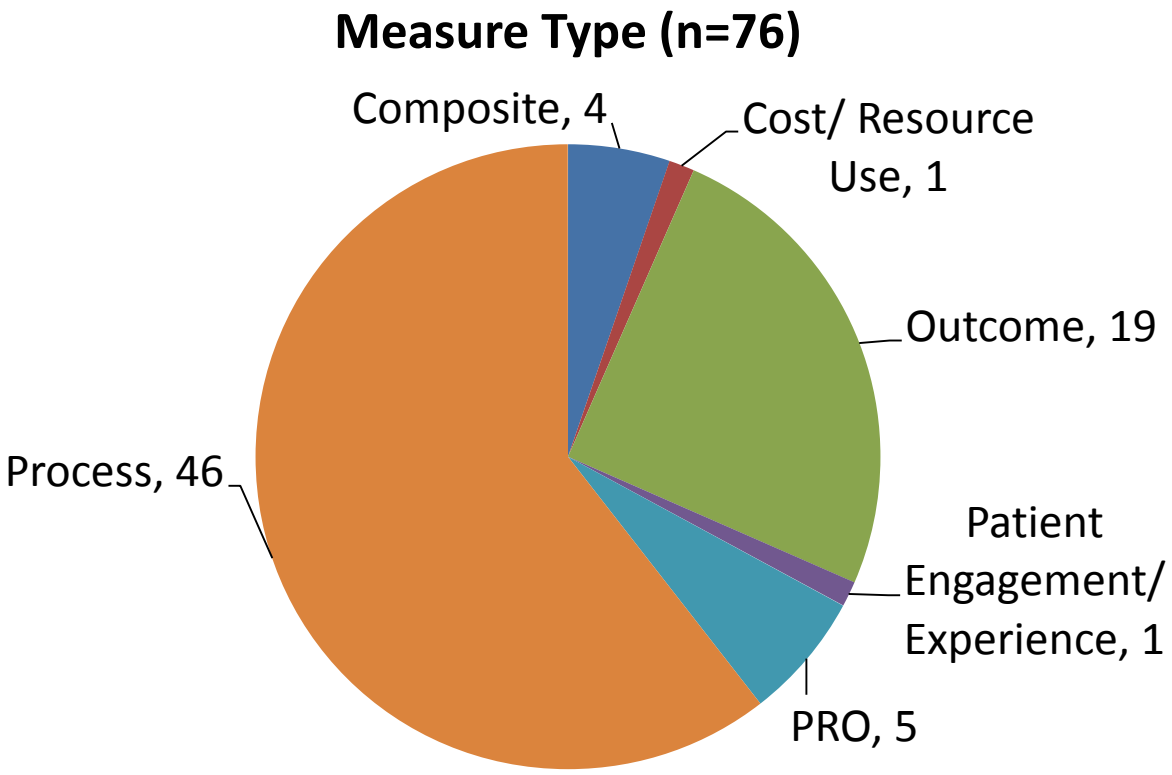


Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

Current Starter Set of Measures

- 0004 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)
- 0008 Experience of Care and Health Outcomes (ECHO) Survey (behavioral health, managed care versions)
- 0022 Use of High-Risk Medications in the Elderly (DAE)
- 0028 Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention
- 0101 Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls
- 0228 3-Item Care Transition Measure (CTM-3)
- 0418 Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
- 0419 Documentation of Current Medications in the Medical Record
- 0421 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
- 0576 Follow-Up After Hospitalization for Mental Illness (FUH)
- 1768 Plan All-Cause Readmissions (PCR)
- 1909 Medical Home System Survey (MHSS) – No Loner Endorsed

Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

Priority Gap Areas for Dual Eligible Beneficiaries

- Goal-directed, person-centered care planning and implementation
- Shared decisionmaking
- Systems to coordinate acute care, long-term services and supports, and nonmedical community resources
- Beneficiary sense of control/autonomy/self-determination
- Psychosocial needs
- Community integration/inclusion and participation
- Optimal functioning (e.g., improving when possible, maintaining, managing decline)

Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

Overview of In-Person Activities

- Workgroup will vote to maintain the family of measures
  - Vote to remove measures from or add measures to family
    - 60% threshold for workgroup consensus
- Prioritization of measures in the family to update the starter set
  - Staff Preliminary Analysis considered the MAP Measure Selection Priorities, Workgroup high-leverage opportunities, for improvement, prioritized gap areas, and prior input
  - Staff picks are a reference point to start the conversation, not a predetermined decision

Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

Summary of Workgroup Prioritization Exercise

- 8 Workgroup members responded to the exercise
- 6 measures were identified as low priority
  - These measures will be considered for removal from the Family throughout Day 1
  - 2 have had endorsement removed
- Not up for consideration for removal from the Family
  - Only 22 measures were not identified as a low priority
  - 32 measures were also identified by only 1 member as low priority
  - Workgroup members can nominate for removal from the Family throughout the day with rationale for workgroup vote
- ALL measures were identified as high priority by at least one member
  - Only measures with 6 or 7 high-priority will be considered for inclusion in the starter set on Day 2

Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

Summary of Workgroup Prioritization Exercise

- Focus and concentration of available measures mismatch for population
  - Large portion of acute care measures, though the population relies significantly on care in PAC/LTC and other settings
  - Significant impact of mental/behavioral health issues and functional impairments in the population, while measures focus on the physical medical model
- Measures of screening or assessment should include elements of treatment and follow up
  - Screening should not be required in absence of resources to treat

Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

Summary of Workgroup Prioritization Exercise

- Few available measures represent the person or family member's perspectives, nor would they be meaningful to these individuals
- Support for measures promoting effective communication and care coordination, management of medications and polypharmacy in vulnerable populations
- Concerns about the application of clinical/medical measures to individuals with serious mental illness
- NQS Priorities created some confusion
- Effort to be parsimonious drove vote for low priority measures

Issues for Upcoming Discussion

- Review of measures that were voted low priority or lost endorsement: does the workgroup want to suggest that measures be retired from the family? Or replaced?
- Review of newly endorsed measures: does the workgroup want to add measures to the family?
- Prioritization of Measures to the Starter Set for Dual Eligible Beneficiaries – Day 2
- Workgroup will vote using the voting application. Greater than 60% agreement is consensus.

NQF Trial Period on Risk-Adjustment for Socio-Demographic Factors

Agenda

- Background
- Views on SDS Adjustment
- Policy change
- Trial Period and Implications for Measure Evaluation
- Implications for the Duals Family of Measures
- Update on the Readmissions Project
- Questions and Discussion

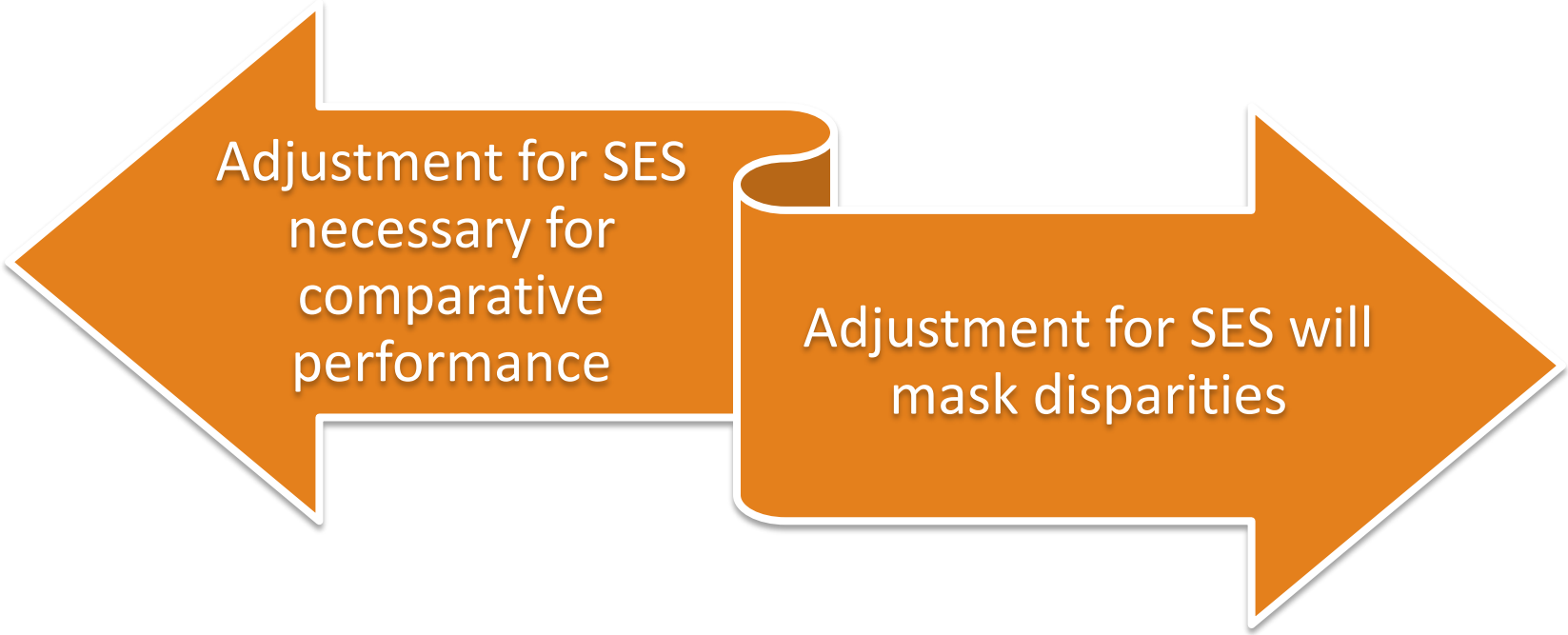
Background
Why risk adjust?

- Patients are not randomly assigned to healthcare units and the characteristics of the patients treated varies across healthcare unit
- Avoid incorrect inferences
- In the context of comparative performance assessment, the general question being addressed is:
  - ***How would the performance of measured entities compare if, hypothetically, they had the same mix of patients*?**

Background
Why consider adjustment for SDS?

- Overall quality has improved, but disparities have not
- Growing evidence regarding role of SDS factors on many outcomes
- Evidence-based interventions that could help close the gap require additional resources
- Stratification has largely failed to materialize
- Shift from process to outcomes reporting
- Higher financial stakes has heightened concern, especially for safety net providers

SES Adjustment: At Least Two Divergent Views



SDS Expert Panel

- To consider and address these issues, NQF convened an **SDS Expert Panel** to consider if, when, and how outcome performance measures should be adjusted for SES or related demographic factors
- The Expert Panel was composed of multiple stakeholders with a variety of experiences related to outcome measurement and disparities
- The Panel's recommendations were presented for public comment and modified in response to comments received

SDS Expert Panel: Core Principles

1. Outcome performance measurement is critical to the aims of the National Quality Strategy.
2. Disparities in health and healthcare should be identified and reduced.
3. Performance measurement should not lead to increased disparities in health and healthcare.
4. Outcomes may be influenced by patient health status, clinical, and sociodemographic factors, in addition to the quality and effectiveness of healthcare services, treatments, and interventions.

SDS Expert Panel: Core Principles (cont.)

5. When used in accountability applications, performance measures that are influenced by factors other than the care received, particularly outcomes, need to be adjusted for relevant differences in case mix to avoid incorrect inferences about performance.
6. Risk adjustment may be constrained by data limitations and data collection burden.
7. The methods, factors, and rationale for risk adjustment should be transparent.

NQF Policy Change: Trial Period

- The Panel recommended, and the NQF Board approved, a **two-year trial period** prior to a permanent change in NQF policy.
- Under the new policy, adjustment of measures for SDS factors is no longer prohibited.
- During the trial period, if SDS adjustment is determined to be appropriate for a given measure, NQF will endorse one measure with specifications to compute:
  - SDS-adjusted measure
  - Non-SDS version of the measure (clinically-adjusted only) to allow for stratification of the measure

NQF Policy Change: Trial Period (cont.)

- Each measure must be assessed individually to determine if SDS adjustment is appropriate.
- Not all outcomes should be adjusted for SDS factors (e.g., central line infection would not be adjusted)
  - Need conceptual basis (logical rationale, theory) and empirical evidence
- The recommendations apply to any level of analysis including health plans, facilities, and individual clinicians.

Measures Included in the Trial Period

- **ALL measures submitted to NQF after April 15, 2015 will be considered part of the trial period**, and Standing Committees may consider whether such measures are appropriately adjusted for SDS factors as part of their evaluation.
  - Newly-submitted measures
  - Previously-endorsed measures undergoing maintenance
  - Measures with conditional endorsement (e.g., Admissions/Readmissions, Cost & Resource Use)
  - Measures undergoing ad hoc review

NQF Standing Committee Consideration of SDS Adjustment

- Questions for Standing Committees to consider when reviewing SDS-adjusted measures:
  - Is there a conceptual relationship between the SDS factor and the measure focus?
  - Is the SDS factor present at the start of care?
  - Is there variation in prevalence of the SDS factor across measured entities?
  - Does empirical analysis (as provided by the measure developer) show that the SDS factor has a significant and unique effect on the outcome in question?
  - Is information on the SDS factor available and generally accessible for the measured patient population?

Implications for the Dual Eligible Beneficiaries Family of Measures

Five measures in the family have been identified for the trial:

- #2380 Rehospitalization During the First 30 Days of Home Health
- #2502 All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities (IRFs)
- #2505 Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health
- #2510 Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)
- #2512 All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Long-Term Care Hospitals (LTCHs)

Update on the Readmissions Project

- **Admissions/Readmissions:** 16 measures were endorsed with the condition that they enter trial period

  Standing Committee Review:

  - Robustness of proposed factors vs. data availability and accessibility
  - Potential for inclusion: patient characteristics that are present prior to treatment and are known or suspected confounder
  - Encouraged consideration of age, gender, measure of poverty test community-level variables when patient-level data are not available/robust
  - Geographic proxy data should represent the actual SDS characteristics of the patient as accurately as possible (e.g., consideration of 9-digit ZIP Code)
  - Urged caution on the use of race as a proxy for patient SDS, as it is often difficult to assess the underlying concept that race is measuring

Challenges: Input from NQF's Stakeholders

- Limited availability of patient-level data
  - 9-digit ZIP Code/census block data not easily accessible
- Risk models using currently available SDS adjustors are not demonstrating an association for measures with a clear conceptual basis for SDS adjustment
- Concerns about factors selected/analyzed to date
  - Available proxies may not be adequate
  - Inclusion of race questioned
- Call for a more prescriptive approach
  - Empirical methods
  - Variables tested

Discussion

- Does the Dual Eligible Beneficiaries Workgroup have any input to the Readmissions Standing Committee as they review these measures for potential SDS adjustment?

Lunch

Maintaining the Family of Measures: Measures with Changes to Endorsement, Voted Low-Priority, and Newly-Endorsed Measures

Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

Considering 6 measures No Longer Endorsed

- 0007 NCQA Supplemental items for CAHPS® 4.0 Adult Questionnaire
  - Workgroup previously voted to retain – has this position changed?
- 0201 Pressure ulcer prevalence (hospital acquired)
  - Consider 3 alternatives
- 0554 Medication Reconciliation Post-Discharge (MRP)
  - Combined with an existing measure in the family
- 0692 Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Long-Stay Resident Instrument
- 1902 Clinicians/ Groups' Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy
- 1909 Medical Home System Survey (MHSS)

Question to consider: Would the workgroup like to remove any measures from the Family?

Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

Considering newly available measures

- Several new measures in the NQF portfolio since the workgroup met last Spring
- Staff reviewed 25 newly available measures
  - 15 measures identified for the workgroup to consider
  - Remainder determined to be inappropriate for the population or do not address a high-leverage opportunity or gap area

- *Questions to consider: Would the workgroup like to add any of the newly-endorsed measures to the family? Replace current measures because the new measures better meets the population needs?*

Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

Measures Received Endorsement Recently

- 0 Affordability Measures
  - None to consider
- 6 Health and Well Being Measures
  - 4 condition-specific, do not target a priority gap area
  - 2 Limited to children, not appropriate for the population
- 3 Prevention and Treatment of Leading Causes of Mortality
  - 3 Condition-specific, considered too narrow for the Family
- 3 Patient Safety Measures
  - **2 Medication Measures**
  - 1 condition-specific, considered too narrow for the Family
- 1 Effective Communication and Care Coordination Measure
  - Condition-specific, considered too narrow for the Family
- **12 Person- and Family-Centered Care**
  - **Measures address measurement opportunities in quality of life and priority gap area in optimal functioning as well as person-centered care**

Maintaining the Family of Measures: Measures with Changes to Endorsement

Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

NQF #0007 NCQA Supplemental items for CAHPS® 4.0 Adult Questionnaire

- **In 2015, Workgroup voted to retain after endorsement removed**
  - Retired by the measure steward, substantial revisions of shared decision-making and care coordination questions underway
- NQF staff will bring revised CAHPS measures on these topics for the workgroup consideration when they become available
- Other applicable endorsed CAHPS measures remain in Family (excluding pediatric measures)
- Workgroup Prioritization Exercise Results
  - High Priority: 2 votes; Rationale: Consumer perspective is important
  - Low Priority: 4 votes; Rationale: Not endorsed; sensitive to cultural differences

Does the workgroup want to vote to overturn the 2015 decision to retain?

Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

NQF #0554 Medication Reconciliation Post-Discharge (MRP)

- **Measure no longer maintained as individual measure**
  - Combined with 0097 Medication Reconciliation Post-Discharge, which has maintained endorsement and is currently in the family
- The percentage of discharges during the first 11 months of the measurement year (e.g., January 1–December 1) for patients 66 years of age and older for whom medications were reconciled on or within 30 days of discharge.
- Workgroup Prioritization Exercise Results:
  - High Priority 4 votes; Rationale: Addresses important medication reconciliation for effective care; integrated with 0097
  - Low Priority: 3 votes; Rationale: Endorsement removed
- 3 related measures of medication management and transitions in the Family

Workgroup vote on removal or retention of 0554 in the family

Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

#0692 Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Long-Stay Resident Instrument

- **No longer endorsed – *Recent change, not included in exercise materials***
  - Steward no longer maintaining performance measures derived from survey items
- Scores on 5 topics valued by residents: (1) Environment; (2) Care; (3) Communication & Respect; (4) Autonomy and (5) Activities. In addition, the survey provides nursing home level scores on 3 global items.
- Workgroup Prioritization Exercise Results:
  - High Priority: 6 votes; Rationale: Quality of care varies widely and should improve; Important to understand consumer satisfaction in Nursing Home care
  - Low Priority: 1 vote; Rationale: Parsimony
- Staff Preliminary Analysis: Remove, consider addition of newly-endorsed measures to address priorities in person- and family-centered care

Workgroup consider removal of this measure from the family

Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

#1902 Clinicians/ Groups' Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy

- **No longer endorsed - *Recent change, not included in exercise materials***
- Item set domains: Communication with Provider (Doctor), Disease Self-Management, Communication about Medicines, Communication about Test Results, and Communication about Forms.
  - Steward no longer maintaining performance measures derived from survey items
- Workgroup Prioritization Exercise Results:
  - High Priority: 4 Votes; Rationale: Consumer experience and satisfaction is an important area for population
  - Low Priority: 1 vote: Rationale: Consumers may not understand measure "
- Staff Preliminary Analysis: Remove, consider addition of newly-endorsed measures to address priorities in person- and family-centered care

Workgroup consider removal of this measure from the family

Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

NQF #1909 Medical Home System Survey (MHSS)

- **Endorsement Removed: Withdrawn by developer, no longer able to support measure**
- Assesses the degree to which an individual primary-care practice or provider has in place the structures and processes of an evidence-based Patient Centered Medical Home. The survey is composed of six composites to assess a particular domain.
- Workgroup Prioritization Exercise Results
  - High Priority: 3 votes; Rationale: Supports innovative care
  - Low Priority: 3 votes; Rationale: Not endorsed; complex measure to use; limited system focus, can be measured other ways
- *Staff Preliminary Analysis: Remove, no alternatives available; encouraged continued use of 0005 CAHPS Clinician based measure and development of patient-reported outcome and experience of care performance measures*

Workgroup vote on removal or retention of 1909 in the family

Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

NQF #0201 Pressure ulcer prevalence (hospital acquired)

- **Endorsement Removed: Steward no longer maintaining measure**
- The total number of patients that have hospital-acquired (nosocomial) category/ stage II or greater pressure ulcers on the day of the prevalence measurement episode.
- Risk-adjusted outcome measure
- Specified for Hospital/Acute Care Facility and PAC/LTC settings for clinician level of analysis
- Workgroup Prioritization Exercise Results:
  - High Priority: 4 votes; Rationale: Important screening measure; pressure ulcers lead to institutionalization
  - Low Priority: 2 votes; Rationale: Parsimony; endorsement removed
- *Staff Preliminary Analysis* Remove, consider addition of available alternatives

