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Measure Applications Partnership (MAP)

Dual Eligible Beneficiaries Workgroup

In-Person Meeting

July 25-26, 2011

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Welcome and Review of Meeting Objectives

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Introductions

Flow of Information to Inform Reports

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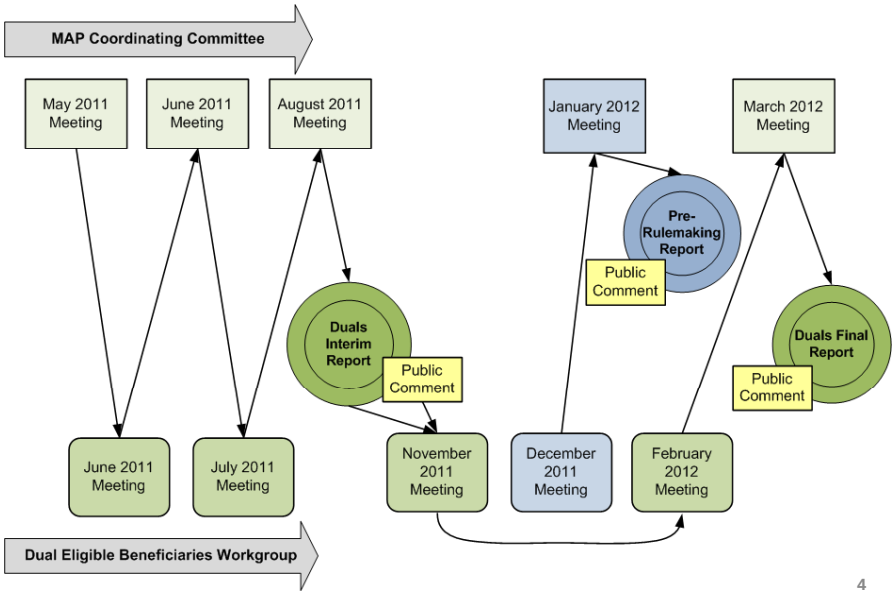
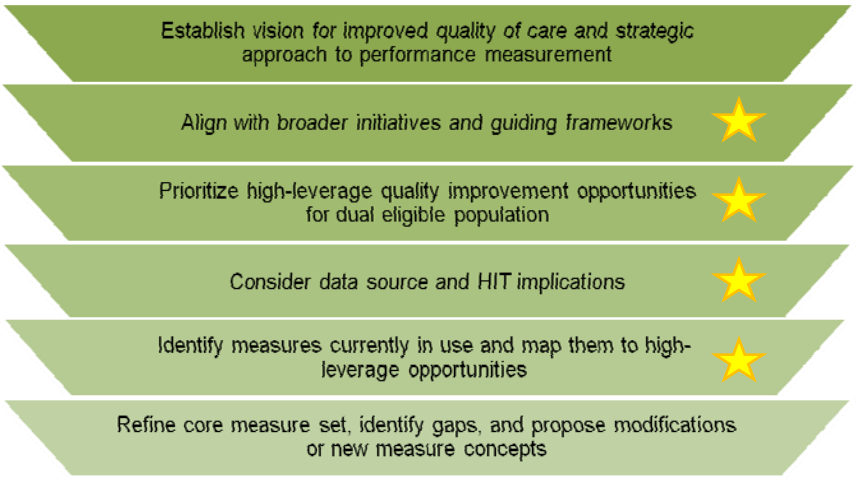


Analytic Strategy–In-Person Meeting



Meeting Objectives

- Finalize vision, guiding principles, and strategic approach to performance measurement
- Discuss strengths and weaknesses of current applications of measures
- Identify current measures that apply to high-leverage opportunities for improvement
- Develop themes, recommendations, and questions for public comment to include in interim report to HHS

