NATIONAL QUALITY FORUM

# Patient Experience and Function

***Measure Evaluation Meeting Continued***
***February 5, 2018***

Kyle Nicholls Cobb, MS, Senior Director
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# Today's Agenda

- Standing Committee Roll Call
- Consideration of Candidate Measures Continued
- Review of Care Coordination Measures
- Adjourn

# Patient Experience and Function Committee Roster – Fall 2017 Cycle

- **Gerri Lamb**, PhD, RN, FAAN - Co-Chair
- **Lee Partridge** - Co-Chair
- **Chris Stille**, MD, MPH - Co-Chair
- **Samuel Biernier**, MD
- **Rebecca Bradley**, LCSW
- **Donald Casey,** MD, MPH, MBA, FACP, FAHA
- **Ryan Coller,** MD, MPH
- **Nicole Friedman**
- **Barbara Gage,** PhD, MPA
- **Dawn Hohl,** RN, BSB, MS, PhD
- **Stephen Hoy**
- **Sherrie Kaplan,** PhD, MPH
- **Brian Lindberg,** BSW, MMHS
- **Brenda Leath,** MHSA, PMP
- **Linda Melillio,** MA, MS, CPHRM, CPXP
- **Lisa Morrise,** MA
- **Patricia Ohtake,** PT, PhD
- **Charissa Pacella,** MD
- **Lenard Parisi,** RN, MA, CPHQ, FNAHQ
- **Debra Saliba,** MD, MPH
- **Ellen Schultz,** MS
- **Lisa Gale Suter,** MD
- **Peter Thomas,** JD

# Review of Measure 3324

- **Title:** Long Term Services and Supports (LTSS) Comprehensive Care Plan Update
- **Developer:** Mathematica Policy Research
- **Measure Type:** Process
- **Data Source:** Management Data, Paper Records, Other
- **Level of Analysis:** Health Plan
- **Care Setting:** Home Care, Other
- **Status:** New Measure

# Review of Measure 3325

- **Title:** Long Term Services and Supports (LTSS) Shared Care Plan with Primary Care Practitioner
- **Developer:** Mathematica Policy Research
- **Measure Type:** Process
- **Data Source:** Management Data, Paper Records, Other
- **Level of Analysis:** Health Plan
- **Care Setting:** Home Care, Other
- **Status:** New Measure

# Review of Measure 3326

- **Title:** Long Term Services and Supports (LTSS) Re-Assessment/Care plan Update after Inpatient Discharge
- **Developer:** Mathematica Policy Research
- **Measure Type:** Process
- **Data Source:** Claims, Management Data, Paper Medical Records, Other
- **Level of Analysis:** Health Plan
- **Care Setting:** Home Care, Other
- **Status:** New Measure

# Public Comment

# Care Coordination Measures

# Previous NQF Care Coordination Portfolio

| | Process | Outcome \| Resource Use | Structural | Composite |
|---|---|---|---|---|
| ED Transfers | 4 | - | - | - |
| Plan of Care | 1 | - | - | - |
| E-Prescribing | - | - | - | - |
| Timely Transitions | 1 | 2 | - | - |
| Medication Management | 2 | 1 | - | - |
| Transition Records | 3 | - | - | - |
| Medical Home | - | - | - | - |
| TOTAL | 11 | 3 | 0 | 0 |

# Communication

| NQF# | Measure Title | Status \| Portfolio |
|---|---|---|
| 0291 | Emergency Transfer Communication | Endorsed - PEF |
| 0647 | Transition Record with Specified Elements Received by Discharged Patients | Endorsement Removed (2017) |
| 0648 | Timely Transmission of Transition Record | Endorsement removed (2017) |
| 0649 | Transition Record with Specified Elements Received by Discharged Patients | Endorsement removed (2017) |

# Transitions and Handoffs

| NQF# | Measure Title | Status \| Portfolio |
|---|---|---|
| 0097 | Medication Reconciliation Post-Discharge | Patient Safety |
| 0171 | Acute Care Hospitalization During the First 60 Days of Home Health | All-Cause Admissions and Readmission |
| 0173 | Emergency Department Use without Hospitalization During the First 60 Days of Home Health | All-Cause Admissions and Readmission |
| 0495 | Median Time from ED Arrival to ED Departure for Admitted ED Patients | Cost and Efficiency |
| 0496 | Median Time from ED Arrival to ED Departure for Discharged ED Patients | Cost and Efficiency |
| 0497 | Admit Decision Time to ED Departure Time for Admitted Patients | Cost and Efficiency |
| 0553 | Care for Older Adults (COA) – Medication Review | Patient Safety |