Workgroup consider removal of this measure from the family

Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

NQF #0201 Pressure ulcer prevalence (hospital acquired)

- 0531 Patient Safety for Selected Indicators (modified version of PSI90) *Staff Pick
- 1789 Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)
  - Currently included in the family, does not focus on pressure ulcers
- 0679 Percent of High Risk Residents with Pressure Ulcers (Long Stay)
- 0678 Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay)
- 0538 Pressure Ulcer Prevention and Care

Workgroup consider alternatives to 0201 for inclusion in the family

Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

NQF #0531 Patient Safety for Selected Indicators (modified version of PSI90) **Staff Pick*

- Patient Safety for Selected Indicators is a weighted average of the reliability-adjusted, indirectly standardized, observed-to-expected ratios for indicators:
  - **PSI03 Pressure Ulcer Rate,** PSI06 Iatrogenic Pneumothorax Rate, PSI08 Postoperative Hip Fracture Rate, PSI09 Postoperative Hemorrhage or Hematoma, PSI10 Physiologic and Metabolic Derangement, PSI11 Postoperative Respiratory Failure, PSI12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate, PSI13 Postoperative Sepsis Rate, PSI14 Postoperative Wound Dehiscence Rate, and PSI15 Accidental Puncture or Laceration Rate
- Risk adjusted composite measure for Hospital/Acute Care Facilities
- Current Use: Hospital Inpatient Quality Reporting, Hospital VBP
- *Staff Preliminary Analysis:* Consider as an alternative to 0201 Pressure ulcer prevalence (hospital acquired): Also a hospital and facility-based measure; in use in federal program; addresses wide range of safety issues relevant for the population

Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

NQF #1789 Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)

- Hospital-level risk-standardized readmission rate (RSRR) of unplanned, all-cause readmission after admission for any eligible condition within 30 days of hospital discharge.
- Risk-adjusted Hospital/Acute Care Facility outcome measure
- Current Use: Medicare Shared Savings Program; Inpatient Hospital Quality Reporting Program and Meaningful Use
- *Staff Preliminary Analysis:* **Measure currently included in the Family of Measures for Dual Beneficiaries**; includes but does not focus on pressure ulcers

Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

NQF #0679 Percent of High Risk Residents with Pressure Ulcers (Long Stay)

- Percentage of long-stay residents identified as at high risk for pressure ulcers in a nursing facility who have one or more Stage 2-4 or unstageable pressure ulcer(s) reported on a target MDS assessment during their episode during the quarter.
  - High risk populations: those who are comatose, or impaired in bed mobility or transfer, or suffering from malnutrition
  - Long-stay residents: at least 101 cumulative days of nursing facility care
- Risk-adjusted outcome measure collected via electronic clinical data
- Specified for Nursing Homes/Skilled Nursing Facilities
- Current Use: Nursing Home Quality Initiative and Nursing Home Compare
- *Staff Preliminary Analysis:* Consider as an alternative to 0201 Pressure ulcer prevalence (hospital acquired): Skilled Nursing Facility measure does not address hospital-acquired pressure ulcers; risk adjusted and focused on high-risk residents; uses electronic clinical data; in use in federal program

Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

NQF #0678 Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay) **Staff Pick*

- Percent of patients or short-stay residents with Stage 2-4 pressure ulcers that are new or worsened since admission.
- Risk-adjusted outcome measure collected via electronic clinical data
- Specified for Inpatient Rehabilitation Facility, Long Term Acute Care Hospital, and Nursing Home/Skilled Nursing Facility
- Current Use: Inpatient Rehabilitation Facilities Quality Reporting, Long-Term Care Hospital Quality Reporting, Nursing Home Quality Initiative and Nursing Home Compare
- *Staff Preliminary Analysis:* Consider as an alternative to 0201 Pressure ulcer prevalence (hospital acquired): Specified for multiple LTC settings but does not address hospital-acquired pressure ulcers; risk adjusted and focused on high-risk residents; uses electronic clinical data; in use in multiple federal programs"

Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

NQF #0538 Pressure Ulcer Prevention and Care

- Percentages of three components: 1) Pressure Ulcer Risk Assessment Conducted; 2) Pressure Ulcer Prevention Included in Plan of Care; 3) Pressure Ulcer Prevention Implemented
- Process measure specified for Home Health collected via electronic clinical data
- Current Use: Home Health Quality Reporting
- *Staff Preliminary Analysis:* Consider as an alternative to 0201 Pressure ulcer prevalence (hospital acquired): Home Health measure does not address hospital-acquired pressure ulcers; uses electronic clinical data; in use in federal program

Maintaining the Family of Measures: Newly Endorsed Measures

Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

6 Newly-Endorsed Measures of Health and Well-Being

Staff Preliminary Analysis Do not recommend: Condition-specific, does not address a priority area

- Cardiovascular Medication Management Measure
  - 1662 Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy
- End-Stage Renal Disease Measures
  - 2594 Optimal End Stage Renal Disease (ESRD) Starts
  - 2701 Avoidance of Utilization of High Ultrafiltration Rate (>/= 13 ml/kg/hour)
  - 2704 Minimum Delivered Peritoneal Dialysis Dose

Staff Preliminary Analysis Do not recommend: Not appropriate for the population

- Pediatric Measures
  - *Staff Preliminary Analysis* Do not recommend: not appropriate for population
  - 2706 Pediatric Peritoneal Dialysis Adequacy: Achievement of Target Kt/V
  - 2721 Screening for Reduced Visual Acuity and Referral in Children

Should any of the newly endorsed measures be included in the family?

Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

4 Newly-Endorsed Measures

- *Staff Preliminary Analysis* Do not recommend: Condition-specific, does not address a priority area
- 2396 Carotid artery stenting: Evaluation of Vital Status and NIH Stroke Scale at Follow Up
- 2712 Statin Use in Persons with Diabetes
- 2643 Average change in functional status following lumbar spine fusion surgery
- 2653 Average change in functional status following total knee replacement surgery

Should any of the newly endorsed measures be included in the family?

Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

3 Newly-Endorsed Measures Patient Safety Measures

- 2720 National Healthcare Safety Network (NHSN) Antimicrobial Use Measure
  - *Staff Preliminary Analysis* Consider for addition to the family: addresses important area of patient safety structure and culture; does not address high-leverage opportunity for measurement or priority gap area
- 2723 Wrong-Patient Retract-and-Reorder (Wrong Patient-RAR) Measure**Staff Pick*
  - *Staff Preliminary Analysis* Consider for addition to the family: outcome measure; addresses important area of patient safety structure and culture; does not address high-leverage opportunity for measurement or priority gap area
- 2732 INR Monitoring for Individuals on Warfarin after Hospital Discharge
  - *Staff Preliminary Analysis:* Do not recommend: condition-specific, does not adequately address a priority gap area

Should any of the newly endorsed measures be included in the family?

Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

NQF #2720 National Healthcare Safety Network (NHSN) Antimicrobial Use Measure

- This measure assesses antimicrobial use in hospitals based on medication administration data that hospitals collect electronically at the point of care and report via electronic file submissions to CDC's NHSN.
- Risk-adjusted process measure
- Specified for Hospital/Acute Care Facility, Inpatient Rehabilitation Facility, and Long Term Acute Care Hospital analysis
- Collected via Electronic Health Record, Management Data
- *Staff Preliminary Analysis*: Consider for discussion: addresses important area of patient safety structure and culture; does not address high-leverage opportunity for measurement or priority gap area

Workgroup consider inclusion of this newly-endorsed measure to the family

Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

NQF #2723 Wrong-Patient Retract-and-Reorder (Wrong Patient-RAR) Measure **Staff Pick*

- A Wrong-Patient Retract-and-Reorder (Wrong Patient-RAR) event occurs when an order is placed on a patient within an EHR, is retracted within 10 minutes, and then the same clinician places the same order on a different patient within the next 10 minutes. Rate calculated by dividing Wrong Patient-RAR events by total orders examined.
- Risk-adjusted outcome measure
- Specified for Clinician, Integrated Delivery System level of analysis across settings
- Collected via Electronic Clinical Data, Electronic Health Record, Imaging/Diagnostic Study, Laboratory, Pharmacy, and Registry
- *Staff Preliminary Analysis* Consider for addition to the family: outcome measure; addresses important area of patient safety structure and culture; does not address high-leverage opportunity for measurement or priority gap area

Workgroup consider inclusion of this newly-endorsed measure to the family

Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

NQF #2732 INR Monitoring for Individuals on Warfarin after Hospital Discharge

- Percentage of adult inpatient hospital discharges to home for which the individual was on warfarin and discharged with a non-therapeutic International Normalized Ratio (INR) who had an INR test within 14 days of hospital discharge
- Process measure
- Specified for Clinician or Integrated Delivery System level of analysis across a variety of settings
- Collected via Administrative claims, Electronic Clinical Data, Electronic Health Record, Laboratory, Pharmacy for Hospital/Acute Care Facilities
- *Staff Preliminary Analysis* Do not recommend: condition-specific, does not address a priority gap area

Workgroup consider inclusion of this newly-endorsed measure to the family

NQF Member and Public Comment

Break

Maintaining the Family of Measures: Review of NQF Person- and Family- Centered Care Endorsement Project

NQF Person and Family Centered Care – Consensus Development Projects

NQF Definition: Person- and family-centered care (PFCC) is an approach to the planning and delivery of care across settings and time that is centered on collaborative partnerships among individuals, their defined family, and providers of care. It supports health and well-being by being consistent with, respectful of, and responsive to an individual's priorities, goals, needs, and values.

PFCC – Phase 1 (2014 – 2015): Experience of Care Focus

Experience of Care Measures

- Recommended endorsement (maintenance and new) of 10 measures
  - Examples: Hospital CAHPS, Care Transition Measure, Patient Experience of Psychiatric Care
- Identified themes regarding gaps in the portfolio:
  - Measures, and related surveys, must be relevant and inclusive of populations that speak languages other than English;
  - Measures should be developed for other care settings, including rehabilitation facilities; and
  - A need exists to better understand commonly excluded populations and how their "voices" may not be heard across surveys (e.g., pediatrics, maternity, behavioral health).

PFCC – Phase 2 (2015 – 2016): Functional Status Focus

- Recommended 28 measures for new or maintenance endorsement
  - Examples: FOTO measures, CARE-Item process and outcome measures, FIM-based self-care and mobility

NQF PFCC Measure Portfolio

	Process	Outcome
Experience with Care	0	20
Function/HR QOL	8	27
Symptom/Symptom Burden	1	4
Miscellaneous (language, communication, culture)	2	8
Totals	11	59

PFCC Phase 2 Themes applicable to Dual population

Theme: Parsimony in Functional Status Measurement

- In order to promote measure alignment, specific measure sets should be used in multiple settings to the extent possible.
- Implementation of new measures and new assessment tools may introduce significant burden across care settings which can impact measure feasibility and usability. There is a need to assess costs associated with changing tools/measures, and the burden of conducting multiple assessments to meet demands for measures.
- Consideration of a common core of items that could be used across settings, while allowing providers the flexibility to include extra questions where appropriate (e.g., body part, condition, and setting).

Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014

- **Bipartisan bill passed on September 18, 2014 and signed into law by President Obama on October 6, 2014**

- **Requires Standardized Patient Assessment Data that will enable:**
  - Data Element uniformity
  - Quality care and improved outcomes
  - Comparison of quality and data across post-acute care (PAC) settings
  - Improved discharge planning
  - Exchangeability of data
  - Coordinated care

Driving Forces of the IMPACT Act

- **Purposes Include:**
  - Improvement of Medicare beneficiary outcomes
  - Provider access to longitudinal information to facilitate coordinated care
  - Enable comparable data and quality across PAC settings
  - Improve hospital discharge planning
  - Research

- **Why the attention on Post-Acute Care:**
  - Escalating costs associated with PAC
  - Lack of data standards/interoperability across PAC settings
  - Goal of establishing payment rates according to the individual characteristics of the patient, not the care setting

PAC-PRD & the CARE Tool:
Goals and Guiding Principles

Goals

- ✓ Fosters seamless care transitions
- ✓ Measures that can follow the patient
- ✓ Evaluation of longitudinal outcomes for patients that traverse settings
- ✓ Assessment of quality across settings
- ✓ Improved outcomes, and efficiency
- ✓ Reduction in provider burden

Guiding Principles

Data Uniformity

- ✓ Reusable
- ✓ Informative
- ✓ Increases Reliability/validity
- ✓ Facilitates patient care coordination

Interoperability

- ✓ Data that can communicate in the same language across settings
- ✓ Data that can be transferable forward and backward to facilitate care coordination
- ✓ Follows the individual

Addressing Critical Gaps
IMPACT Act & Opportunity

The Act provides an opportunity to address all goals within the CMS Quality Strategy:

Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries: Newly-Endorsed Measures of Person- and Family Centered Care

Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

12 Newly-Endorsed Measures of Person- and Family-Centered Care

- 2287 Functional Change: Change in Motor Score
- 2612 CARE: Improvement in Mobility
- 2613 CARE: Improvement in Self Care
- 2624 Functional Outcome Assessment **Staff Pick*
- 2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function **Staff Pick*
- 2632 Long-Term Care Hospital (LTCH) Functional Outcome Measure: Change in Mobility Among Patients Requiring Ventilator Support
- 2635 Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients
- 2636 Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients
- 2286 Functional Change: Change in Self Care Score
- 2321 Functional Change: Change in Mobility Score
- 2633 Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients
- 2634 Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients
- *Should any of the newly endorsed measures be included in the family?*

Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

NQF #2287 Functional Change: Change in Motor Score

- Change in rasch derived values of motor function from admission to discharge among adult inpatient rehabilitation facility patients aged 18 years and older who were discharged alive. The timeframe is 12 months.
  - Includes 12 FIM® items: Feeding, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, Memory, Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs.
- Risk-adjusted outcome measure
- Specified for Inpatient Rehabilitation Facility
- *Staff Preliminary Analysis* Consider for addition to the family: addresses high-leverage measurement opportunity of quality of life and priority gap area in optimal functioning

Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

NQF #2612 CARE: Improvement in Mobility

- SNFs average change in mobility for patients admitted from a hospital who are receiving therapy. The measure calculates the average change in **mobility** score between admission and discharge for all residents admitted to a SNF from a hospital or another post-acute care setting for therapy (i.e., PT or OT) regardless of payor status.
  - Based on CARE Tool mobility subscale and MDS 3.0 assessment
  - Calculated on rolling 12 month, average updated quarterly.
- Risk-adjusted outcome measure
- Specified for Nursing Home/Skilled Nursing Facility
- Collected via Electronic Clinical Data, other sources
- *Staff Preliminary Analysis* Consider for addition to the family: addresses high-leverage measurement opportunity of quality of life and priority gap area in optimal functioning

Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

NQF #2613 CARE: Improvement in Self Care

- SNFs average change in self care for patients admitted from a hospital who are receiving therapy. The measure calculates the average change in **self care** score between admission and discharge for all residents admitted to a SNF from a hospital or another post-acute care setting for therapy (i.e., PT or OT) regardless of payor status.
  - Based on CARE Tool self care subscale and MDS 3.0 assessment
  - Calculated on rolling 12 month, average updated quarterly.
- Risk-adjusted outcome measure
- Specified for Nursing Home/Skilled Nursing Facility
- Collected via Electronic Clinical Data, other sources
- *Staff Preliminary Analysis* Consider for addition to the family: addresses high-leverage measurement opportunity of quality of life and priority gap area in optimal functioning

Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

NQF #2624 Functional Outcome Assessment **Staff Pick*

- Percentage of visits for patients aged 18 and older with documentation of a current functional outcome assessment using a *standardized functional outcome assessment tool on the date of the encounter AND documentation of a care plan based on identified functional outcome deficiencies* on the date of the identified deficiencies.
- Risk adjusted outcome measure
- Specified for Ambulatory Care and Outpatient Rehabilitation Analysis
- Collected via Administrative Claims and Medical Records
- *Staff Preliminary Analysis* Consider for addition to the family: addresses high-leverage measurement opportunity of quality of life and priority gap areas in goal-directed, person-centered care planning and implementation and optimal functioning

Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

NQF #2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function **Staff Pick*

- This quality measure reports the percentage of all Long-Term Care Hospital (LTCH) patients with an *admission and discharge functional assessment and a care plan that addresses function*.
- Specified for Long Term Acute Care Hospital Analysis
- Process measure collected via Electronic Clinical Data
- *Staff Preliminary Analysis* Consider for addition to the family: addresses high-leverage measurement opportunity of quality of life and priority gap areas in goal-directed, person-centered care planning and implementation and optimal functioning

Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

NQF #2632 Long-Term Care Hospital (LTCH) Functional Outcome Measure: Change in Mobility Among Patients Requiring Ventilator Support

- This measure estimates the *risk-adjusted change in mobility score between admission and discharge* among LTCH patients requiring *ventilator support* at admission.
- Risk adjusted outcome measure
- Specified for Long Term Acute Care Hospital Analysis
- Collected via Electronic Clinical Data
- *Staff Preliminary Analysis*
  - Consider for addition to the family: addresses high-leverage measurement opportunity of quality of life and priority gap areas in goal-directed, person-centered care planning and implementation and optimal functioning;
  - Noted limited scope in patients requiring ventilator support

Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

NQF #2635 Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients

- This measure estimates the percentage of IRF patients who meet or exceed an expected discharge self-care score.
- Risk adjusted outcome measure
- Specified for Inpatient Rehabilitation Facility Analysis
- Collected via Electronic Clinical Data
- *Staff Preliminary Analysis* Consider for addition to the family: addresses high-leverage measurement opportunity of quality of life and priority gap area in optimal functioning

Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

NQF #2636 Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients

- This measure estimates the percentage IRF patients who meet or exceed an expected discharge mobility score.
- Risk adjusted outcome measure
- Specified for Inpatient Rehabilitation Facility Analysis
- Collected via Electronic Clinical Data
- *Staff Preliminary Analysis* Consider for addition to the family: addresses high-leverage measurement opportunity of quality of life and priority gap area in optimal functioning

Measures of Person- and Family-Centered Care

NQF #2286 Functional Change: Change in Self Care Score

- Change in rasch derived values of self-care function from admission to discharge among adult patients treated at an inpatient rehabilitation facility who were discharged alive. The timeframe for the measure is 12 months.
  - Includes 8 items: Feeding, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, and Memory.
- Risk adjusted outcome measure
- Specified for Inpatient Rehabilitation Facility
- *Staff Preliminary Analysis* Consider for addition to the family: addresses high-leverage measurement opportunity of quality of life and priority gap area in optimal functioning

Measures of Person- and Family-Centered Care

NQF #2286 Functional Change: Change in Self Care Score

- Change in rasch derived values of self-care function from admission to discharge among adult patients treated at an inpatient rehabilitation facility who were discharged alive. The timeframe for the measure is 12 months.
  - Includes 8 items: Feeding, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, and Memory.
- Risk adjusted outcome measure
- Specified for Home Health, Inpatient Rehabilitation Facility, Long Term Acute Care Hospital, and Nursing Home/Skilled Nursing Facility Analysis
- Collected via Electronic Clinical Data, Electronic Health Data, or Other
- *Staff Preliminary Analysis* Consider for addition to the family: addresses high-leverage measurement opportunity of quality of life and priority gap area in optimal functioning

Measures of Person- and Family-Centered Care

NQF #2321 Functional Change: Change in Mobility Score

- Change in rasch derived values of mobility function from admission to discharge among adult inpatient rehabilitation facility patients aged 18 years and older who were discharged alive. The timeframe for the measure is 12 months.
  - Includes 4 mobility FIM® items: Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs.
- Risk adjusted outcome measure
- Specified for Inpatient Rehabilitation Facility
- *Staff Preliminary Analysis* Consider for addition to the family: addresses high-leverage measurement opportunity of quality of life and priority gap area in optimal functioning

Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

NQF #2633 Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients

- This measure estimates the risk-adjusted mean change in self-care score between admission and discharge for Inpatient Rehabilitation Facility (IRF) Medicare patients.
- Risk adjusted outcome measure
- Specified for Inpatient Rehabilitation Facility Analysis
- Collected via Electronic Clinical Data
- *Staff Preliminary Analysis* Consider for addition to the family: addresses high-leverage measurement opportunity of quality of life and priority gap area in optimal functioning

Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

NQF #2634 Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients

- This measure estimates the mean risk-adjusted mean change in mobility score between admission and discharge for Inpatient Rehabilitation Facility (IRF) Medicare patients.
- Risk adjusted outcome measure
- Specified for Inpatient Rehabilitation Facility Analysis
- Collected via Electronic Clinical Data
- *Staff Preliminary Analysis* Consider for addition to the family: addresses high-leverage measurement opportunity of quality of life and priority gap area in optimal functioning

Measures of Person- and Family-Centered Care

Should any of the newly endorsed measures be included in the family?