Agenda: July 25

9:00 am	Welcome and review of meeting objectives
9:30 am	Opportunities for alignment
10:00 am	Synthesize strategic approach to performance measurement
11:15 am	Defining high-need population subgroups
Noon	Working lunch
12:30 pm	Applications of quality measurement: Medicare
1:30 pm	Applications of quality measurement: Medicaid
2:45 pm	Applications of quality measurement: integrated models
3:45 pm	Data sources and alignment of the data platform
4:30 pm	Summary of Day 1 and Look Forward to Day 2
4:45 pm	Adjourn for the day

Interim Report Draft Outline

I. Preface

II. Introduction

III. Overarching frameworks

IV. Population background

V. Vision for quality care

VI. Opportunities for quality improvement with greatest impact

VII. Current performance measurement landscape for this population

VIII. Measures associated with quality improvement opportunities

IX. Recommendations

X. Next phase of work

XI. Issues for public comment

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Opportunities for Alignment

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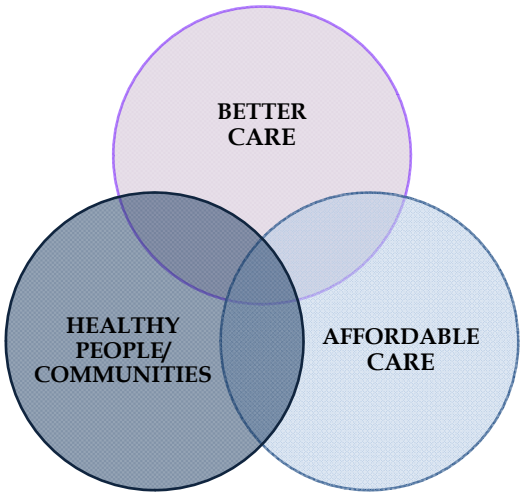
National Quality Strategy

National Quality Strategy Domains and Principles



Principles reflect:

- Patient-centeredness and family engagement
- Quality care for patients of all ages, populations, service locations, and sources of coverage
- Elimination of disparities
- Alignment of public and private sectors

NPP's Ongoing Role in Consultation to HHS on the National Quality Strategy

NPP has been specifically asked to provide input to HHS on identified priorities as well as at least:

- Three goals per priority area;
- Two measures per goal; and
- Two strategic opportunities per goal.

Healthy People/Healthy Communities
Proposed Goals and Measure Concepts

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Priority Area: ***Working with communities to promote wide use of best practices to enable healthy living and well-being.***

- Promote healthy living and well-being through community interventions that result in improvement of social, economic, and environmental factors.
  - Social connectedness
  - Injury
- Promote healthy living and well-being through interventions that result in adoption of the most important healthy lifestyle behaviors across the lifespan.
  - Exercise/healthy behaviors
  - Alcohol or substance abuse
  - Obesity
- Promote healthy living and well-being through receipt of effective clinical preventive services across the lifespan in clinical and community settings.
  - Depression
  - Oral Health

Healthy People/Healthy Communities
Proposed Goals and Measure Concepts

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Priority Area: ***Promoting the most effective prevention, treatment, and intervention practices for the leading causes of mortality, starting with cardiovascular disease.***

- Promote cardiovascular health through community interventions that result in improvement of social, economic, and environmental factors.
  - Availability of healthy food options
  - Physical environment/open space
- Promote cardiovascular health through interventions that result in adoption of the most important healthy lifestyle behaviors across the lifespan.
  - Smoking and tobacco use
  - Healthy diet/nutrition
- Promote cardiovascular health through effective clinical preventive services across the lifespan in clinical settings and the community at large.
  - Blood pressure
  - Cholesterol level

Better Care
Proposed Goals and Measure Concepts

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Priority Area: *Ensuring Person- and Family-Centered Care*

- Improve patient, family, and caregiver experience of care related to quality, safety, and access across settings.
  - Patient experience of care
  - Patient-centered hospital care
- In partnership with patients, families, and caregivers – and using a shared decisionmaking process – develop care plans that are culturally sensitive and understandable.
  - Patient engagement in shared decision-making
  - Patient involvement in development of individualized care plans
- Enable patients and their families and caregivers to appropriately and effectively navigate, coordinate, and manage their care.
  - Confidence in managing their condition
  - Communication with their provider regarding self-management
  - Promoting culturally sensitive and linguistically appropriate care