# Proactive Plan of Care and Follow-Up

| NQF# | Measure Title | Status \| Portfolio |
|---|---|---|
| 0326 | Advance Care Plan | Geriatric and Palliative Care |
| 1626 | Patients Admitted to ICU who Have Care Preferences Documented | Geriatric and Palliative Care |
| 1641 | Hospice and Palliative Care – Treatment Preferences | Geriatric and Palliative Care |

# Next Steps

# Activities and Timeline – Fall 2017 Cycle

| Activity | Date |
|---|---|
| Draft Report Posted for Public Comment and NQF member comment | March 8 - April 6 |
| **Post Draft Report Comment Call** | **Friday, April 20, 2:00-4:00pm** |
| CSAC Review Recommendations | May 21 - June 11 |
| Appeals Period | June 13 - July 12 |
| Final Report Posted | August 2018 |

# Activities and Timeline – Spring 2018 Cycle

| Activity | Date |
|---|---|
| Intent to Submit Deadline | January 4, 2018 |
| Measure submission deadline | April 9, 2018 |
| Commenting & member support period on submitted measures opens | May 1, 2018 |
| **Measure Evaluation Web Meeting (1/3)** | **Friday, June 22, 2018 1:00-3:00pm ET** |
| **Measure Evaluation Web Meeting (2/3)** | **Monday, June 25, 2018 1:00-3:00pm ET** |
| **Measure Evaluation Web Meeting (2/3)** | **Friday, June 29, 2018 1:00-3:00pm ET** |
| **Post Measure Evaluation Web Meeting** | **Monday, July 9, 2018 10:00am-12:00pm ET** |
| Report Posted for Public Comment | July 31-August 29, 2018 |
| **Post Draft Report Comment Call** | **Monday September 17, 2018 11:00am-1:00pm ET** |
| CSAC Review Recommendations | October 15-November 2 |
| Appeals Period | November 6-December 5 |
| Final Report Posted | January 2019 |

# Project Contact Info

- Email: PatientExperience@qualityforum.org
- NQF Phone: 202-783-1300
- Project page:
- http://www.qualityforum.org/Patient_Experience_and_Function.aspx
- SharePoint site:

http://share.qualityforum.org/Projects/Patient_Experience_and_fucntion/SitePages/Home.aspx

# Adjourn

# Appendix: NCQA Slides

# Assessment and Care Planning Measures: Managed Long-Term Services and Supports (MLTSS)

January 31, 2018

**Roxanne Dupert-Frank**, *Center for Medicaid and CHIP Services*
**Jessica Ross**, *Mathematica Policy Research*
**Erin Giovannetti**, *National Committee for Quality Assurance*

# Medicaid Long-Term Services and Supports

**Broad range of medical and personal care services for people with some self-care needs due to aging, chronic illness or disability**

**Services include:**

- Nursing Home
- Adult day care
- Home health aide
- Personal care aide
- Transportation
- Supportive employment
- Other home- and community-based services

**Medicaid is the largest payer for LTSS**

**Almost half of states deliver (or are planning to deliver) LTSS through managed LTSS plans (MLTSS)**

# Managed LTSS Plans are accountable

- In 2015, 18 state Medicaid agencies contracted with plans to provide MLTSS
- States typically contract with 3-10 MLTSS plans; 1 in RI and VT, 36 in NY (total of ~120 plans nationally)
- State contracts with MLTSS plans obligate plans to conduct in-person assessments and care plans with new LTSS members shortly after they are enrolled, and update them annually, and arrange for needed services and supports
- In many states, MLTSS plans cover medical services, so they also contract with primary care providers; if medical services are not covered, most states require MLTSS plans to coordinate care with medical care providers

# CMS Contracts to Develop MLTSS Measures

## Project Team:

- CMS: CCSQ, MMCO, CMCS DQ & CMCS DMCP
- Contractors: Mathematica Policy Research and NCQA

## Goals: Identify key MLTSS measure domains and concepts, develop and test measures

## Result:

- 4 Assessment and Care Planning measures
- 3 Rebalancing/Utilization measures
- 1 Falls Risk Reduction measure