Opportunity for Member and Public Comment

Adjourn

Day 2: Continental Breakfast

Welcome and Recap of Day 1

Themes from Day 1

TBD

Summary of Additions to the Family of Measures

TBD

Summary of Removals from the Family of Measures

TBD

Prioritizing Measures in the Family

Prioritizing Measures in the Family

Summary of Workgroup Prioritization Exercise

- 8 Workgroup members responded to the exercise
- 6 measures were identified as low priority
  - These measures considered for removal from the Family throughout Day 1
- ALL measures were identified as high priority by at least one member
  - 9 measures with 6 or 7 high priority votes will be considered for the Starter Set on Day 2
  - Considered alongside similar measures currently in the Starter Set
- All measures in the Starter Set had more than 3 or more votes to retain; most had 0-1 vote to remove

Prioritizing Measures in the Family

Summary of Workgroup Prioritization Exercise

- Focus and concentration of available measures mismatch for population
  - Large portion of acute care measures, though the population relies significantly on care in PAC/LTC and other settings
  - Significant impact of mental/behavioral health issues and functional impairments in the population, while measures focus on the physical medical model
- Measures of screening or assessment should include elements of treatment and follow up
  - Screening should not be required in absence of resources to treat

Prioritizing Measures in the Family

Summary of Workgroup Prioritization Exercise

- Few available measures represent the person or family member's perspectives, nor would they be meaningful to these individuals
- Support for measures promoting effective communication and care coordination, management of medications and polypharmacy in vulnerable populations
- Concerns about the application of clinical/medical measures to individuals with serious mental illness
- NQS Priorities created some confusion
- Effort to be parsimonious drove vote for low priority measures

Prioritizing Measures in the Family

11 Endorsed Measures Currently in the Starter Set

- 0004 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)
- 0008 Experience of Care and Health Outcomes (ECHO) Survey (behavioral health, managed care versions)
- 0022 Use of High-Risk Medications in the Elderly (DAE)
- 0028 Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention
- 0101 Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls
- 0228 3-Item Care Transition Measure (CTM-3)
- 0418 Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
- 0419 Documentation of Current Medications in the Medical Record
- 0421 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
- 0576 Follow-Up After Hospitalization for Mental Illness (FUH)
- 1768 Plan All-Cause Readmissions (PCR)

Prioritizing Measures in the Family

1909 Medical Home System Survey (MHSS) **No Longer Endorsed*

- The Medical Home System Survey (MHSS) assesses the degree to which an individual primary-care practice or provider has in place the structures and processes of an evidence-based Patient Centered Medical Home
- Decision from Day 1 – TBD

- Workgroup Prioritization Exercise Results:
  - High Priority: 3 votes; Rationale: Supports innovative care
  - Low Priority: 3 votes; Rationale: Not endorsed; complex measure to use; limited system focus, can be measured other ways
- Staff Preliminary Analysis: Remove from Starter Set, no longer endorsed

Workgroup vote to remove from the Starter Set

Prioritizing Measures in the Family: Measures Voted Low-Priority

Maintaining the MAP Family of Measures for Dual Eligible Beneficiaries

Considering 6 Measures Identified as Low Priority

- 0007 NCQA Supplemental items for CAHPS® 4.0 Adult Questionnaire – No longer endorsed
- 0176 Improvement in management of oral medications
- 1909 Medical Home System Survey (MHSS) – No longer endorsed
- 2091 Persistent Indicators of Dementia without a Diagnosis—Long Stay
- 2092 Persistent Indicators of Dementia without a Diagnosis—Short Stay
- 2158 Payment-Standardized Medicare Spending Per Beneficiary (MSPB)

Question to consider: Would the workgroup like to remove any of these measures from the Family?

Prioritizing Measures in the Family

NQF #0176 Improvement in management of oral medications

- Percentage of home health episodes of care during which the patient improved in ability to take their medicines correctly, by mouth.
  - Outcome measure for Home Health
  - Collected via Electronic Clinical Data
  - Current use: CMS Home Health Quality Reporting
- Workgroup Prioritization Exercise Results:
  - High Priority 4 votes; Rationale: Beneficiaries often have multiple medications that can have unintended consequences if poorly managed; essential for self management and self care
  - Low Priority: 3 votes; Rationale: Does not address priority area for population
- 8 other medication management measures in the Family
  - 4 focused on transitions of care, others on older adults, documentation, or discrepancies

Workgroup vote on removal or retention of 0176 in the family

Prioritizing Measures in the Family

#2091 Persistent Indicators of Dementia without a Diagnosis - Long Stay

- Percentage of nursing home residents age 65+ with persistent indicators of dementia and no diagnosis of dementia.
  - Specified for Nursing Home/Skilled Nursing Facility
- Workgroup Exercise Results:
  - High Priority: 1 vote; Rationale: Important to screen and initiate treatment for Dementia; diagnosis will impact care and experience for individual and family
  - Low Priority: 3 votes; Rationale: Anticipate treatment would not be affected by the diagnosis; parsimony
- *Staff Preliminary Analysis:* Consider removal from the Family

Workgroup consider removal of this measure from the family

Prioritizing Measures in the Family

#2092 Persistent Indicators of Dementia without a Diagnosis - Short Stay

- Number of adult patients 65 and older who are included in the denominator (i.e., have persistent signs and symptoms of dementia) and who do not have a diagnosis of dementia on any MDS assessment.
  - Specified for Nursing Home/Skilled Nursing Facility
- Workgroup Exercise Results:
  - High Priority: 1 vote; Rationale - Important to screen and initiate treatment for Dementia; diagnosis will impact care and experience for individual and family
  - Low Priority: 3 votes; Rationale - Anticipate treatment would not be affected by the diagnosis; parsimony
- Staff Preliminary Analysis: Consider removal from the Family

Workgroup consider removal of this measure from the family

Prioritizing Measures in the Family

#2158 Payment-Standardized Medicare Spending Per Beneficiary

- Cost of services performed by hospitals and other healthcare providers during an MSPB hospitalization episode
  - Episode includes costs 3 days prior to hospital admission through 30 days post-discharge
  - Does not include post-acute care or long-term care hospitals
- Medicare beneficiaries enrolled in Medicare Parts A and B who were discharged from short-term acute hospitals
  - No risk adjustment for dual eligibility, measure performance was not impacted
  - More work is needed on the use of SES variables in outcome and resource use measures
- Aims to improve care coordination
  - Excludes transfers because of feasibility determining attribution
- Workgroup Prioritization Exercise Results:
  - High Priority: 3 votes; Rationale: Only available measure to understand the critical issue of cost
  - Low Priority: 4 votes; Rationale: None
- Staff Preliminary Analysis: Maintain in the Family as the only measure of cost and affordable care

Prioritizing Measures in the Family: Measures Voted High-Priority

Prioritizing Measures in the Family

9 additional Measures with 6-7 votes for High Priority

- 0018 Controlling High Blood Pressure
- 0097 Medication Reconciliation Post-Discharge
- 0202 Falls with injury
- 0326 Advance Care Plan
- 0553 Care for Older Adults (COA) – Medication Review
- 0647 Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care)
- 0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care)
- 0674 Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)
- 2111 Antipsychotic Use in Persons with Dementia
- 2510 Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)

Workgroup Voting on the Addition or Removal of Measures from the Starter Set

Medication Measures

- Currently in the Starter Set:
  - 0419 Documentation of Current Medications in the Medical Record
    - High Priority: 6 votes; Rationale: Understanding medications is particularly important for the population; Important for effective treatment and communication; prevents medication complications
    - Low Priority: 2 votes; Rationale: Minimum requirement that should always be done; not of specific importance to the population"
  - 0022 Use of High-Risk Medications in the Elderly (DAE)
    - High Priority: 4 votes; Rationale: Prevent adverse drug reactions and hospitalizations in the elderly; list of high risk medications readily available
    - Low Priority: 2 votes: Lacking exclusions for treatment rationale; parsimony
- Consider substitution for measures that received 7 high priority votes:
  - 0553 Care for Older Adults (COA) – Medication Review
    - High Priority: 7 votes; Rationale: Population at high risk for poly pharmacy and related adverse events; important for effective treatment; in home review would be more effective for persons in the community
    - Low Priority: 1 vote; Rationale: narrow target population
  - 0097 Medication Reconciliation Post-Discharge
    - High Priority: 7 votes; Rationale: Important for effective treatment; Population at high risk for complications from polypharmacy and medication errors; must be timely in transitions of care

Workgroup Voting on the Addition or Removal of Measures from the Starter Set

Falls Measures

- Currently in the Starter Set:
  - 0101 Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls
    - High Priority: 7 votes; Rationale: priority patient safety issue in dual beneficiaries and older adults; risk of falling increases after a fall; falls are a major cause of death and institutionalization
- Consider measures that received 6 or 7 high-priority votes:
  - 0202 Falls with injury
    - High Priority: 6 votes; Rationale: Aligned with other programs; Priority for dual beneficiaries and older adults; Risk adjust
    - Low Priority: 1 vote; Rationale: Minor falls should not be included
  - 0674 Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)
    - High Priority: 6 votes; Rationale: Important safety issue in dual beneficiaries and older adult populations; falls with injuries are very important quality issue; falls are a major cause of death and institutionalization
    - Low Priority:1 vote; Rationale: Parsimony

Workgroup Voting on the Addition or Removal of Measures from the Starter Set

Care Transitions

- Currently in the Starter Set:
  - 0228 3-Item Care Transition Measure (CTM-3)
    - » High Priority: 4 votes; Rationale: Addresses priority area; low burden
- Consider other measures that received 6 high priority votes:
  - 0647 Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care)
    - » High Priority: 6 votes; Rationale: Important for patient/caregiver to understand discharged plan; effective care; important for Care coordination and discharge planning"
  - 0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care)
    - » High Priority: 6 votes; Rationale: important for effective care continuity, coordination, transitions, especially for individuals with complex illnesses, beneficiaries using LTSS; streamline measures
    - » Low Priority: 1 vote

Workgroup Voting on the Addition or Removal of Measures from the Starter Set

Readmissions

- Currently in the Starter Set:
  - 1768 Plan All-Cause Readmissions (PCR)
    - » High Priority: 7 votes; Rationale: Aligned with federal programs; encourages system approach to disease management; promotes care planning
- Consider measures that received 6 or 7 high priority votes:
  - 2510 Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)
    - » High Priority: 6 votes; Rationale: Global measure of care planning and implementation; encourages system approach to disease management; readmissions lead to deterioration; addresses frequent transitions in care and instability; addresses priority area for dual beneficiaries
    - » Low Priority: 1 vote; Rationale: None

Workgroup Voting on the Addition or Removal of Measures from the Starter Set

- Consider addition of other measures that received 6 or 7 high-priority votes:
  - 0018 Controlling High Blood Pressure
    - High Priority: 7 votes; Rationale: : Standard of care for an important physical health condition that can lead to other issues; maintain with current guidelines
    - Low Priority: 1 vote; Rationale: Parsimony
  - 0326 Advance Care Plan
    - High Priority: 7; Rationale: Addresses high priority area for dual beneficiaries and older adults; Important for shared decision-making; Support self determination, appropriate care at the end of life, and patient and family centered care
  - 2111 Antipsychotic Use in Persons with Dementia
    - High Priority: 7; Rationale: Important to prevent overuse of medications in at risk population and prevent harm; address quality of life and supports individual in lowest level of appropriate care
    - Low Priority: 2; Rationale: None

Break

NQF Home and Community Based Services (HCBS) Project Update

Addressing Performance Measure Gaps in Home and Community-Based Services to Support Community Living

NATIONAL QUALITY FORUM

MAP Duals In-Person Meeting
April 20, 2016
10:30-11:30AM

Objectives

- Discuss the drivers of HCBS quality measurement
- Project overview
- Summarize findings of 1st Interim Report
- Summarize findings of 2nd Interim Report
- Discuss next steps

NQF Project Staff

- Margaret Terry, PhD, RN
  - Senior Director
- Rachel Roiland, PhD, RN
  - Senior Project Manager
- Andrew Anderson, MHA
  - Project Manager
- Kim Ibarra, MS
  - Project Manager
- Desmirra Quinnonez
  - Project Analyst

HHS Advisory Group

- Sophia Chan, CMS
- Eliza Bangit, ACL
- Ellen Blackwell, CMS
- Mike Smith, CMS
- Elizabeth Ricksecker, CMS
- D.E.B. Potter, ASPE
- Lisa Patton, SAMHSA

Project Overview

Why Measure Quality of HCBS?

- Home and community-based services (HCBS) are critical to promoting independence, wellness, and self-determination for people with long-term care needs
  - Most people prefer to live in community-based settings
  - Examples of HCBS services include personal care, supported employment, and family caregiver supports
- States continue to shift resources from institutional care to HCBS
- Data from FY 2013 show that HCBS outlays are over half of Medicaid's long term care expenditures, continuing a trend from recent years
  - Beyond Medicaid, HCBS are also provided for by other federal agencies, a significant “private pay” market, and informal supports of family members and friends

What is Driving HCBS Quality Measurement?

- Growing demand for LTSS
- Shift from volume to value
- Push to make care more person-centered and coordinated
- Rebalancing public spending on LTSS
- Move towards standardizing quality measurement across care settings
- “Better care”, “smarter spending”, and “healthier people”

Evolving HCBS Landscape: Policies, Guidance, Legislation, and Regulations

- National Quality Strategy
- IMPACT Act
- Secretary Sebelius' Guidance on Person-Centered Planning and Self-Direction
- Americans with Disabilities Act (ADA)
- Olmstead Ruling
- Department of Justice Statement on Community Integration
- CMS HCBS Final Rule
- Developmental Disabilities Assistance & Bill of Rights Act
- Individuals with Disabilities Education Act
- Older Americans Act & Age Discrimination in Employment Act
- Affordable Care Act

Evolving HCBS Landscape: Programs, Grants, Demonstrations, and Models

- Money Follows the Person
- Balancing Incentive Program
- Managed Care Organizations
- HCBS Waivers
- Health Homes
- Testing Experience and Functional Tools (TEFT)
- Accountable Health Communities

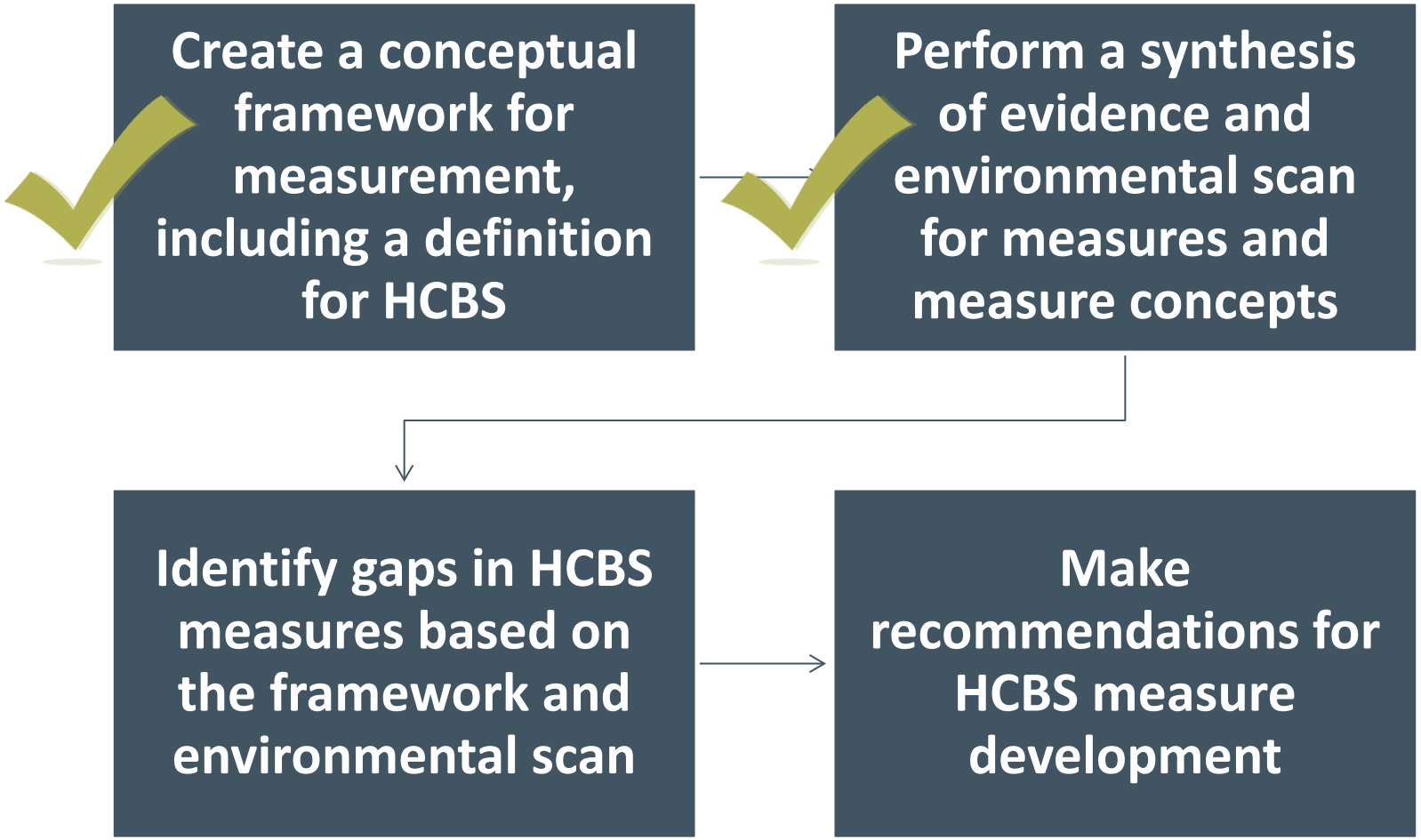
Project Purpose

Provide multistakeholder guidance on the highest priorities for measuring home and community-based services that support high-quality community living

HCBS Quality Committee

- Joe Caldwell (Co-Chair)
- Stephen Kaye (Co-Chair)
- Robert Applebaum
- Kimberly Austin-Oser
- Suzanne Crisp
- Jonathan Delman
- Camille Dobson
- Sara Galantowicz
- Ari Houser
- Patti Killingsworth
- Charlie Lakin
- Clare Luz
- Sandra Markwood
- Barbara McCann
- Sarita Mohanty
- Gerry Morrissey
- Ari Ne'eman
- Andrey Ostrovsky
- Mike Oxford
- Lorraine Phillips
- Mary Smith
- Anita Yuskauskas

Key Milestones



First Interim Report:

"Addressing Performance Measure Gaps in Home and Community-Based Services to Support Community Living: Initial Components of the Conceptual Framework"

HCBS refers to an array of services and supports that promote the independence, well-being, self-determination, and community inclusion of an individual of any age who has significant, long-term physical, cognitive, and/or behavioral health needs and that are delivered in the home or other integrated community setting

Characteristics of High Quality HCBS

- Provides for a person-driven system that optimizes individual choice and control in the pursuit of self-identified goals and life preferences
- Promotes social connectedness and inclusion of people who use HCBS in accordance with individual preferences
- Includes a flexible range of services that are sufficient, accessible, appropriate, effective, dependable, and timely to respond to individuals' strengths, needs, and preferences and are provided in a setting of the individual's choosing
- Integrates healthcare and social services to promote well-being

Characteristics of High Quality HCBS cont.

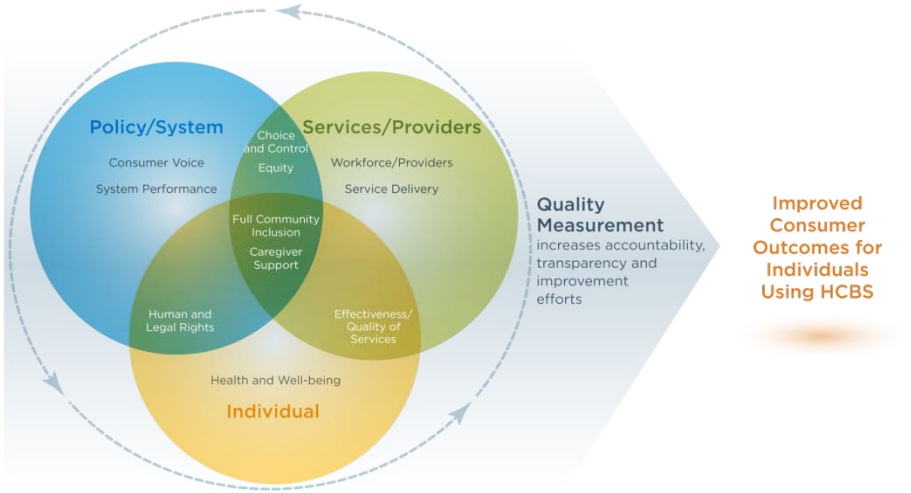
- Promotes privacy, dignity, respect, and independence; freedom from abuse, neglect, exploitation, coercion, and restraint; and other human and legal rights
- Ensures each individual can achieve the balance of personal safety and dignity of risk that he or she desires
- Supplies and supports an appropriately skilled workforce that is stable and adequate to meet demand
- Supports family caregivers
- Engages individuals who use HCBS in the design, implementation, and evaluation of the system and its performance

Characteristics of High Quality HCBS cont.