Better Care
Proposed Goals and Measure Concepts

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Priority Area: *Making Care Safer*

- Reduce preventable hospital admissions and readmissions.
  - Admissions for ambulatory-sensitive conditions
  - All-cause readmissions
- Reduce the incidence of adverse healthcare-associated conditions.
  - Hospital-acquired conditions (all-cause)
  - Hospital-acquired conditions (individual)
- Reduce harm from inappropriate or unnecessary care.
  - Receipt of potentially inappropriate medications
  - Elective deliveries prior to 39 completed weeks
  - Imaging for acute low back pain without risk factors
  - Cardiac imaging for preoperative risk assessment for non-cardiac low-risk surgery

Better Care
Proposed Goals and Measure Concepts

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Priority area: ***Promoting Effective Communication and Care Coordination***

- Improve quality of care transitions and communication across care settings.
  - Care transitions experience
  - Transition record elements
- Improve the quality of life for patients with chronic illness and disability by following a current care plan that anticipates and addresses pain and symptom management, psychosocial needs, and functional status.
  - Chronic disease control
  - Care according to end-of-life wishes
  - Quality of life for vulnerable populations
- Establish shared accountability and integration between communities and healthcare systems to improve the quality of care and reduce health disparities.
  - Health outcomes (e.g., mortality, morbidity)
  - Children with access to medical home

Affordable Care
Proposed Goals and Measure Concepts

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Priority area: ***Make care affordable for people, families, employers, and governments***

- Ensure accessible and affordable high-quality healthcare for people, families, employers, and governments.
  - Affordability index
  - Insurance coverage
  - Delay in getting care
- Reduce total national healthcare costs per capita by 5 percent and escalating healthcare costs to no more than one percent above the consumer price index without compromising quality.
  - Healthcare expenditures per capita
  - Annual percent growth in healthcare expenditures
  - Quality of life for vulnerable populations
- Support and enable communities to ensure high-quality care while reducing unnecessary costs.
  - Menu of opportunities to reduce unwarranted variation or overuse

National Priorities Partnership Key Themes

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- Balancing achievable and aspirational goals
- Emphasizing the importance of composite and outcome measures
- Placing patients, families, and caregivers at the center of care
- Addressing goals, measures, and interventions across the lifespan
- Addressing health equity through the lens of “goodness and fairness”
- Bridging clinical and community communication and efforts across the continuum of care
- Incorporating community, behavioral, and clinical concepts into goals, measures, and strategic opportunities
- Addressing primary measure gaps and ongoing measure development

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NQF’s Multiple Chronic Conditions (MCC) Measurement Framework

Purpose

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This project seeks to achieve consensus through NQF's Consensus Development Process (CDP) on a measurement framework for assessing the efficiency of care—defined as quality and costs— provided to individuals with multiple chronic conditions (MCCs).

Scope

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- Establish definitions, domains and guiding principles that are instrumental for measuring and reporting the efficiency of care for patients with MCCs
- Adapt the NQF-endorsed® Patient-focused Episodes of Care Measurement Framework for patients with MCCs
- Build upon the National Quality Strategy, HHS's MCC Framework and the work of other private sector initiatives
- Support the development and application of measures

Timelines and Deliverables

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Proposed Activity/Deliverable	Timeline
Committee in-person meeting #1	July 8, 2011
Draft commission paper	July 22, 2011
Committee web meeting #2	July 29, 2011
Committee in-person meeting #2	August 8, 2011
Final commission paper	September 30, 2011
Committee web meeting #3	December 2, 2011
Draft framework report	December 5, 2011
Public comment	Late December 2011 – January 2012
Final framework report	Early February 2012
Member voting	March 2012
CSAC consideration and Board Endorsement	April 2012