# MLTSS Person-Centered Planning and Coordination Quality Measures

**Few existing nationally standardized measures to help make fair comparisons across MLTSS plans and state Medicaid MLTSS programs**

**Proposed measures address priority measurement gaps in person-centered planning and coordination identified by NQF's HCBS Quality Committee:**

- NQF 3319: Comprehensive LTSS Assessment and Update
- NQF 3324: Comprehensive LTSS Care Plan and Update
- NQF 3325: Shared Care Plan with Primary Care Physician
- NQF 3326: Re-Assessment/Care Plan Update After Inpatient Discharge

# Conceptual Model

# NQF 3319: LTSS Comprehensive Assessment and Update

The percentage of MLTSS enrollees who have documentation of an in-home, comprehensive assessment covering core elements, within 90 days of enrollment or annually

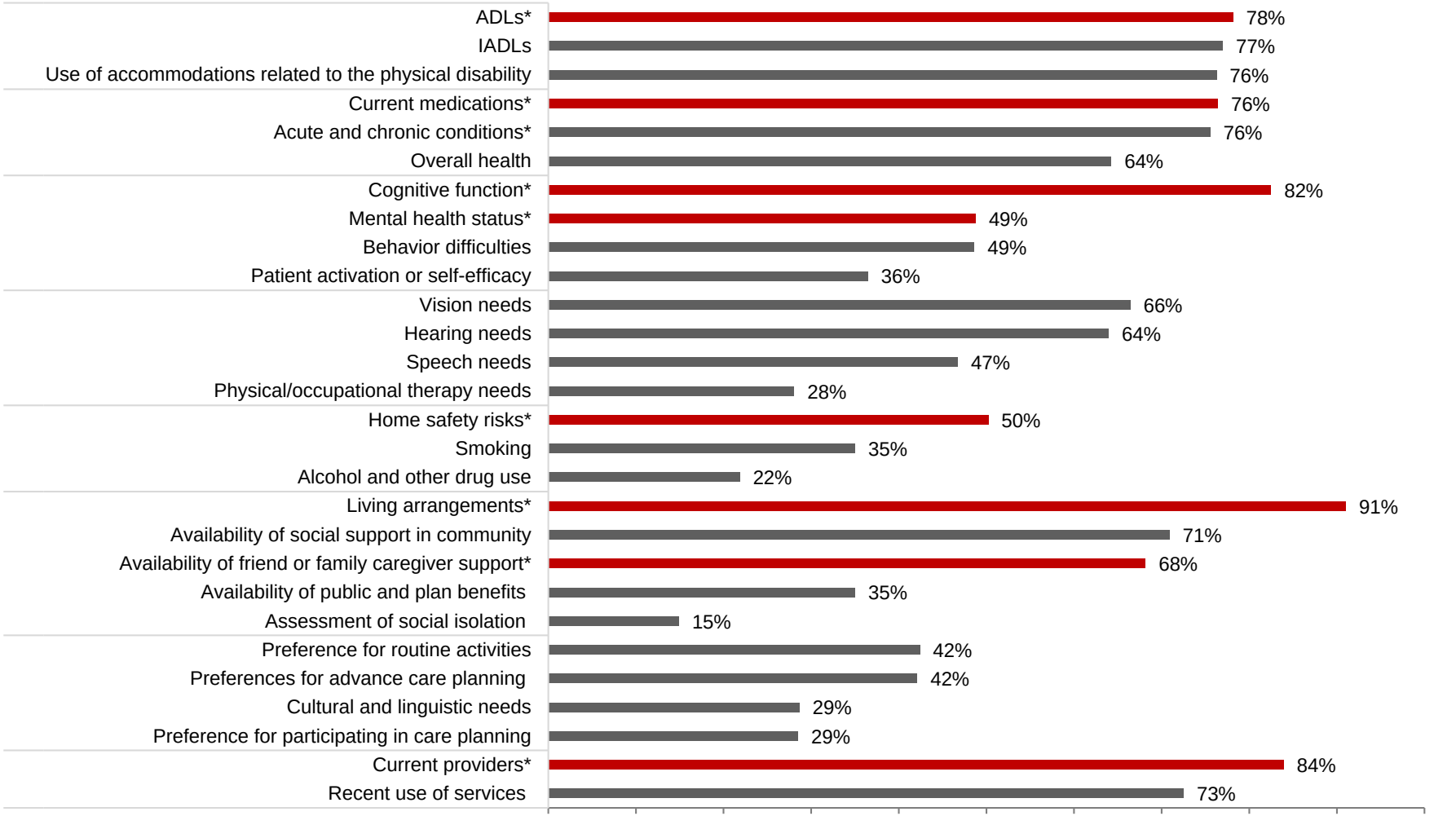
**97%** had an assessment completed

**73%** had an assessment completed in the specified timeframe

**66%** had an assessment in the home

# Assessment Elements

*Evaluated whether 28 different elements were documented*