- Reduces disparities by offering equitable access to and delivery of services that are developed, planned, and provided in a culturally sensitive and linguistically appropriate manner
- Coordinates and integrates resources to best meet the needs of the individual and maximize affordability and long-term sustainability
- Receives adequate funding to deliver accessible, affordable, and cost-effective services to those who need them
- Supplies valid, meaningful, integrated, aligned, accessible, outcome-oriented data to all stakeholders
- Fosters accountability through measurement and reporting of quality and outcomes

Domains of HCBS Quality Measurement

- Effectiveness of Services and Delivery
- Person-centered Planning and Coordination
- Choice and Control
- Community Inclusion
- Caregiver Support
- Workforce
- Human and Legal Rights
- Equity
- Health and Wellbeing
- System Performance and Accountability
- Consumer Leadership in System Development



Second Interim Report:

"Addressing Performance Measure Gaps in Home and Community-Based Services to Support Community Living: Synthesis of Evidence and Environmental Scan"

Environmental Synthesis & Environmental Scan Objectives

- Identify measures, measure concepts, and instruments used or proposed for use to assess HCBS quality
- Identify examples of HCBS measures to guide the Committee's discussion of implementation barriers and mitigation strategies
- Facilitate the Committee's identification of key measurement gaps and prioritization of measure concepts and instruments that should developed into HCBS performance measures

Approach

1. Collect information sources
2. Review information sources
3. Review state-level (Minnesota, Oregon, and Washington) and international (England , Canada, And Australia) HCBS systems

Environmental Scan Results– Measures, Measure Concepts, and Instruments Across Domains

Domains for Measurement	Measures n=261	Measure Concepts n=394	Instruments n=75
Service Delivery	75	173	8
System Performance	42	166	3
Effectiveness/Quality of Services	111	13	25
Choice and Control	17	61	34
Health and Well-Being	60	6	16
Workforce	10	65	6
Human and Legal Rights	4	28	1
Community Inclusion	4	15	7
Caregiver Support	4	3	11
Equity	4	4	0
Consumer Voice	0	0	0

State Findings

- WA is developing two measures sets to assess consumer outcomes for:
  1. Use in contracts with agencies providing HCBS services
  2. Public and private health providers.
- OR is using consumer experience and provider self-assessment survey tools to assess various HCBS settings
- MN is disseminating the National Core Indicator - Aging and Disabilities Survey among state programs

International Findings

Country	Example Framework	Example Domains / Attributes
England	Adult Social Care Outcomes Framework	• Enhancing quality of life • Delaying and reducing need for care • Ensuring a positive experience • Safeguarding adults
Canada	Ontario Home Care Quality Measures	• Accessible • Effective • Safe • Patient-Centered • Efficient • Population Health Focus
Australia	National Disability Insurance Scheme	• Choice and control • Home • Work • Daily activities • Health and well-being • Social, community, and civic participation • Relationships • Lifelong learning

Next Steps

- Committee workgroup calls
- **3rd Interim Report**: Recommendations on HCBS Measure Concepts for Translation and Advancing Measurement
- July public webinar
- **Final Report:** Recommendations on Addressing Performance Measure Gaps in HCBS to Support Community Living Quality

Q&A

Questions or Comments?

HCBS@qualityforum.org

Andrew Anderson, Project Manager:
aanderson@qualityforum.org

Peg Terry, Senior Director:
mterry@qualityforum.org

Opportunity for Member and Public Comment

Addressing Community Integration for Dual Eligible Beneficiaries

Discuss the Priority Measure Gap Areas in Community Integration

Overview of Previous Recommendations

- IOM Vital Signs report of 2015 recently listed Engaged People as a critical domain, including Individual and Community Engagement elements
  - Recognizes the interrelatedness of these elements with others such as health and wellbeing
  - Acknowledges involvement of range of stakeholders and wide variation in individual and community interests and resources

Blumenthal D, Malphrus E, McGinnish JM, eds. Vital Signs Core Metrics for Health and Health Care Progress. Washington, DC: National Academies Press; 2015. Available at http://iom.nationalacademies.org/Reports/2015/Vital-Signs-Core-Metrics.aspx. Last accessed February

Information and Strategies for Discussion

- Background on the topic from Center for Health Care Strategies (CHCS)
  - Context setting
- NQF National Quality Partners Population Health Framework
  - Action guide to improving population health with measures
- State Integration of Health and Social Services
  - Key program attributes and characteristics
- Report by Center for Health Care Strategies for RWJ
  - Key domains for integration
- AHRQ Clinical-Community Relationship Measure Atlas
  - Catalogue of measures and gaps of care coordination for preventive services outside of healthcare settings

Community Integration and Data

- Integrated care programs have gained traction and seen an increase in enrollment of dually eligible Medicare-Medicaid beneficiaries
- Quantitative data on impact of these programs is, at present, unavailable
- Currently information available on the successes of these programs comes from health plans participating in an national effort

N. Archibald and S. Barth. "Assessing Success in Medicare -Medicaid Integration: A Review of Measurement Strategies." Center for Health Care Strategies, Inc. Issue Brief December 2015. Available at : http://www.chcs.org/resource/assessing-success-medicare-medicaid-integration-review-measurement-strategies

Community Integration: *PRIDE (Promoting Integrated Care for Dual Eligibles)*

- *PRIDE* is a national effort funded by The Commonwealth Fund
- A consortium of seven integrated health care organizations
- The goal is to gather and examine:
  - *program elements that lead to success*
  - *Potential for existing measures to accurately assess performance*
  - *Potential for measure under development to accurately assess performance*

N. Archibald and S. Barth. "Assessing Success in Medicare -Medicaid Integration: A Review of Measurement Strategies." Center for Health Care Strategies, Inc. Issue Brief December 2015. Available at : http://www.chcs.org/resource/assessing-success-medicare-medicaid-integration-review-measurement-strategies

PRIDE Framework Domains

- Domain I: Leadership and Organizational Culture
- Domain II: Infrastructure to "Scale Up" and "Stretch Out While Maintaining Quality and Value"
- Domain III: Financial and Nonfinancial Incentives and related Mechanisms that Align Plan, Provider and Member Interests
- Domain IV: Coordinated Care Provided through Comprehensive, Accessible Networks and Person/Family-Centered Care Planning

PH Feldman PhD. "Key Attributes of High-Performing Integrated Health Plans for Medicare-Medicaid Enrollees." August 2014. Available at:http://www.chcs.org/media/PRIDE-Key-Attributes-of-High-Performing-Health-Plans_090514.pdf

Community Integration: Program Characteristics

- Goal of integration is to improve quality of care and life, and reduce costs for this high-need, high-cost population.

- **Integrated benefits include**:
  - *Person-centered primary care*
  - *Acute care*
  - *Behavioral health care*
  - *Long-term services and supports (LTSS)*

- Main components of a program include person-centered assessments, care plans and care coordination.

N. Archibald and S. Barth. "Assessing Success in Medicare -Medicaid Integration: A Review of Measurement Strategies." Center for Health Care Strategies, Inc. Issue Brief December 2015. Available at : http://www.chcs.org/resource/assessing-success-medicare-medicaid-integration-review-measurement-strategies

Successful Integrated Care Program Attributes

- Person-centered, accountable primary care
- Care management and coordination across all benefits and settings of care
- Comprehensive provider networks to meet the broad needs of the target population
- Data-sharing and communication across an individual's providers and caregivers
- Financial alignment that blends Medicare and Medicaid funding

N. Archibald and S. Barth. "Assessing Success in Medicare -Medicaid Integration: A Review of Measurement Strategies." Center for Health Care Strategies, Inc. Issue Brief December 2015. Available at : http://www.chcs.org/resource/assessing-success-medicare-medicaid-integration-review-measurement-strategies/

Performance Measures and Integrated Care Assessment

Performance Measures for Integrated Care

- Effective measures need to capture performance in the following areas:
  - *Implementing needs assessments and person-centered care plans*
  - *Engaging individuals in their care*
  - *Addressing LTSS needs*
  - *Improving quality of life*

N. Archibald and S. Barth. "Assessing Success in Medicare -Medicaid Integration: A Review of Measurement Strategies." Center for Health Care Strategies, Inc. Issue Brief December 2015. Available at : http://www.chcs.org/resource/assessing-success-medicare-medicaid-integration-review-measurement-strategies/

Performance Measures: Current Landscape

- Implementing needs assessments and person-centered care plans
  - Existing measures as well as measures under development are available
- Engaging individuals in their care
  - Existing measures are inadequate and do not address activities undertaken to engage individuals in their care
  - New measures in this area are under development by NCQA
- Addressing LTSS needs
  - Existing measures provide limited data
  - New measures are under development
- Improving quality of life
  - Current measures incapable of adequately capturing data on quality of life

N. Archibald and S. Barth. "Assessing Success in Medicare -Medicaid Integration: A Review of Measurement Strategies." Center for Health Care Strategies, Inc. Issue Brief December 2015. Available at : http://

/

Performance Measures: Future Direction

- Measure Gap Areas:
  - Care coordination
  - Care management
  - Quality of Life

N. Archibald and S. Barth. "Assessing Success in Medicare -Medicaid Integration: A Review of Measurement Strategies." Center for Health Care Strategies, Inc. Issue Brief December 2015. Available at : http://

Integrated Care: Framework for Consideration

- Moving from individual to population health
- Maximize community involvement
- Improve and sustain quality

NQF National Quality Partners Population Health Framework

✓	Element	Questions to Consider
	Collaborative self-assessment	*What is needed to foster effective collaboration on population health?*
	Leadership across the region and within organizations	*Which individuals or organizations in the region are recognized or potential leaders in population health improvement?*
	Audience-specific strategic communication	*What is the level of skill or capability to engage in effective communication with each of the key audiences in the region?*
	A community health needs assessment and asset mapping process	*Which organizations in the region already conduct community health needs assessments or asset mapping regarding population health?*
	An organizational planning and priority-setting process	*Which organizations in the region engage in collaborative planning and priority-setting to guide activities to improve health in the region?*
	An agreed-upon, prioritized set of health improvement activities	*What are the focus areas of existing population health improvement projects or programs, if any?*
	Selection and use of measures and performance targets	*Which measures, metrics, or indicators are already being used to assess population health in the region, if any?*
	Joint reporting on progress toward achieving intended results	*Which organizations in the region publicly or privately report on progress in improving population health?*
	Indications of scalability	*For current or new population health work, what is the potential for expansion within the region or to other regions?*
	A plan for sustainability	*What new policy directions, structural changes, or specific resources in the region may be useful for sustaining population health improvement efforts over time?*

See the full Action Guide v2.0 for details about each element, examples, and links to useful resources.

NQF. Health and well-being website. Available at http://www.qualityforum.org/Topics/Health_and_Well-Being.aspx. Last accessed March 2016.

State Level Perspectives

- Most of the innovation and work is happening at the state level
- Frame shift from national to state level efforts and program attributes

State Policy Components

Three components necessary for integration of health and social services at the state level:

- A coordinating mechanism responsible for managing collaboration across services
  - "Integrator" responsible for coordination and communication across state level services
- Quality measurement and data-sharing tools to track outcomes and exchange information
- Payment and financing methods that support and reward effective service integration

T. McGinnis, M. Crawford, and S. A. Somers. "A State Policy Framework for Integrating Health and Social Services." Commonwealth Fund Pub. 1757 Vol. 14. July 2014. Available at : http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2014/jul/1757_mcginnis_state_policy_framework_ib.pdf

State Policy Components by Stakeholder: Table Adapted for Discussion

Level	Coordinating Mechanisms	Quality Measurement and Data-Sharing Tools
State	• Integrator agencies/entities • Formalized interagency arrangements	• Population health metrics • Integrated claims database/analysis
Community	• Health outcomes trusts • Accountable care communities	• Integrated population health/quality report cards
Provider	• Accountable care organizations • Medicaid health homes	• E-referrals • Integrated patient-level data sharing

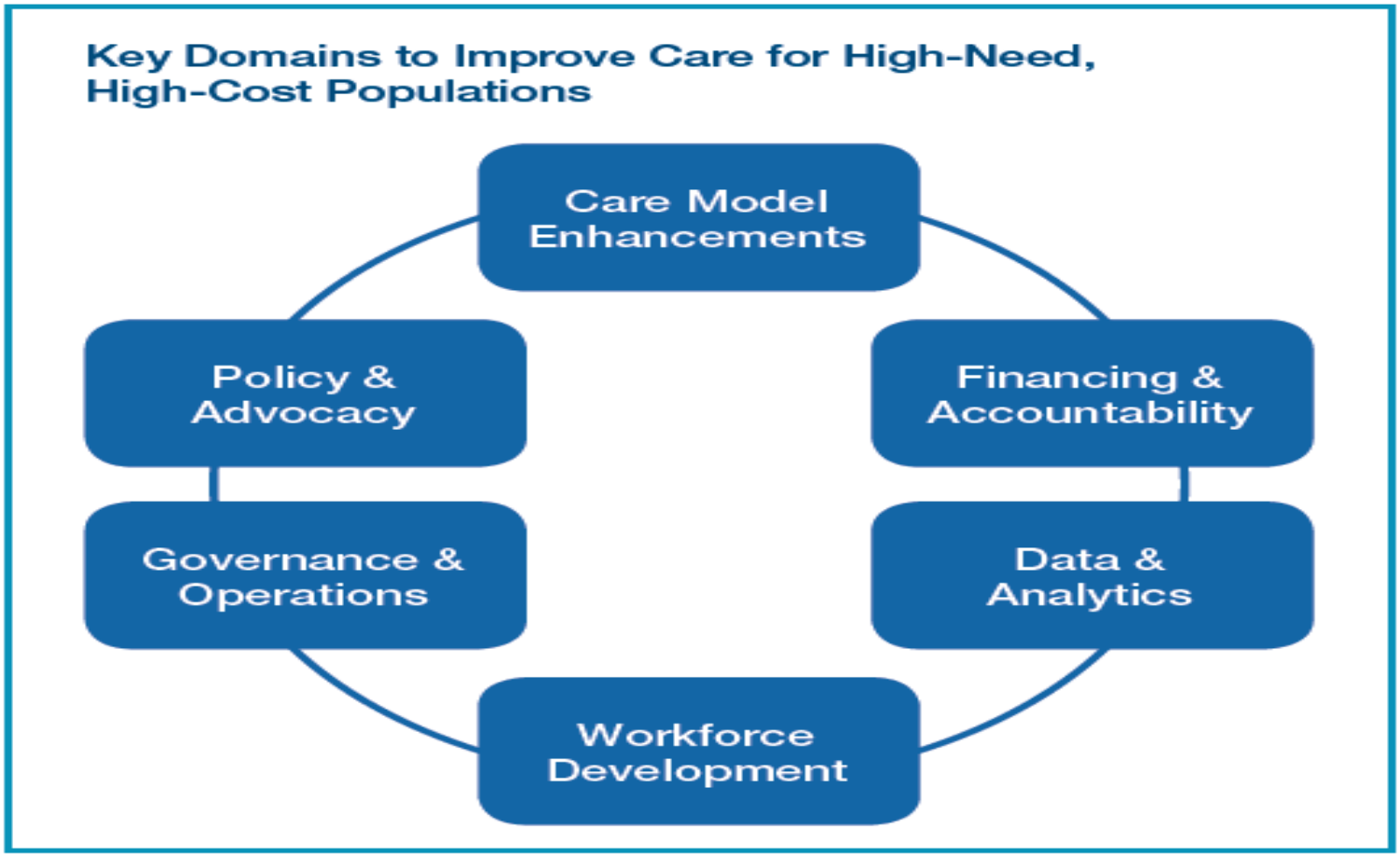
T. McGinnis, M. Crawford, and S. A. Somers. "A State Policy Framework for Integrating Health and Social Services." Commonwealth Fund Pub. 1757 Vol. 14. July 2014. Available at : http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2014/jul/1757_mcginnis_state_policy_framework_ib.pdf

State Policy: Framework Implementation Steps

- **Step 1: Establish Goals**
  - Based on current needs, circumstances , and priorities
- **Step 2: Identify Gaps and Opportunities**
  - Identify where needs are not being met
  - Identify inefficiencies and reallocation of funds for increased ROI
- **Step 3: Prioritize Opportunities for Integration**
  - Based on community strengths and resources
  - Balance both long- and short- term planning efforts
- **Step 4: Establish an Implementation Roadmap**
  - Highlight policy concerns
  - Plan out both long- and short- term activities

T. McGinnis, M. Crawford, and S. A. Somers. "A State Policy Framework for Integrating Health and Social Services." Commonwealth Fund Pub. 1757 Vol. 14. July 2014. Available at : http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2014/jul/1757_mcginnis_state_policy_framework_ib.pdf

State Integration Model: Key Domains



C. Thomas-Henkel, A. Hamblin, and T. Hendricks. *Supporting a Culture of Health for High-Need, High-Cost Populations: Opportunities to Improve Models of Care for People with Complex Needs*. The Robert Wood Johnson Foundation and the Center for Health Care Strategies, October 2015 . Available at: http://www.chcs.org/media/HNHC_CHCSreportFactSheet_final.pdf

State Integration Model: Key Domains of Framework

- Care Model Enhancements
  - Evaluate the effectiveness of specific interventions
  - Identify appropriate care management intensity
- Financial and Accountability
  - Establish risk-adjustment methodologies that include social as well as medical complexity
  - Refine approaches to managed care rate setting
- Data and Analytics
  - Identify unique population subsets to tailor intervention approaches
  - Increase access to real-time, integrated data systems

C. Thomas-Henkel, A. Hamblin, and T. Hendricks. *Supporting a Culture of Health for High-Need, High-Cost Populations: Opportunities to Improve Models of Care for People with Complex Needs*. The Robert Wood Johnson Foundation and the Center for Health Care Strategies, October 2015 . Available at: http://www.chcs.org/media/HNHC_CHCSreportFactSheet_final.pdf

State Integration Model: Key Domains of Framework Contd.

- Workforce Development
  - Standardize tools and training specific to caring for high-need, high-cost populations
  - Incorporate new or different types of health professionals and non-traditional health workers
- Governance and Operations
  - Leverage governance to promote reinvestment in community capacity
  - Develop management capacity to support operational excellence
- Policy and Advocacy
  - Address key policy barriers
  - Ensure that the voice of consumers is represented

C. Thomas-Henkel, A. Hamblin, and T. Hendricks. *Supporting a Culture of Health for High-Need, High-Cost Populations: Opportunities to Improve Models of Care for People with Complex Needs*. The Robert Wood Johnson Foundation and the Center for Health Care Strategies, October 2015 . Available at: http://www.chcs.org/media/HNHC_CHCSreportFactSheet_final.pdf

Current Performance Measurement Resources

AHRQ Clinical-Community Relationship Measure Atlas

The *Clinical-Community Relationships Measures (CCRM) Atlas* is:

- Designed to provide users with a measurement framework and listing of existing measures for clinical-community relationships;
- Intended to help facilitate research, quality improvement projects, and other interventions investigating clinical-community relationships that have been formed for the purposes of improving the delivery of clinical preventive services; and
- Intended to be used by researchers studying clinical-community relationships as well as evaluators of these relationships.

Dymek C, Johnson M Jr, McGinnis P, Buckley D, Fagnan L, Mardon R, Hassell S, Carpenter D. Clinical-Community Relationships Measures Atlas. (Prepared under Contract No. HHSA 290-2010-00021. Westat prime contractor) AHRQ Publication No. 13-0041-EF. Rockville, MD: Agency for Healthcare Research and Quality. March 2013.

AHRQ Clinical-Community Relationship Measure Atlas

- The idea of measuring clinical-community relationships is new
- The measurement domains may evolve over time
- Some domains lack measures, or the measures that do exist require additional evidence to establish their effectiveness in evaluating clinical-community relationships.
- The *Atlas* is being established, in part, to investigate potential measures for evaluating clinical-community relationships.

Dymek C, Johnson M Jr, McGinnis P, Buckley D, Fagnan L, Mardon R, Hassell S, Carpenter D. Clinical-Community Relationships Measures Atlas. (Prepared under Contract No. HHSA 290-2010-00021. Westat prime contractor) AHRQ Publication No. 13-0041-EF. Rockville, MD: Agency for Healthcare Research and Quality. March 2013.

Discussion

- Based on the information provided on community integration:
  - What is the most relevant framework/model for this population?
  - What domains are high priority for this population?
  - What should the next level of strategic discussion include?

Field Examples

CARE COORDINATION STRATEGIES IN HEALTH CARE DELIVERY

April 20, 2016

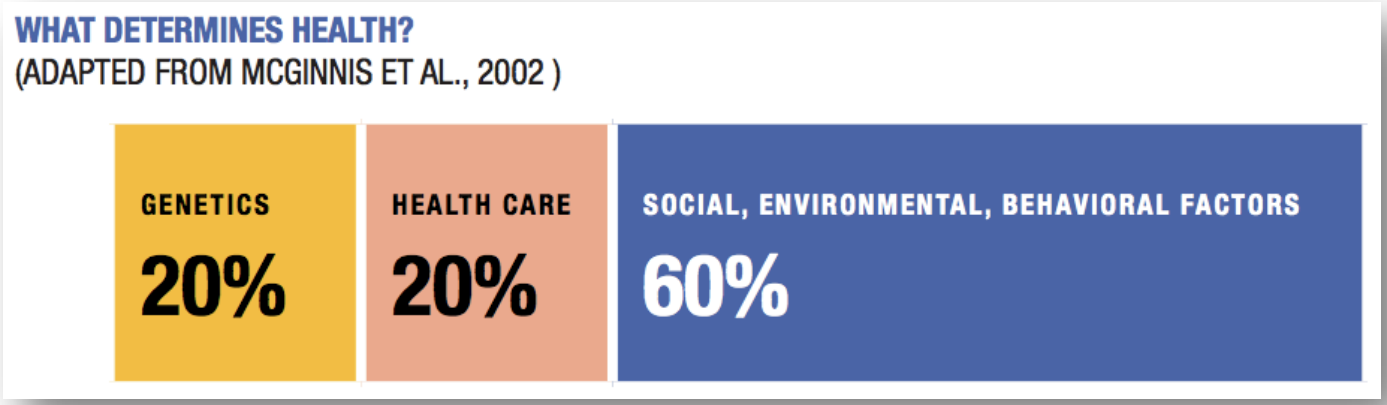
Robyn Golden, LCSW
Director of Health & Aging
Rush University Medical Center

RUSH UNIVERSITY MEDICAL CENTER

"Social determinants of health have taken center stage in recent health policy discussions because of the growing focus on global payment, accountable care organizations, and other initiatives focusing on improving population health."

-- Yale Global Health Leadership Institute

Social Factors Impact Health Outcomes



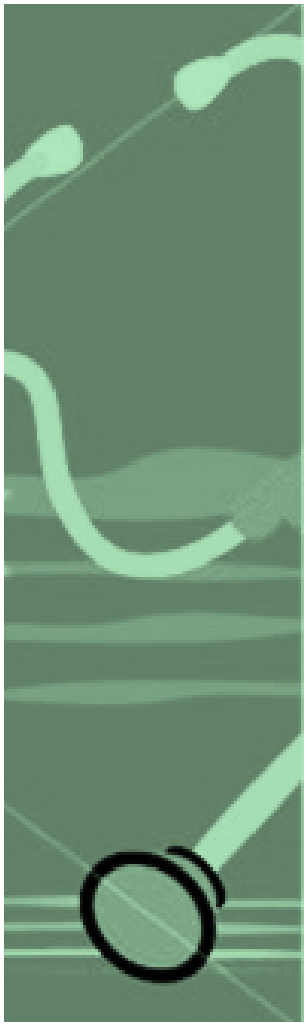
- Psychosocial issues can lead to deterioration of physical symptoms or non-adherence to the clinical care plan
  - → visits to the hospital or outpatient practices to treat physical symptoms of psychosocial issues
  - → negative impact on patient outcomes, population health, and health care expenditures
- Increased investments in social services, partnerships between health care and social services, and psychosocial interventions can help reach Triple Aim
  - Yet, hard to capture value of these investments via current quality and utilization metrics

In Health Care's Blind Spot

- We know that psychosocial and community factors greatly impact health outcomes and costs
- Yet, person- and family-centered, coordinated care with links to the community are rare in care models
  - Mental health forgotten
  - Not "bilingual" or "bicultural" to bridge medical and social systems
- Community-based services and supports system could be addressing psychosocial issues
- Institute of Medicine recommendation: "community links"
  - Assessing psychosocial issues
  - Delivering services in the community
  - Communicating these issues with medical team

Institute of Medicine. *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America.* September 2012.

It takes a team!



- 2011 Robert Wood Johnson Foundation survey of 1,000 primary care physicians
  - 4 out of 5 not confident can meet social needs, hurting their ability to provide quality care
  - 85% feel social needs directly contribute to poor health
  - R_x for social needs, if they existed, would be 1 in 7 R_x's written
- Psychosocial issues treated as physical concerns
- Responsibility cannot solely reside with the physician, or with acute care, or with the family caregiver, or with older adults themselves

Robert Wood Johnson Foundation. *Health care's blind side: the overlooked connection between social needs and good health.* December 2011.

Comprehensive Care Coordination

- Person and family-centered
- Based on an assessment of individual's preferences, needs, and strengths
- Multicultural approach
- Focus on:
  - Medical aspects
  - Social aspects
  - Behavioral aspects
  - Communications
- Integrate health and social services
- Interdisciplinary
  - Involve range of providers – from PCP to PT to SW to direct care workers

-National Coalition on Care Coordination

The Patient Perspective

- What interferes with access to care?

Feel intimidated when talking to medical providers – afraid to say the "wrong" thing

The Rush Response

- Rush University Medical Center
  - Not-for-profit health care, education, and research enterprise
  - Located in diverse urban neighborhood in Chicago, IL
  - Inpatient and outpatient services
  - Multiple community service programs
- Health & Aging department offers wrap-around services
  - Health promotion
  - Care management (as part of ACO)
  - Care coordination (ambulatory care & after hospitalization)
  - Social Work clinical services
  - Resource centers

Rush Health & Aging (Est. 2004)

Transitional Care

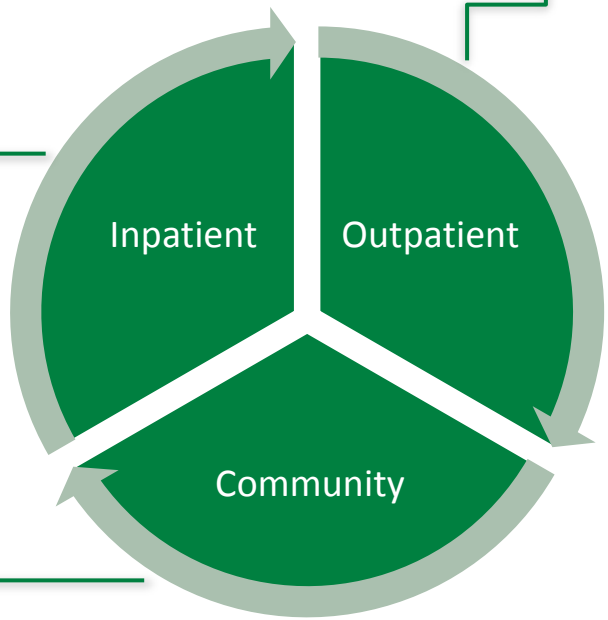
- Nationally replicated Bridge Model
- Interdisciplinary team-based
- Social determinant focus
- 30% readmission reduction for Medicare patients with Home Health
- 25% readmission reduction for highest utilizers

Outpatient Social Work

- Pilot: Reductions in 30-day readmissions, hospital admissions and Emergency Department utilization
- Commonwealth funded study looking at AIMS Model-- impact on the non-medical
- Psychotherapy services

Medical Health Network ACO

- 76,783 network patients/ 13,084 Rush patients
- Medicaid Countycare ACO
- Shared Savings Focus
- Partnership with 3 hospitals and 9 FQHCs
- Providing complex care coordination for referred patients across the network



The Bridge Model of Transitional Care

Overarching principles:

- *Social Determinants of Health*
- *Hospital-Community Collaboration*

Client & Caregiver

Hospital

BCC

Clinical intervention
Comprehensive assessment

Community Agencies

Community-specific focus

Continuous Quality Improvement

Bridge Model Collaborative

Trained supervisor

Community Partners

- BCCs skilled at:
  - Facilitating and maintaining relationships with interdisciplinary teams
    - Hospital
    - Community agencies
    - Skilled Nursing Facility
    - Home Health
    - PCP
  - Navigating community resources, particularly the Aging Network

JAGS Study: Bridge Strengths

- New quantitative & qualitative study completed by external reviewers
- Major model strengths
  - Repeated assessments
  - Person-specific tailored interventions
  - Ability to effectively link individuals to services
- **"Well suited to assess and address the transitional care needs of adults with complex medical, behavioral, and social needs"**
- Social work based transitional care model may be of interest for…
  - "addressing social and economic needs of urban, rural, dually-eligible, and/or adult Medicaid populations"

Boutwell, Johnson, Watkins. *An Evaluation of a Social Work-based Model of Transitional Care to Reduce Hospital Readmissions: Preliminary Data.* Journal of the American Geriatrics Society (accepted October 20 2015).

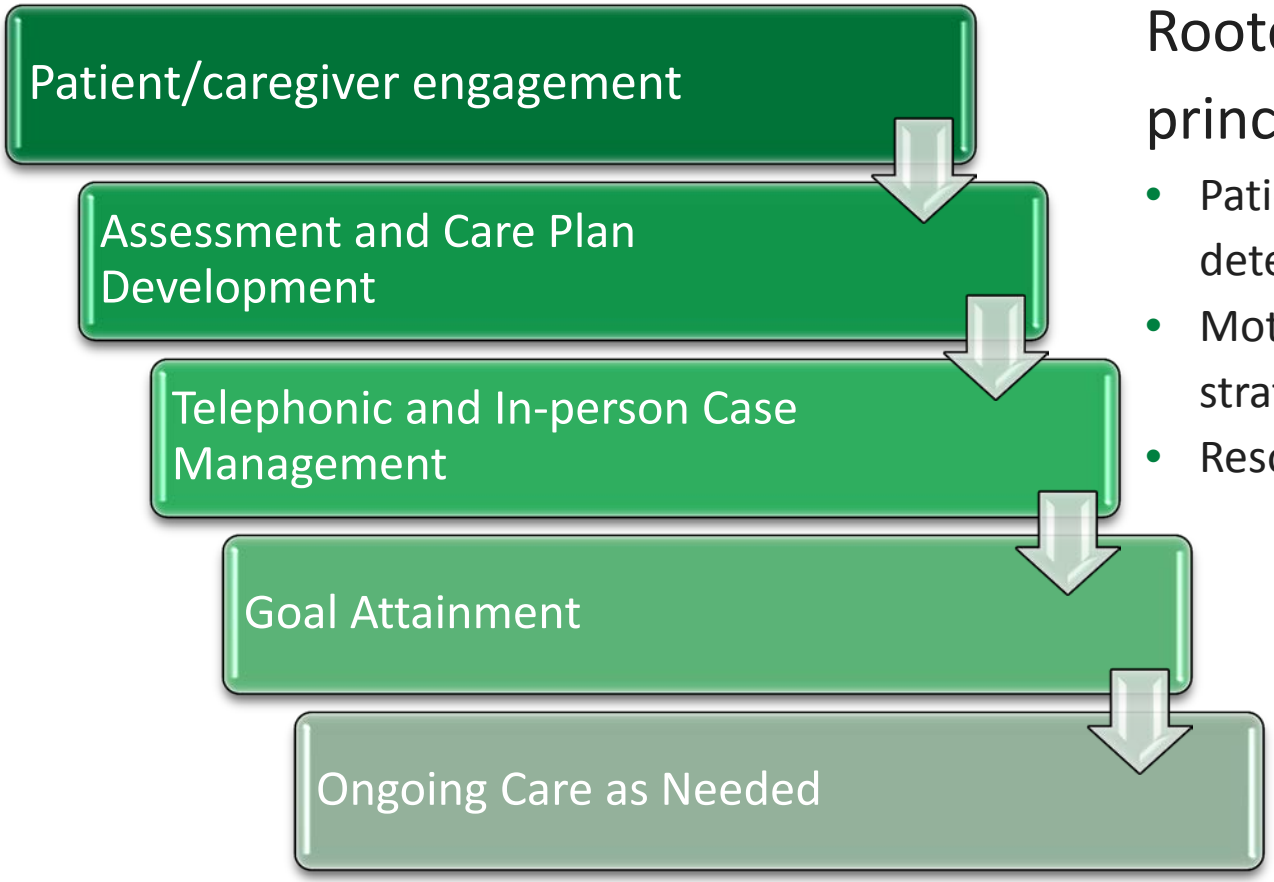
JAGS Study: Quantitative Impact

- Analyzed all-cause, any-hospital 30-day readmissions for Medicare FFS beneficiaries
  - March 1, 2013 through February 28, 2014
  - Discharged home from Rush University Medical Center in Chicago, both with and without home health
- Compared Bridge participants (n=1,546) with:
  - Non-Bridge Rush patients discharged home during same time period, both with and without home health (n=5,278)
  - A statewide comparison group of Medicare FFS beneficiaries during same time period, matched for age, payer, geography, and discharge status (n=4,741)
- **20% reduction in readmissions vs. matched cohorts**

AIMS Model: Overview

- "Ambulatory Integration of the Medical and Social"
  - Team of Master's level clinical social workers
  - Based out of ambulatory setting; telephonic with in-person components
- Wrap around medical care by addressing non-medical needs that are negatively impacting patient outcomes
  - Increase primary/specialty care clinician and team awareness of these issues
  - Increase practice efficiency by best utilizing skills of each discipline
  - Connect patients to evidence-based disease management
- Targets patient complexity
  - Intervention targeted to Medicare and Medicaid beneficiaries, 18+ years old, with identified chronic condition

AIMS Intervention Protocol



Rooted in the following principles:

- Patient empowerment and self determination
- Motivational interviewing strategies
- Resource linkage

Impact of AIMS Social Workers

- Compared utilization rates for AIMS participants vs. similar Rush population, for 6 months after intervention
- Admissions, 30-day readmissions, and ED visits were significantly lower in AIMS participants in 6 month period

Utilization Metric	AIMS Mean (n=640)	Rush Comparison (n=5,987)
Hospital Admission	**0.51**	**1.0***
30-day Readmissions	**0.15**	**0.35***
ED Visits	**0.10**	**0.95***

*Statistically significant using one-sample t-test

AIMS: Overall Accomplishments

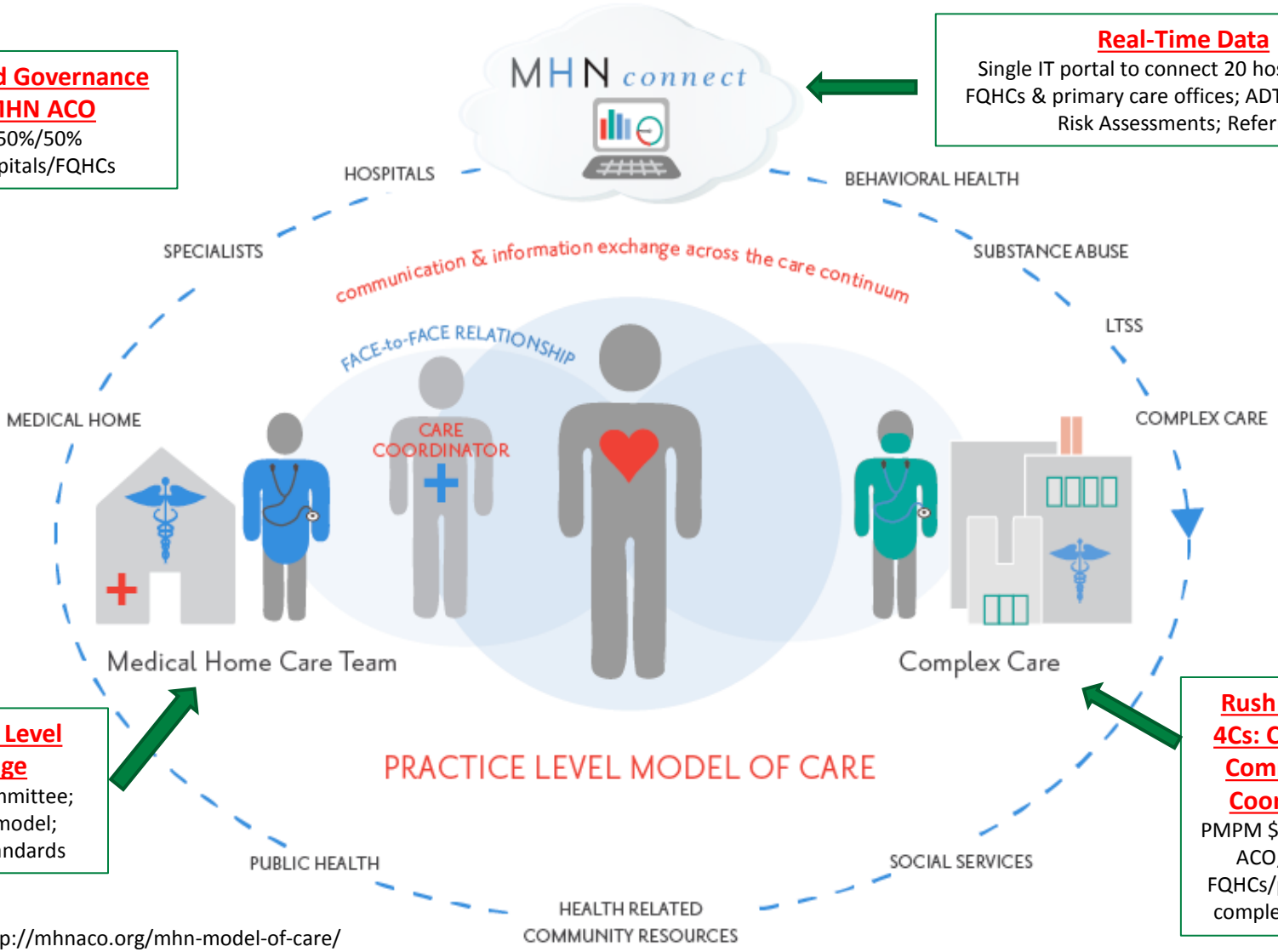
- Successful integration of social issues into medical care
  - Contributed to designation as Level 3 Patient Centered Medical Home by the National Committee for Quality Assurance for seven primary care practices
  - Integration in both primary and specialty care ambulatory clinics
- Recognized as an innovative program by Agency for Health Care Research and Quality (AHRQ) Healthcare Innovations Exchange
- Weinberg Grant
  - Expansion to community-based sites in IL and MD
- Commonwealth Fund
  - Moving toward rigorous research and analysis

Medical Home Network (MHN): Medicaid Managed Care ACO

Shared Governance Supported by Real-Time Data and Care Coordination

Shared Governance MHN ACO
50%/50%
Hospitals/FQHCs

Real-Time Data
Single IT portal to connect 20 hospital EDs to FQHCs & primary care offices; ADT feed; Health Risk Assessments; Referrals