** Core element*

# NQF 3319: LTSS Comprehensive Assessment and Update

## Core Elements

1) ADLs
2) Current Medications
3) Acute and chronic conditions
4) Cognitive Function
5) Mental Health Status
6) Home Safety Risk
7) Living Arrangement
8) Availability of friend/family caregiver support
9) Current Providers

| | Across 5 MLTSS Plans | | |
|---|---|---|---|
| **Comprehensive LTSS Assessment** | **Mean** | **Min** | **Max** |
| Rate 1: 9 Core elements | 7.9% | 0.0% | 25.5% |
| Rate 2: 9 Core elements + at least 12 supplemental elements | 6.4% | 0.0% | 21.6% |

# NQF 3324: LTSS Comprehensive Care Plan and Update

**The percentage of MLTSS enrollees who have documentation of a comprehensive care plan, covering core elements, within 120 days of enrollment or annually with documentation of:**

- **Caregiver involvement**
- **Beneficiary consent**

**68% had a care plan completed**

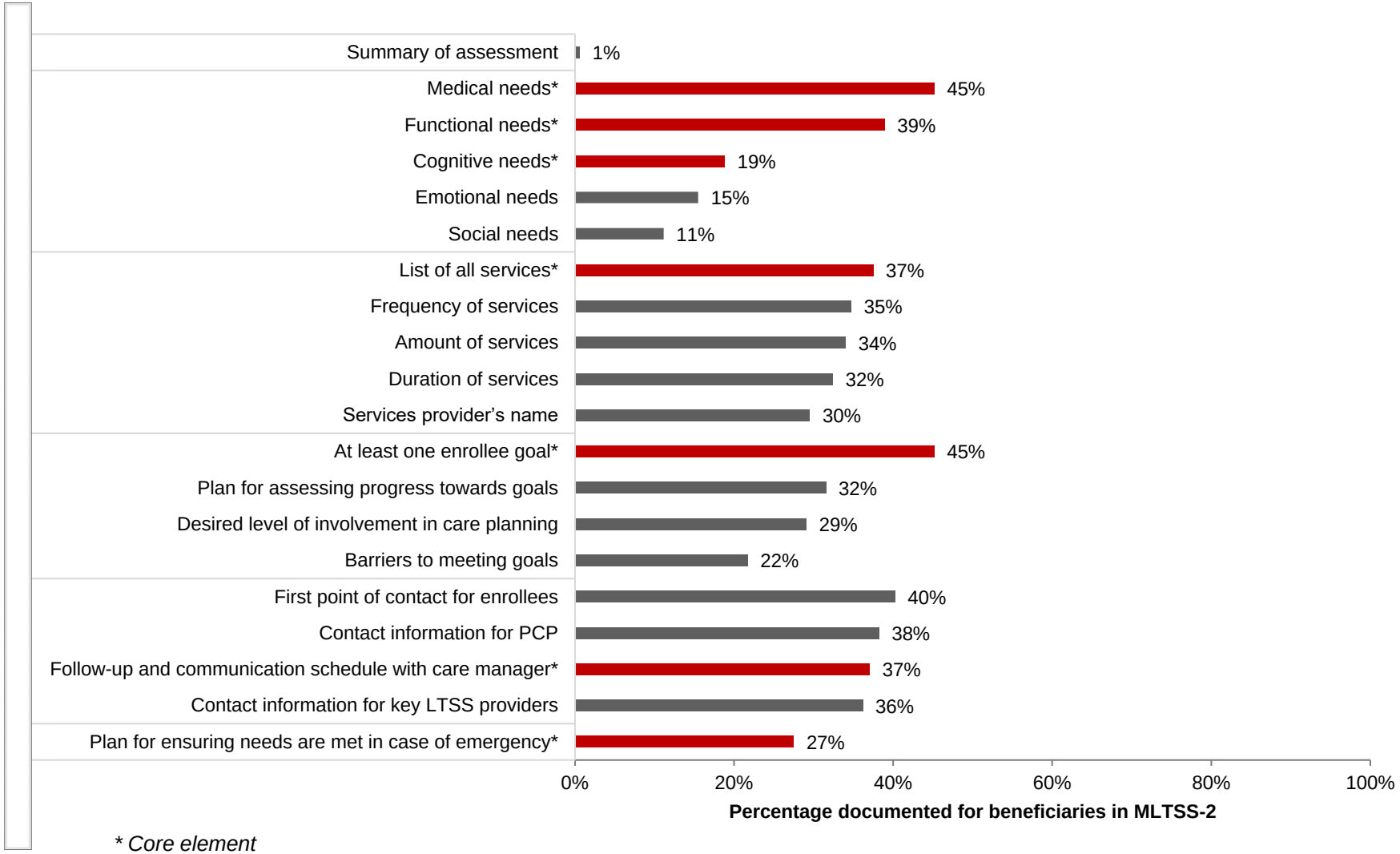
**48% had a care plan completed in specified timeframe**