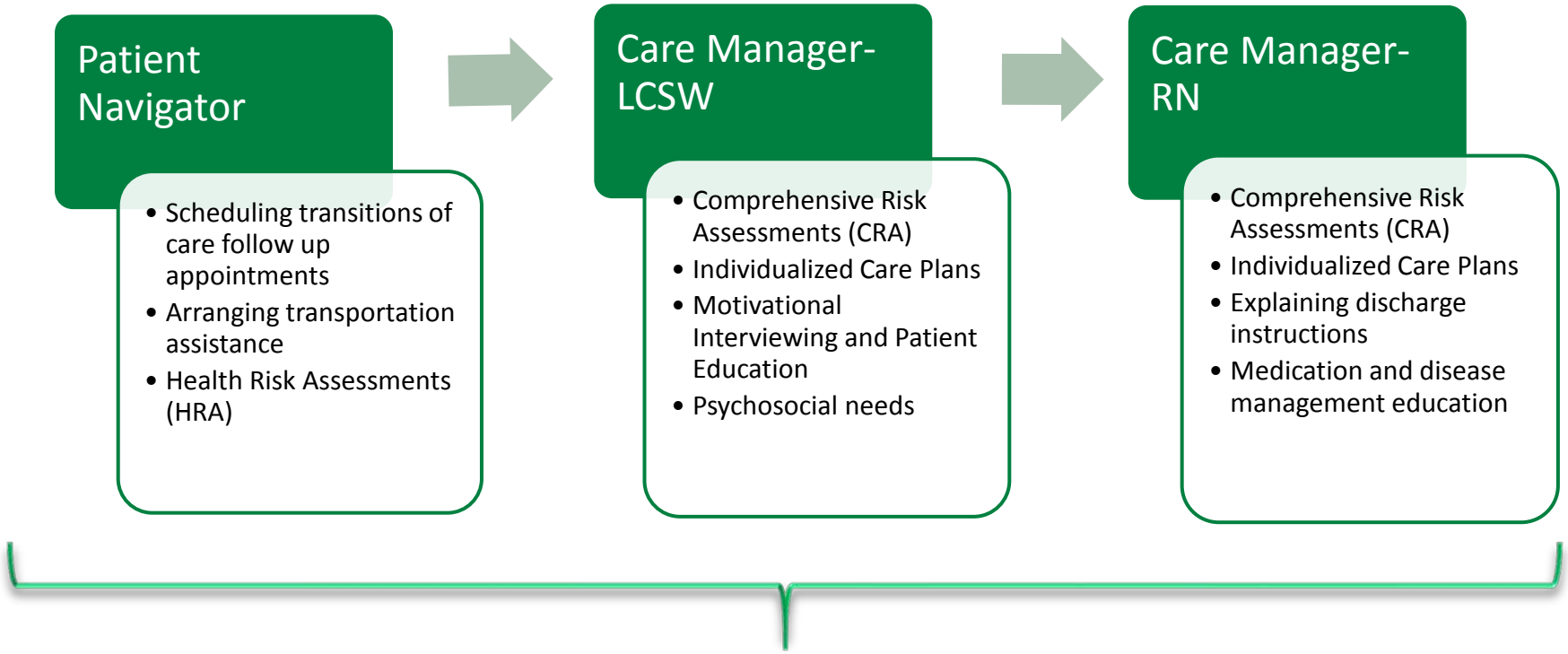


Practice Level Change
Clinical committee;
Practice model;
Shared standards

Rush Performs 4Cs: Centralized Complex Care Coordination
PMPM $ support from ACO; Supports FQHCs/primary care; complex discharges

* Source: http://mhnaco.org/mhn-model-of-care/

MHN: Interprofessional Care Management Triad

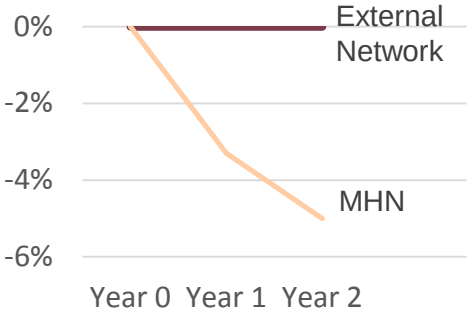


- 16% of patients stratified as medium or high risk
- 34% had transportation problems
- 32% had difficulty paying for medications
- 40% reported being down or depressed
- 28% used alcohol or drugs
- 39% reported needing help getting food, clothing, or housing

MHN's Impact

Total Cost of Care

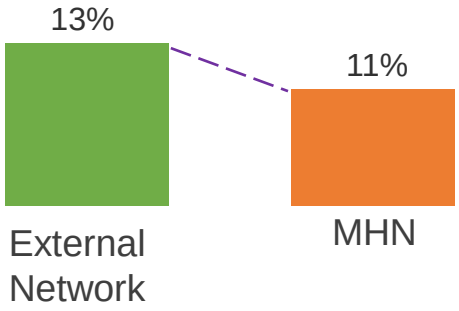
*The difference in cost of care for MHN versus other Medicaid patients in IL is **3.5%** in Year 1 and **5%** in Year 2 below trend*



5% LOWER COST
(risk adjusted)

Difference is MHN risk adjusted cohort vs Non-MHN risk adjusted cohort percent change in cost of care
Source: Findings of the MHN HFS Care Coordination Pilot for the Illinois Health Connect population

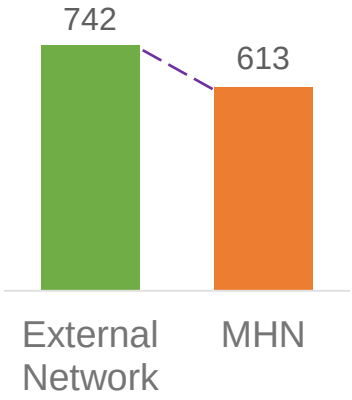
ACA Readmission



15% BETTER OUTCOME

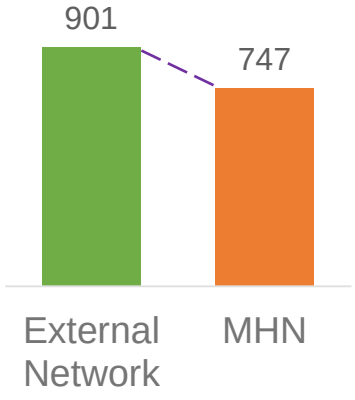
ACA Utilization

Inpatient Days/1000



17% BETTER OUTCOME

ED Visits/1000



17% BETTER OUTCOME

Patient Engagement

*MHN's engagement efforts reach almost **2½ times** as many patients as other Medicaid providers*

MHN ACO:
71% COMPLETE

External Network:
31% COMPLETE

130% BETTER OUTCOME

Period: July 1, 2014 – May 19, 2015

So… What does it take?

- Prevention and wellness strategies
- Innovative models of care coordination
- Attention to multiple chronic conditions
- Collaborative team-based care
  - Seasoned clinicians across disciplines
- Community engagement and partnerships
  - Data sharing between health system & CBO
  - Easy & efficient system for CBO to identify pt's coverage and eligibility, if needed
  - Requires robust CBO – not always the case in current funding climates

How will we measure it?

- It will also take new ways to measure what matters to clients and families
  - Customization of service plan to priorities
  - Comfort
  - Financial control & independence
  - Social interaction
- These things largely not captured by current measures
- Such measures would also help capture value of healthcare systems addressing social factors via psychosocial interventions and partnerships with community

Measuring What Matters

- Suggested topics for measure development
  - Measure care planning processes, develop standards
  - Measure alignment of services with client's stated priorities
  - Measure confidence in the care system
  - Measure well-being at beneficiary and community level (geographic)
    - Housing, food, transportation, isolation, caregiver support
    - Confidence, independence, financial control
  - Measure efficiency, waste
- CMS leadership in this realm could be transformative

"In a time of major changes to the health care delivery and payment systems, connecting clinical work to community partners and resources brings a sense of renewal and hope for the challenges ahead. Going beyond clinical walls to solve complex problems is a prescription for success."

-- The Institute for Clinical Systems Improvement, 2014

QUESTIONS?

THANK YOU!

Robyn Golden, LCSW

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Washington Health Authority Financial Alignment Demonstration

Measuring the Impact of Managed FFS Program for Dual Eligibles: The Washington State Experience

Managed FFS Demonstration in Washington

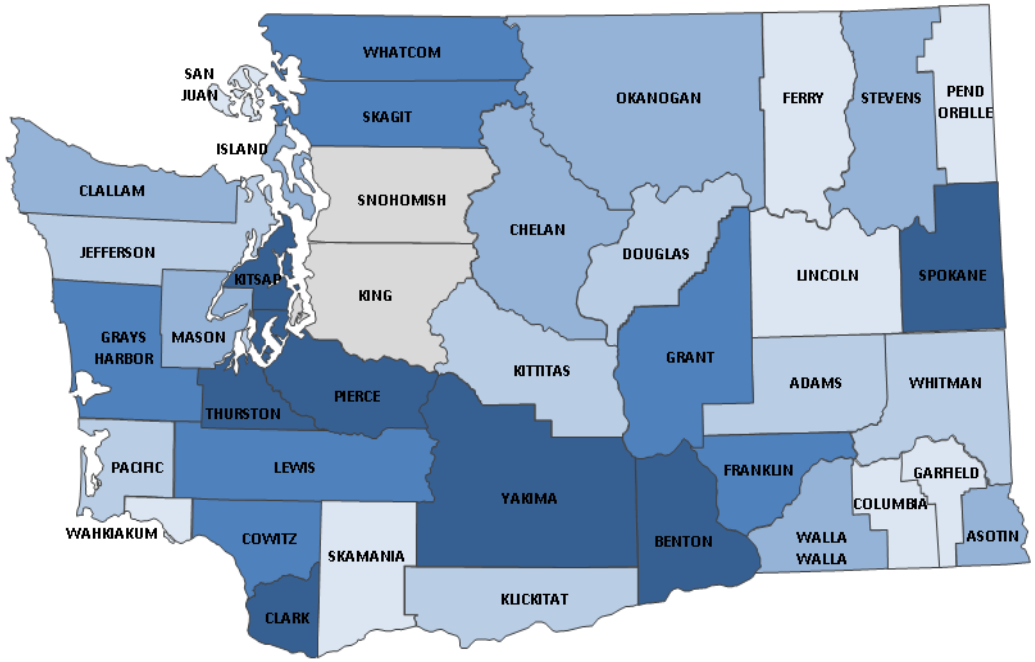
Managed Fee-for-Service

- Began July 2013, growing over time
- Structured as Community-Based Health Homes
- Targeting those with expected high future medical costs

Capitated Demo

- Unable to implement

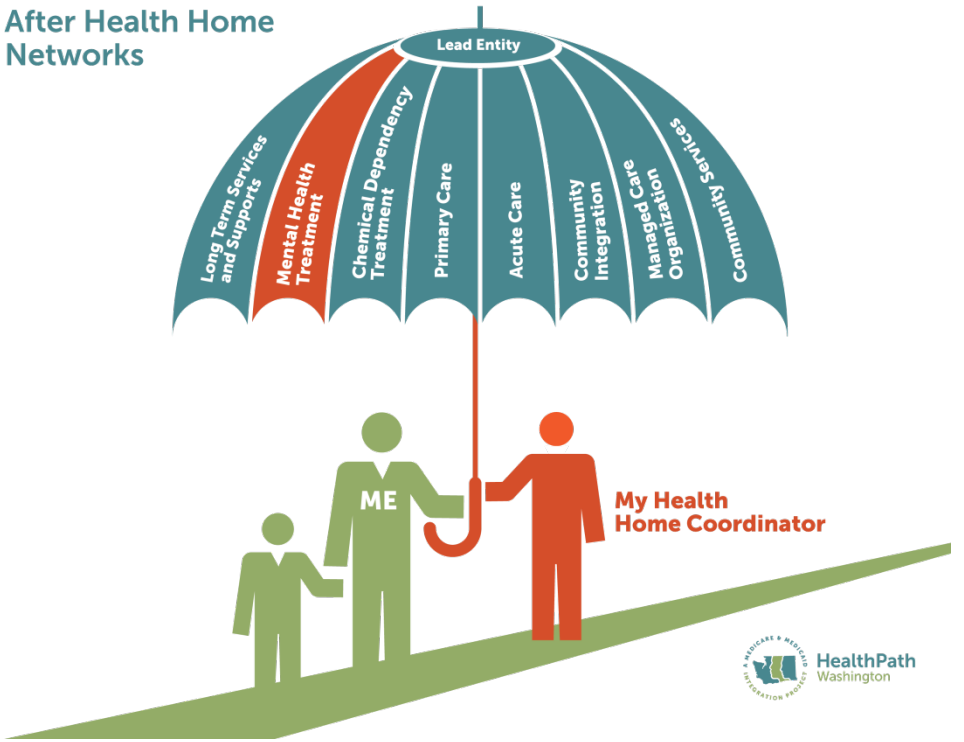
Assignment to Health Homes



NOTES: Includes Full Dual Demonstration eligible clients not aligned with another Medicare shared saving program.
DATA SOURCE: Washington State Health Care Authority, ProviderOne (Medicaid) database.
PREPARED BY: Department of Social and Health Services, Research and Data Analysis Division.

Health Home "Umbrella"

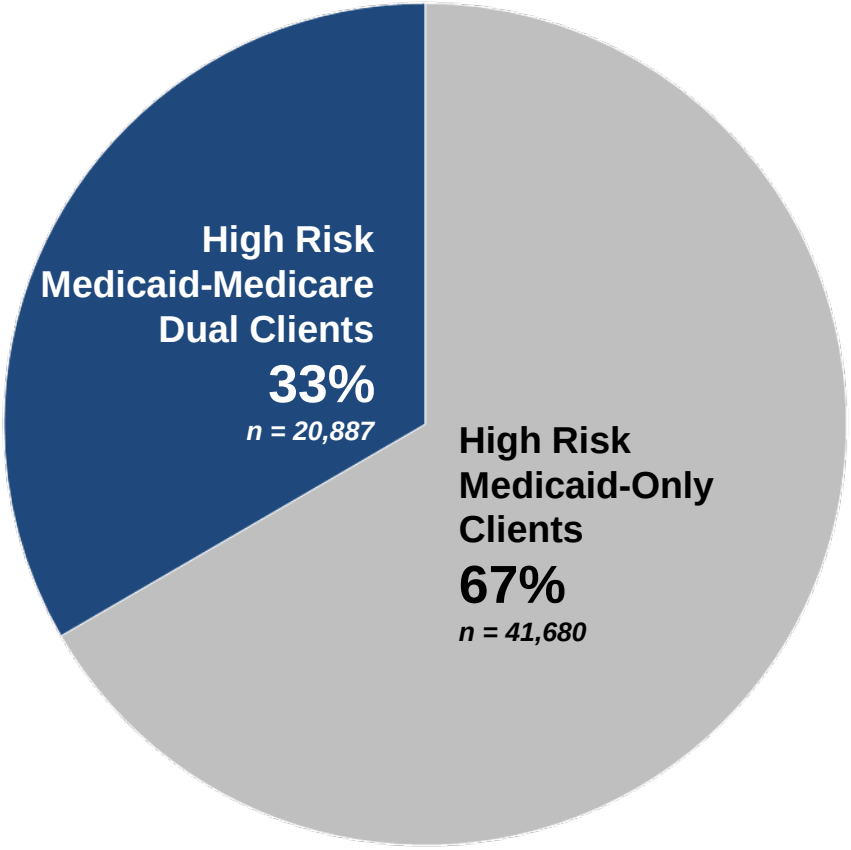
- **Health Homes build a network of Care Coordination Organizations**
- **Health Action Plans**
  - Motivational Interviewing
  - Self-management
- **Integrating Medicaid and Medicare data**



Managed Fee-for-Service Duals are 1/3 of the Health Home Eligible Population

Health Home Eligible Clients – May 2015

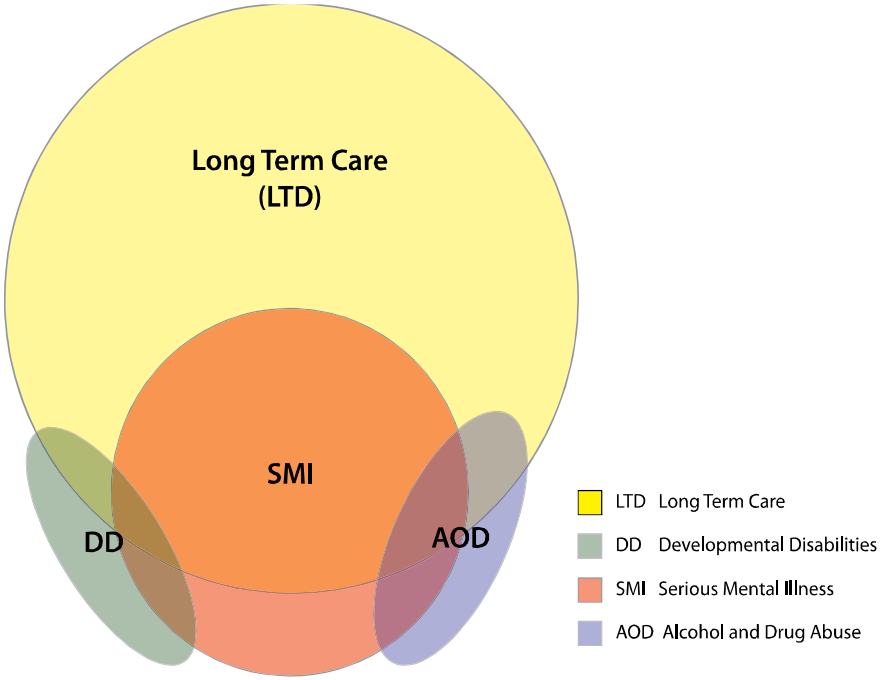
TOTAL = 62,567



NOTES: Includes all Health Home eligible clients
DATA SOURCE: Washington State Health Care Authority, ProviderOne (Medicaid) database
PREPARED BY: Department of Social and Health Services, Research and Data Analysis Division

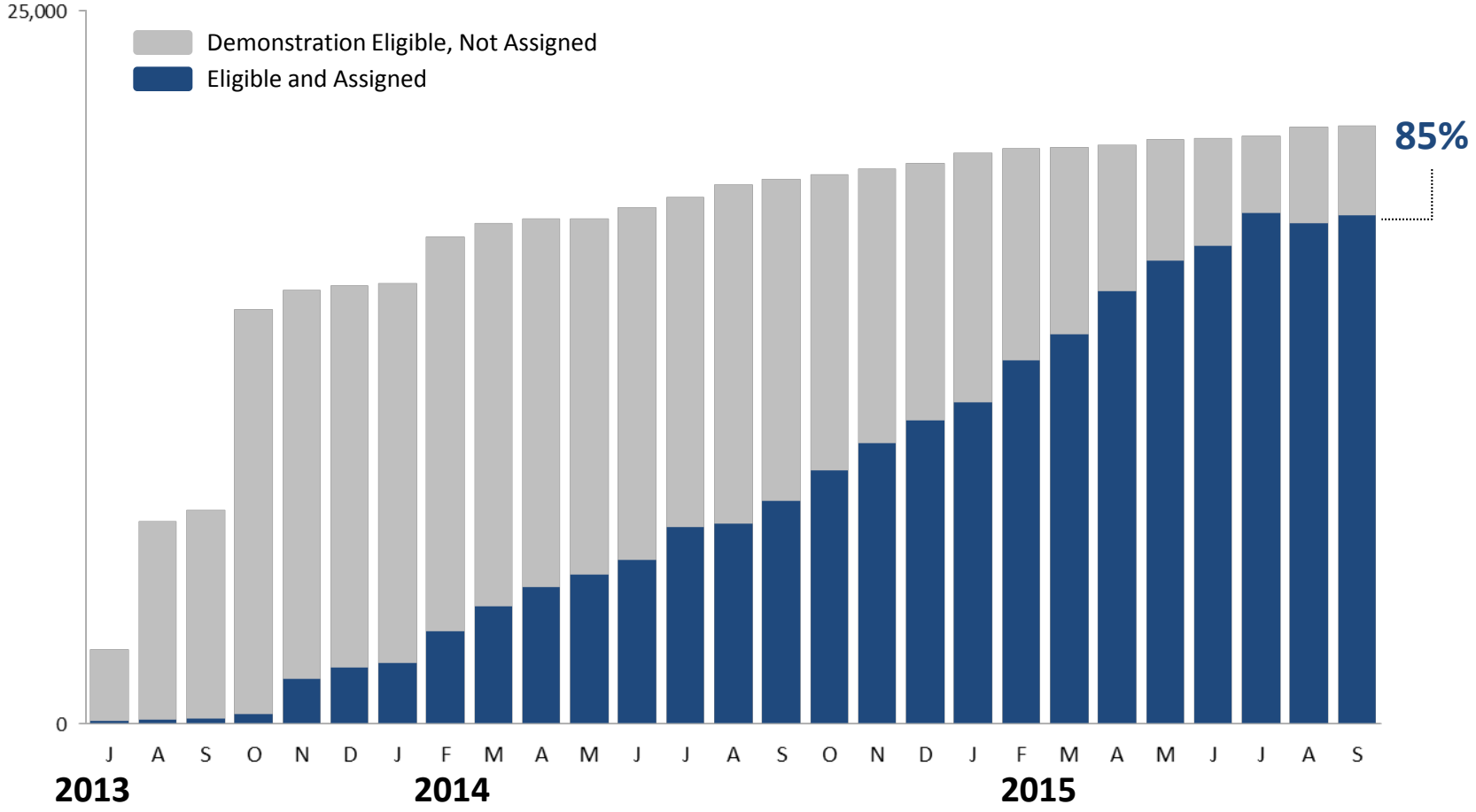
The Case for Integrated Care

Service Needs Overlap for High Risk/Cost Beneficiaries who are Eligible for Medicare and Medicaid