**21% had documentation of caregiver involvement**

**17% had documentation of beneficiary (or proxy) consent**

# Care Plan Elements

*Evaluated whether 20 different elements were documented*




** Core element*

# NQF 3324: LTSS Comprehensive Care Plan and Update

## Core Elements

1) Medical needs
2) Functional needs
3) Cognitive needs,
4) List of all services received/expected to receive
5) Beneficiary goal
6) Follow-up and communication schedule with care manager
7) Plan for ensuring beneficiary needs are met in case of emergency

| | Across 5 MLTSS Plans | | |
|---|---|---|---|
| **Comprehensive LTSS Care Plan** | **Mean** | **Min** | **Max** |
| Rate 1: 7 Core elements | 0.6% | 0.0% | 2.5% |
| Rate 2: 7 Core elements + at least 4 supplemental elements | 0.6% | 0.0% | 2.5% |

# NQF 3325: LTSS Shared Care Plan with Primary Care Physician

The percentage of MLTSS beneficiaries with a care plan for whom all or part of the care plan was transmitted to the PCP within 30 days of development or update

**30%** of care plans are shared

**19%** shared within 30 days

**18%** of care plans are shared within 30 days with a PCP

# NQF 3325: LTSS Shared Care Plan with Primary Care Physician

## Focus on Coordination with PCP

- Preliminary measure specification required care plan sharing with both PCP and at least one key LTSS provider
  - **3%** of care plans met this criteria
- Definition of "key LTSS provider" found to be subjective and confusing
- Focused on coordination with PCP based on expert workgroup feedback

| | Across 5 MLTSS Plans | | |
|---|---|---|---|
| **Shared LTSS Care Plan with PCP** | **Mean** | **Min** | **Max** |
| | 6.5% | 0.0% | 23.4% |

# NQF 3326: LTSS Re-Assessment/Care Plan Update After Inpatient Discharge

The percentage of inpatient discharges of MLTSS enrollees resulting in updates to the assessment and care plan within 30 days of discharge

**33%** of enrollees had at least one unplanned hospital admission (319 discharges total)

Among the **319** discharges:

- **31%** were followed by a re-assessment within 30 days
- **5.2%** also followed by a care plan update within 30 days

# NQF 3326: LTSS Re-Assessment/Care Plan Update After Inpatient Discharge

## Need for Ongoing Monitoring

- Preliminary specification required both a re-assessment and care plan update within 30 days
  - **5.2%** of discharges met this criteria
- Use of two rates reflects current practices (Rate 1) and best practices recommended during development by TEP members and experts (Rate 2)

| | Across 5 MLTSS Plans | | |
|---|---|---|---|
| **Re-Assessment/Care Plan Update after Inpatient Discharge** | **Mean** | **Min** | **Max** |
| Rate 1: Re-Assessment | 22.4% | 7.4% | 40.0% |
| Rate 2: Re-Assessment and care plan update | 5.2% | 0.0% | 14.3% |