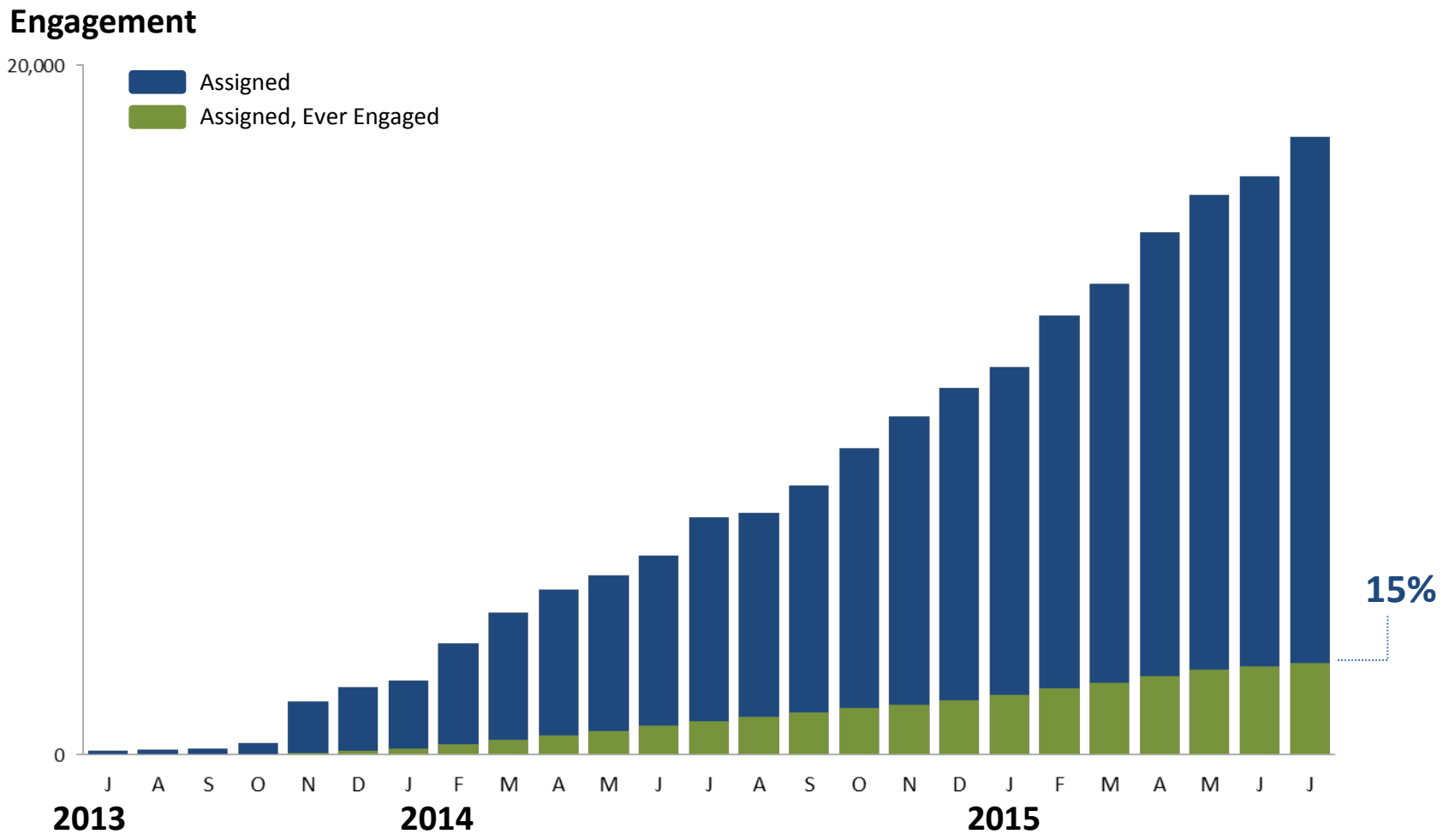
Assignment of Eligible High-Risk Duals to a Health Home has grown over time

Eligibility and Assignment



NOTES: Includes Full Dual Demonstration eligible clients not aligned with another Medicare shared saving program.
DATA SOURCE: Washington State Health Care Authority, ProviderOne (Medicaid) database.
PREPARED BY: Department of Social and Health Services, Research and Data Analysis Division.

Engagement of High-Risk Duals in Health Homes is growing



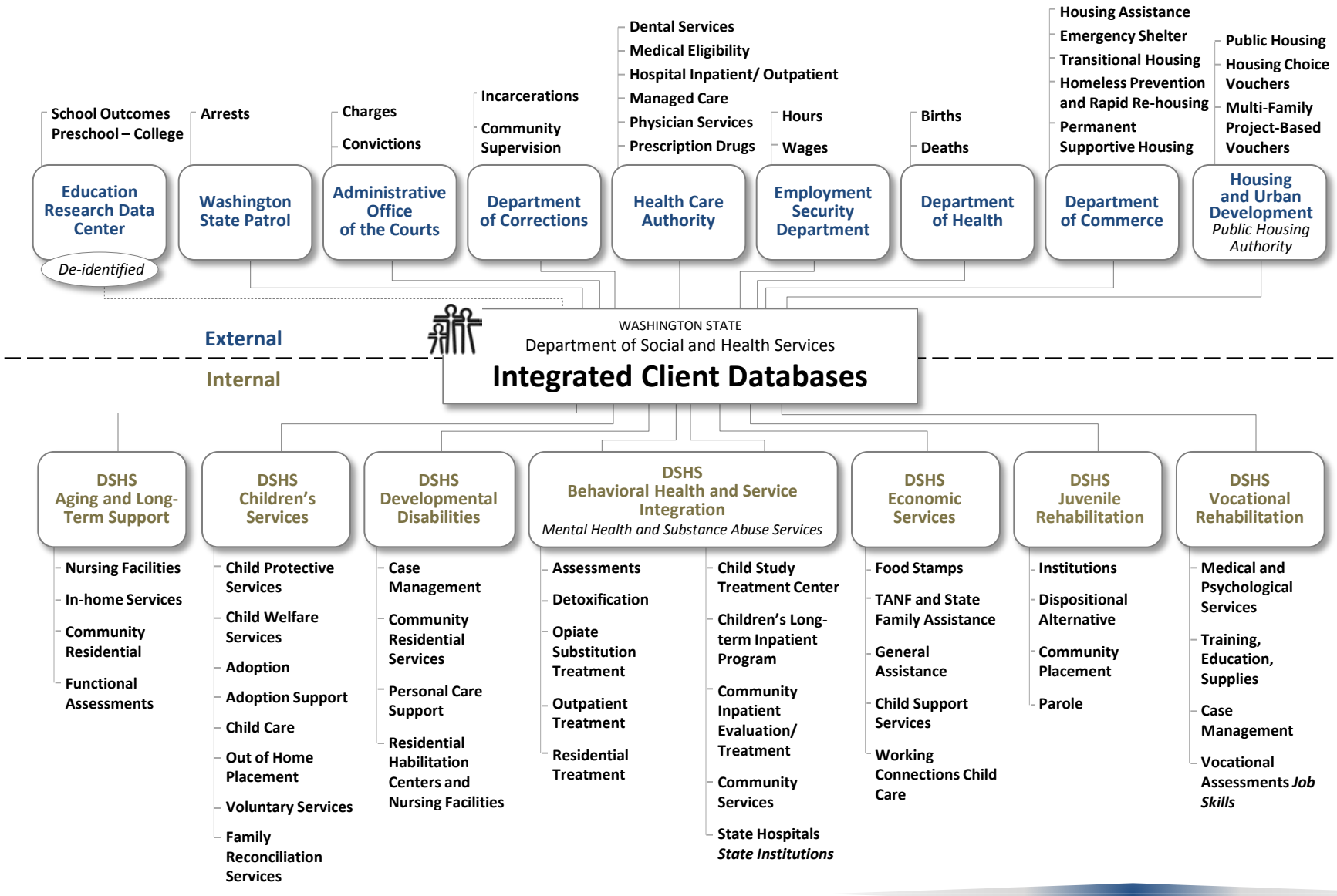
NOTES: Includes Full Dual Demonstration eligible clients not aligned with another Medicare shared saving program.
DATA SOURCE: Washington State Health Care Authority, ProviderOne (Medicaid) database.
PREPARED BY: Department of Social and Health Services, Research and Data Analysis Division.

Successes

"A Rising Tide Floats All Boats"

- Building of community linkages between medical, behavioral health, social services
- Integrated Medicaid/Medicare data for care coordinators
- Expansion of real time emergency room notification

Washington's Integrated Client Databases



Integrated Medicare/Medicaid Data for Care Coordination

- **P**redictive **R**isk **I**ntelligence **S**yste**M** – a secure, web-based tool to support care coordinators
- Data sources
  - Medical, mental health and LTSS services from multiple IT systems
  - Medicare Parts A/B/D data integration for dual eligibles
  - Long term services and support functional assessments
  - Housing status (including some local jail stay data) from the state's eligibility data system
- Data refreshed on a weekly basis for the entire Medicaid/Medicare population
- Over 1,100 currently authorized users

Levels of Health Home Evaluation

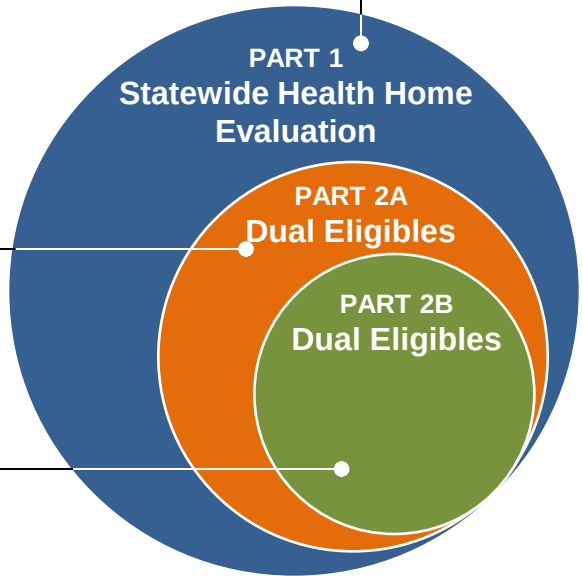
PART 1. Statewide Health Home Evaluation

Independent evaluation by CMS contractor based on survey of states and cost savings /quality measures reported by the state

PART 2. Dual eligibles in health homes served under fee-for-service

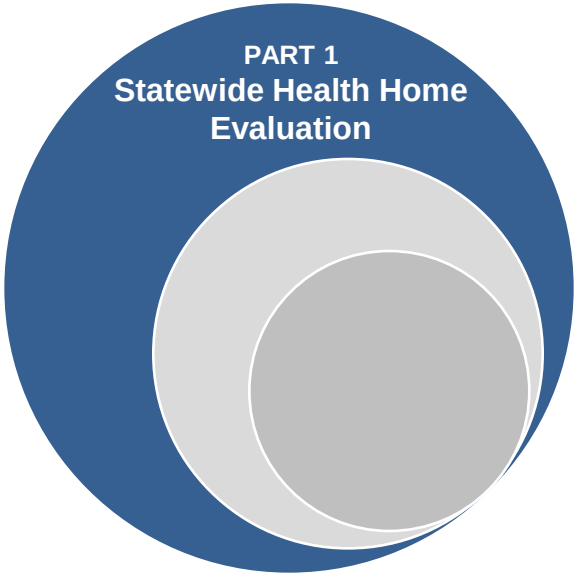
2A. External evaluation by CMS contractor based on measures collected by CMS and augmented with information from the state

2B. Shared savings calculation different from evaluation; subject to performance measures reported by the state



Health Homes Evaluation

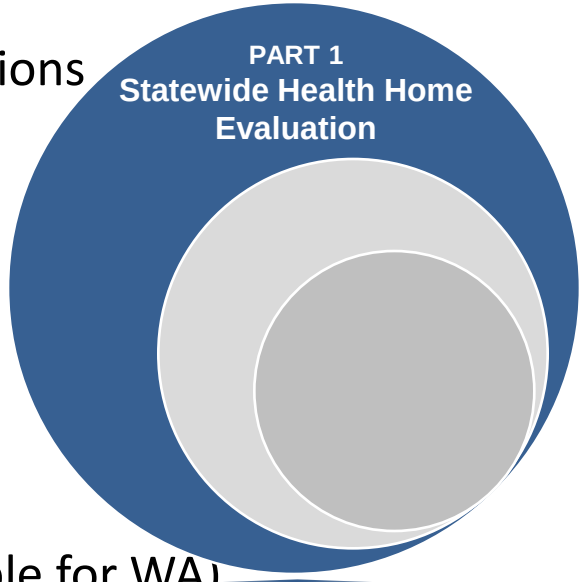
- **Evaluation conducted by external CMS contractor (2017)**
- **Focus on enrolled population**
  - Excludes eligible but not enrolled
- **Cost –savings reported by the state**
- **Quality measures reported by the state**
  - Health home level reporting not required
  - Due April 29, 2016



Health Home Quality Measures

Reported by the state:

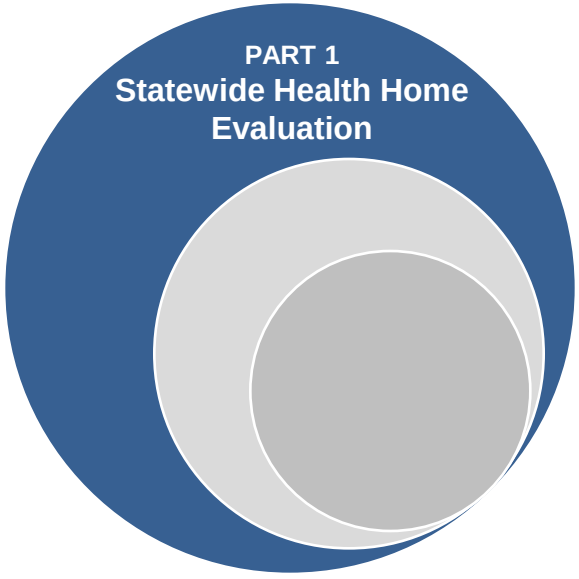
- **Hospital measures**
  - Plan All-cause Readmission rate
  - Inpatient Utilization
  - Emergency Department visits
  - Ambulatory Care Sensitive Hospital Admissions
  - Care Transitions (not possible for WA)



- **Prevention**
  - Adult Body Mass Index
  - Controlling High Blood Pressure (not possible for WA)

Health Home Quality Measures, *continued*

- **Behavioral Health**
  - Screening for Clinical Depression and Follow-Up Plan (not possible for WA)
  - Follow-up After Hospitalization for Mental Illness
  - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- **Long Term Care**
  - Nursing Facility Utilization

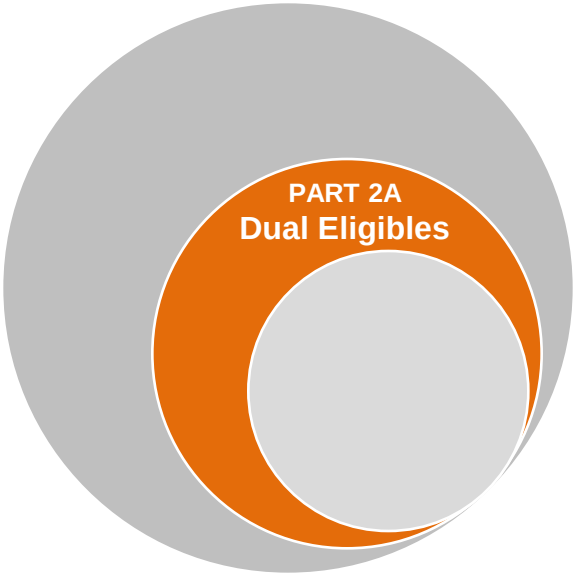


Dual Eligible CMS Utilization and Costs

Focused on eligible dual population (not enrolled or those actually participating)

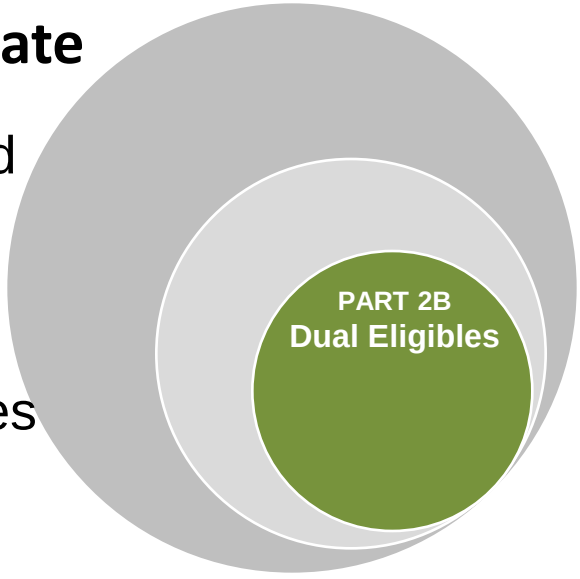
Reported by RTI to CMS on a quarterly basis

- **Acute hospitalization (many types)**
- **Emergency department**
- **Medicare physician office visits**
- **Post-acute skilled nursing**
- **Home Health, Medicaid personal care**
- **Medicaid long-stay nursing facility**
- **And many, many more**



Dual Eligible – Shared Savings Performance Measures

- **Separate Medicare shared savings calculation by CMS contractor using <u>eligible</u> dual clients**
  - Complicated method
  - Design: Pre vs Post with comparison group from other states
  - Subject to performance on quality measures
- **Quality Performance reported by the state**
  - Year 1 (7/1/2013 – 12/31/2014) reported July 30, 2015; Year 2 due June 2016
  - For Year 1, no benchmarks
  - Benchmarks for CMS selected measures determined by CMS; state measures benchmarked by state

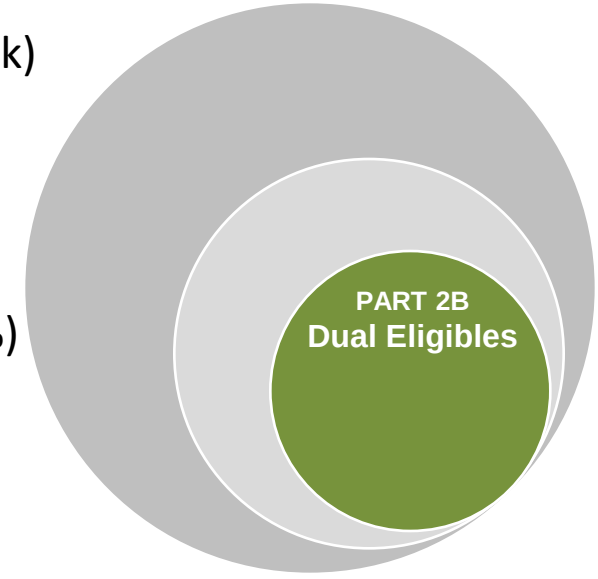


Dual Eligible - Performance Measures, *continued*

Year 1 (2014) Reported Measures v.s. CMS 2015 benchmarks:

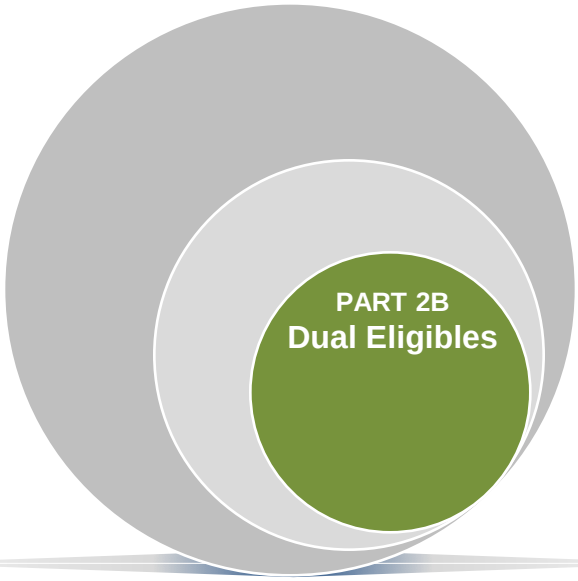
- **Hospital measures**
  - Plan All-cause Readmission rate (17.3% vs 18% benchmark)
  - Emergency Department visits (47.26% avoidable vs 50% benchmark)
  - Ambulatory Care Sensitive Hospital Admissions (1.036/1,000 member months vs 1.20 benchmark)
  - Care Transitions (new in Year 2, no benchmark)
  - Follow-up after discharge (86.56%)
- **Process**
  - Health Action Plans within 90 days* (9.11%)
  - Training for Care Coordinators*(95.14%)
  - Change in Patient Activation* (8.10 points)

* State selected measure



Dual Eligible - Performance Measures, *continued*

- **Prevention**
  - Screening for future fall risk (Year 3, no benchmark)
- **Behavioral Health**
  - Screening for Clinical Depression and Follow-Up Plan (Year 2, unknown)
  - Follow-up After Hospitalization for Mental Illness (78.26% vs 60%)
  - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Year 3, no benchmark)
- **Long Term Care**
  - Receiving Community-based Long Term Care Services* (46.61%)
  - Receiving Institutional Long Term Care Services* (9.96%)



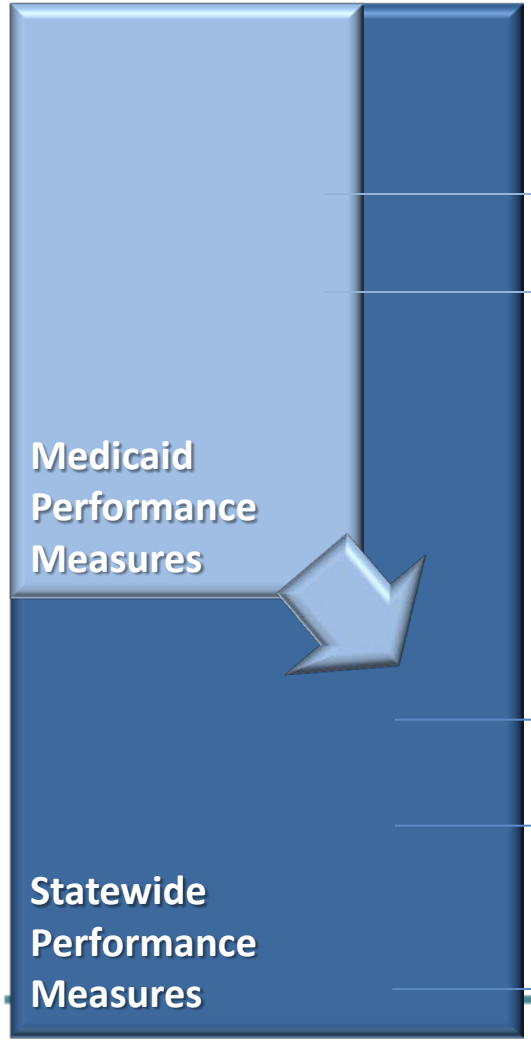
* State selected measure

Measures in Common

Part 1: Health Homes versus Part 2b Duals Shared Savings, CY 2014 performance

- Population: enrolled (health homes) versus eligible (dual demonstration)
- Common measures (* substantially different definitions):
  - Plan all-cause readmission rate)*
  - Ambulatory care-sensitive condition hospital admission*
  - Emergency department visits*
  - Follow-up after hospitalization for mental illness
  - Screening for clinical depression and follow-up plan*
  - Care transition record transmitted*
  - Initiation of alcohol and other drug dependent treatment*

Performance Measures: Evolution of Common Measure Sets in WA



- **Medicaid Adult Quality Measures:** CMS grant supporting use of Medicaid core measure set for WA adults.
- **SB 5732/HB 1519 Requirements for Performance Measures.** Cross-System Steering Committee and work groups develop measures for state agencies contracting with RSNs, county chemical dependency coordinators, Area Agencies on Aging and managed health care plans.
- **SB 2572 in Support of the State Health Care Innovation Plan.** Statewide "health performance" measures by Jan. 1, 2015
- **Performance Measures Coordinating Committee (PMCC) and Workgroups Formed:** Led by HCA and Washington Health Alliance; 29 health care leaders plus state agency representatives. Four meetings through Dec. 17, 2014
- **Final PMCC Recommendations:** Due to HCA by January 1, 2015.

5732-1519 Recommended Performance Measures

APRIL 24, 2014

Health/Wellness, Utilization and Disparities

Access/effectiveness	1	Adults' Access to Preventive/Ambulatory Care	Contract
	2	Well-Child Visits	Contract
	3	Comprehensive Diabetes Care: Hemoglobin A1c Testing	Contract
	4	Alcohol/Drug Treatment Penetration	Contract
	5	Mental Health Treatment Penetration	Contract
	6	SBIRT Service Penetration	Contract
	7	Home- and Community-Based Long Term Services and Supports Use	Contract
	8	Suicide and drug overdose mortality rates	System Monitoring
Utilization	9	Psychiatric Hospitalization Readmission Rate	Contract
	10*	Emergency Department (ED) Visits	Contract
	11	Inpatient Utilization	Contract
	12	Plan All-Cause Readmission Rate	Contract
	13	Hospital Admissions for diabetes complications	Contract
	14	Hospital Admissions for Chronic Obstructive Pulmonary Disease	Contract
	15	Hospital Admissions for Congestive Heart Failure	Contract
	16	Hospital Admissions for asthma	Contract
Care coordination	17	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	Contract
Wellness	18	Medical Assistance with Smoking and Tobacco Use Cessation	System Monitoring
	19	Body Mass Assessment	Contract
	20	Tobacco Use Assessment	Contract

Health Disparities

To support measurement of disparities and performance differences across service contracting entities, where feasible and appropriate, metrics will be reported by:

- Race/ethnicity or primary language
- Age group and gender
- Geographic region
- Service-contracting entities
- Delivery system participation (for example, measuring mental health service penetration for clients receiving long-term services and supports, relative to its own benchmark or the experiences of other disabled clients not served in the long-term services and supports delivery system)
- Medicaid coverage type (for example, persons with disabilities, newly eligible adults)
- Chronic physical and behavioral health conditions
- History of criminal justice involvement
- Housing stability

Housing, Employment, Education and Meaningful Activities

Housing	21*	Homelessness/housing instability (broad)	System Monitoring
	22	HMIS-recorded housing assistance penetration	Contract
	23	Homelessness (narrow)	Contract
	24	Residential instability	Aspirational
Employment	25*	Employment rate	Contract
	26*	Earnings	Contract
	27*	Hours worked	Contract
Education	28	School-age children enrolled in school	Contract
	29	On time and late graduation from high school	Contract
	30	Adult enrollment in post-secondary education or training	Contract
Meaningful Activities	31*	Survey item: "To what extent do you do things that are meaningful to you?"	System Monitoring

Criminal Justice and Forensic Patients

Criminal Justice Involvement	32	Criminal Justice Involvement	Contract
	33	Jail Admissions	Contract
	34	Days in Jail	Contract
	35	Referrals for Competency Evaluation	Contract
	36	Persons in Prison with Serious Mental Illness	Contract
Access to Treatment for Forensic Patients	37	Mental Health Treatment after Release from Incarceration	Contract
	38	Serving Previously Un-served Offenders	System Monitoring
	39	Alcohol or Drug Treatment after Release from Incarceration	Contract
	40	Alcohol or Drug Treatment Retention	Contract
	41	Mental Health Treatment Engagement	Contract
	42	New Medicaid Enrollments after Release from Criminal Justice Facilities	System Monitoring

Quality of Life

Physical Health	43	WHOQOL-BREF Physical Health Scale	System Monitoring
Emotional Health	44	WHOQOL-BREF Emotional Health Scale	System Monitoring
Social Health	45	WHOQOL-BREF Social Health Scale	System Monitoring
Autonomy/Safety	46	WHOQOL-BREF Autonomy/Safety Scale	System Monitoring
Overall Quality	47	WHOQOL-BREF Overall Quality of Life Scale	System Monitoring
Hope	48	WHOQOL item: "How positive do you feel about the future?"	System Monitoring
Respect	49	New survey item: "To what extent are you respected and treated fairly?"	System Monitoring
Choice	50	New survey item: "To what extent do you make your own choices?"	System Monitoring
Cultural Connectedness	51	New survey item: to be defined	System Monitoring

**Measures 10 under Health/Wellness, Utilization, and Disparities and 21, 25, 26, 27, and 31 under Housing, Employment, Education and Meaningful Activities are shared with Quality of Life.*

Final Measures

Washington State Common Measure Set for Health Care Quality and Cost – Approved December 17, 2014

Overview of Measures:

MEASURES – POPULATION
Prevalence within the Population
Results for State, Counties/Accountable Communities of Health
(Note: Many, but not all, measures shown to the right will also have results at the state and/or county levels).

1. Immunization: Influenza
2. Unintended Pregnancies
3. Tobacco: % of Adults who Smoke Cigarettes
4. Behavioral Health: % of Adults Reporting 14 or more Days of Poor Mental Health
5. Ambulatory Care Sensitive Hospitalizations for COPD

MEASURES – HEALTH CARE COSTS

50. Annual State-purchased Health Care Spending Relative to State's GDP
51. Medicaid Spending per Enrollee
52. Public Employee and Dependent Spending per Enrollee (Include Public Schools)

MEASURES – CLINICAL SETTINGS
Clinical Processes or Outcomes
Results for Health Plans, Medical Groups and/or Hospitals

Health Plan (Only)	Primary Care Medical Groups (4 or more Providers)	Hospitals
Children/Adolescents 6. Access to Primary Care 7. Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life 8. Youth Obesity: BMI Assessment/Counseling 9. Oral Health: Primary Caries Prevention/ Intervention	Children/Adolescents 19. Immunization: Childhood Status 20. Immunizations: Adolescent Status 21. Immunizations: HPV Vaccine for Adolescents 22. Appropriate Testing for Children with Pharyngitis	40. Patient Experience: Communication about Medications and Discharge Instructions 41. 30-day All Cause Readmissions* 42. Potentially Avoidable ED Visits* 43. Patients w/ 5 of More ED Visits *without* Care Guidelines 44. C-Section NTSV 45. 30-day Mortality: Heart Attack 46. Catheter-associated Urinary Tract Infection 47. Stroke: Thrombolytic Therapy 48. Falls with Injury per Patient Day 49. Complications/Patient Safety Composite (11 components)
Adults 10. Access to Primary Care 11. Adult Obesity: BMI Assessment/Counseling 12. Medical Assistance with Smoking and Tobacco Use Cessation 13. Colorectal Cancer Screening* 14. Diabetes Care: Blood Pressure Control 15. Diabetes Care: HbA1c Poor Control 16. Hypertension: Blood Pressure Control 17. Follow-up After Hospitalization for Mental Illness @ 7 days, 30 days 18. 30-day Psychiatric Inpatient Readmission **Results available for medical groups starting in 2016.*	Adults 23. Patient Experience: Provider Communication 24. Screening: Cervical Cancer 25. Screening: Chlamydia 26. Screening: Breast Cancer 27. Immunizations: Pneumonia (Older Adults) 28. Avoidance of Antibiotics for Acute Bronchitis 29. Avoidance of Imaging for Low Back Pain 30. Asthma: Use of Appropriate Medications 31. Cardiovascular Disease: Use of Statins 32. COPD: Use of Spirometry in Diagnosis 33. Diabetes: HbA1c Testing 34. Diabetes: Eye Exams 35. Diabetes: Screening for Nephropathy 36. Depression: Medication Management 37. Medication Adherence: Proportion of Days Covered 38. Medication Safety: Annual Monitoring for Patients on Persistent Medications 39. Medications: Rate of Generic Prescribing	**Results also available for medical groups.*

Washington State Managed Fee-for-Service Duals Demonstration

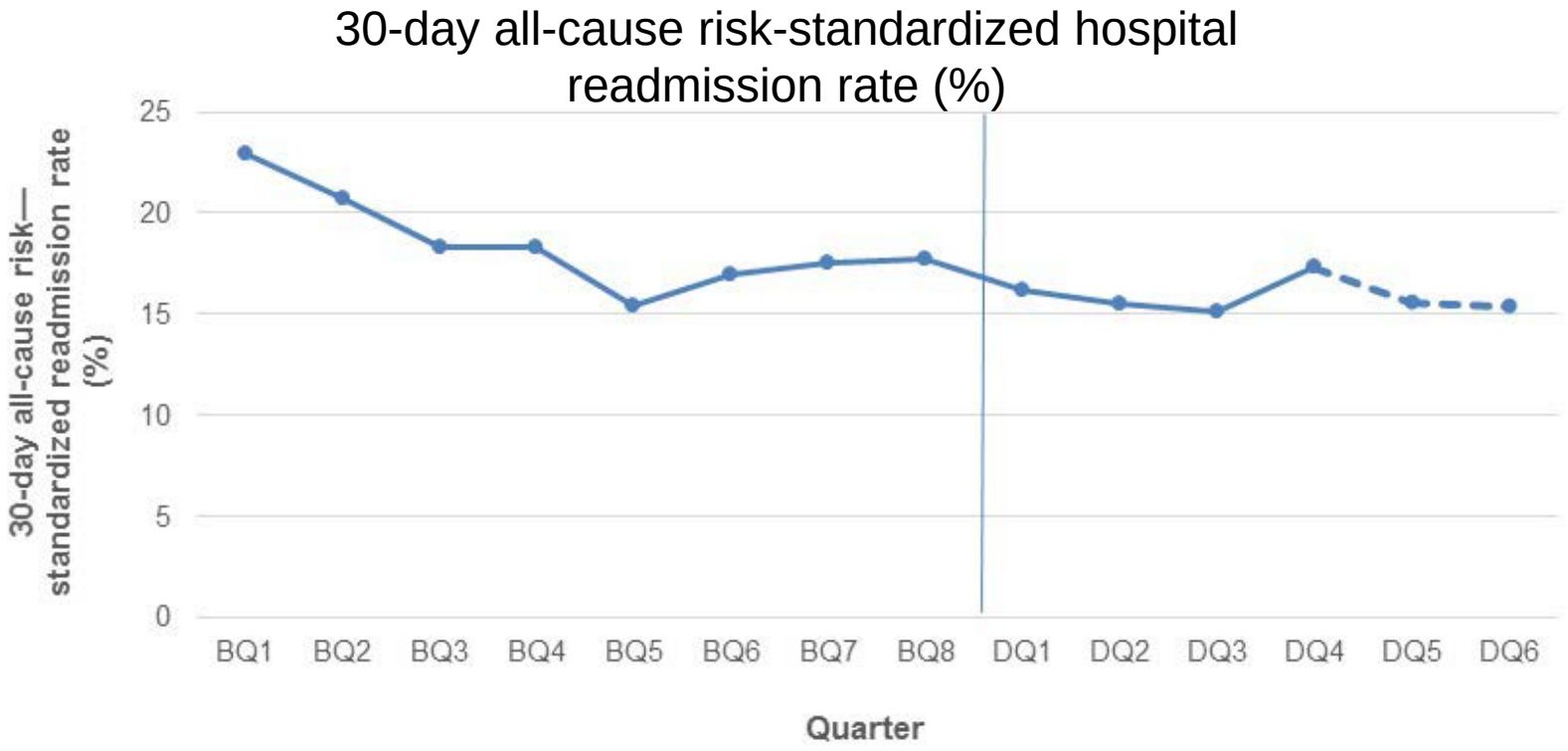
Selected Preliminary Findings

- **Average Patient activation (PAM® score) increased** (54.6 to 59.2, p<.0001, N=285 clients)
- **Percent of high risk duals receiving home and community based long term services and supports increased** (58% to 64%, p<.0002, N=408 clients)
- **Number of emergency department visits deemed non-emergent or primary-care treatable (NYU algorithm) dropped 9.4%** (339 to 307, p<.0316)
- **Ambulatory care-sensitive hospital admissions per 100,000 client months dropped** (1,225 to 817, p<.0001)

— Results not yet compared to high-risk duals not receiving the intervention —

NOTES: Includes Full Dual Demonstration eligible clients not aligned with another Medicare shared saving program.
DATA SOURCE: Washington State Health Care Authority, ProviderOne (Medicaid) database.
PREPARED BY: Department of Social and Health Services, Research and Data Analysis Division.

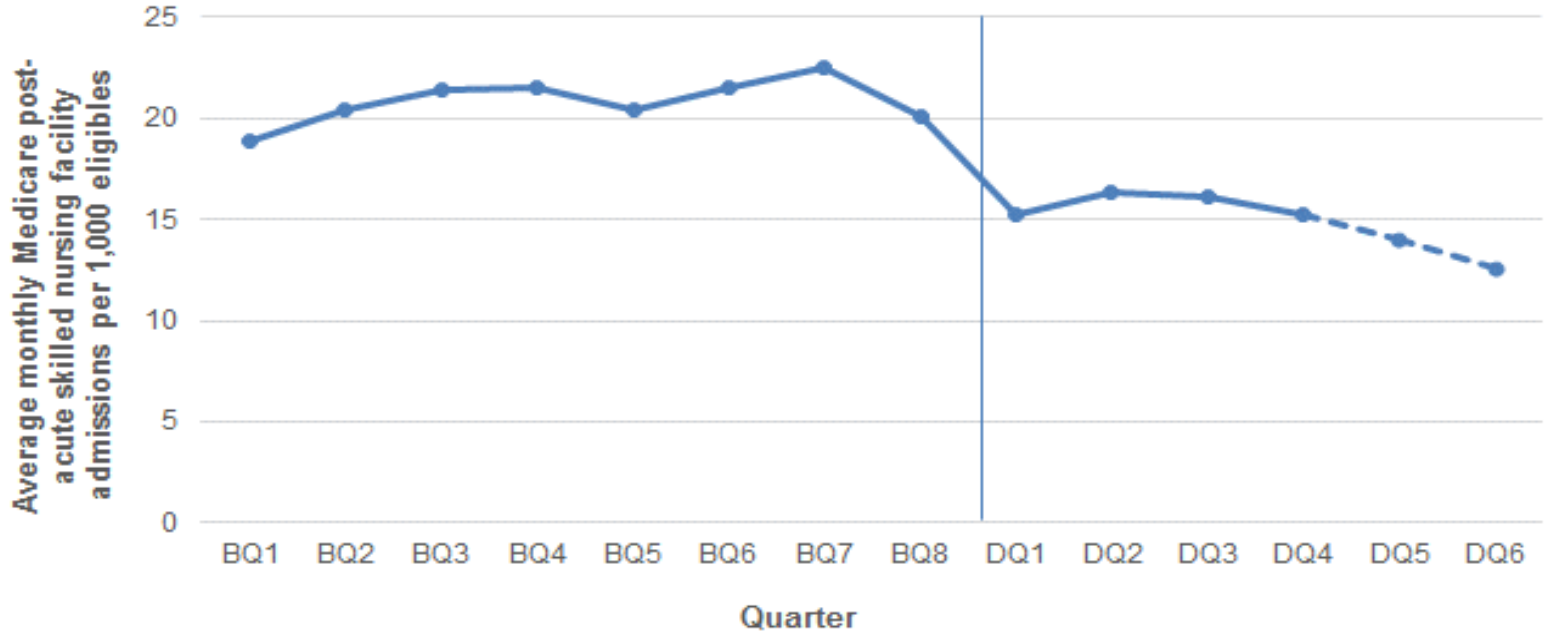
Health Home Impact on Readmission



PREPARED BY: Edith G. Walsh, RTI International, Preliminary Findings from the Washington MFFS Demonstration, January 4, 2016 https://innovation.cms.gov/Files/reports/fai-wa-prelimppone.pdf

Health Home Impact on SNF Admits

Average monthly Medicare post-acute skilled nursing facility admissions per 1,000 eligibles



PREPARED BY: Edith G. Walsh, RTI International, Preliminary Findings from the Washington MFFS Demonstration, January 4, 2016 https://innovation.cms.gov/Files/reports/fai-wa-prelimppone.pdf

Client Focus Group

[Before Health Home Involvement] “I was shut in my house for years. My windows were drawn. I didn’t have company. I just was mentally depressed, and my house was horrible—not dirty, but just like hoarders. …Well, I’m completely off my psych medications, and I was on a lot of them for many years…

[After Health Home Involvement] “I go outside. I interact with my neighbors. I go to church. My cholesterol is down to normal. It was dangerously high for many years. “

PREPARED BY: Edith G. Walsh, RTI International, Preliminary Findings from the Washington MFFS Demonstration, January 4, 2016 https://innovation.cms.gov/Files/reports/fai-wa-prelimppone.pdf

Microsoft

Questions?

Strategic Direction for the Workgroup

Future Directions

- Consider the workgroup's evolution and contribution over the past 5 years, and discuss:
  - *Moving forward, where can the workgroup provide future guidance?*
  - *Where can the workgroup provide strategic guidance related to measurement policies?*

Future Directions Contd.

- What is a feasible level of health systems change with regards to the Dual Eligible Beneficiaries population?
- What would be the ideal level of change, at the health systems level, for the Dual Eligible Beneficiaries population?

Opportunity for Member and Public Comment

Next Steps

Next Steps

- Public Comment: June, 2016, 1 month commenting period
- Final Report: by August 31, 2016

Adjourn

Thank You!