HHS Multiple Chronic Conditions Framework

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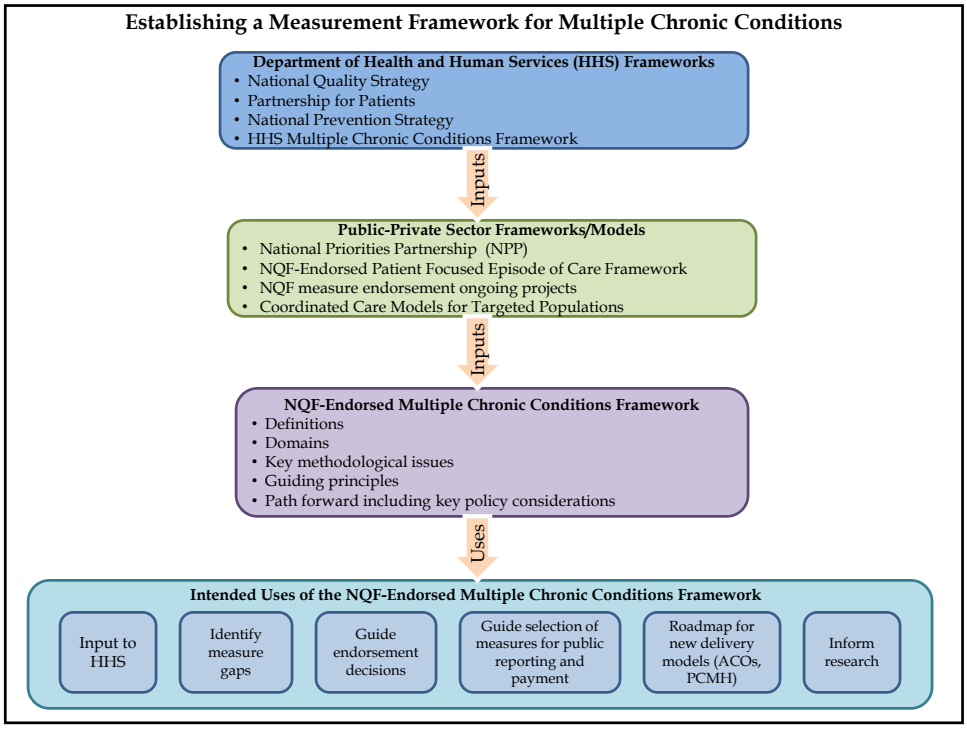
1. Foster healthcare and public health system changes to improve the health of individuals with multiple chronic conditions
2. Maximize the use of proven self-care management and other services by individuals with MCCs
3. Provide better tools and information to healthcare, public health, and social services workers who deliver care to individuals with MCCs
4. Facilitate research to fill knowledge gaps about, and interventions and systems to benefit, individuals with multiple chronic conditions



MCC Draft Definition

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Two or more concurrent chronic conditions* that affect the life expectancy or quality of life and are associated with complicated health needs or perceived burden of care for patient, family, and providers.

* Chronic conditions includes clinical, behavioral, and social conditions

MCC Draft Detailed Definition

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Two or more concurrent chronic conditions that require ongoing clinical/behavioral/mental/health attention that:

1. Influences care of other conditions *or*
2. Leads to high levels of complexity or difficulty stabilizing care coordination *or*
3. Affects functional roles and outcomes *or*
4. Leads to limitations of life expectancy *or*
5. Leads to contraindications or severe interactions *or*
6. Limitations of patients to self-manage and patients and families perceived burden

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MCC Framework Domains

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HHS National Quality Strategy: 6 Priorities	Key Measurement Areas
Effective communication and coordination of care	• Care plans in use • Seamless transitions *between multiple providers* • Shared accountability *that includes patients, families, and providers* • Clear instructions/*simplification of regimen* • Integration between community & healthcare system • Access to patient centered medical home
Person and family centered care	• Patient, family, caregiver experience of care • Shared decision-making • Self-management of chronic conditions, *especially multiple conditions*
Making quality care more affordable	• Access to quality care *particularly a primary care provider that can offer adequate time & attention* • Reasonable patient out of pocket medical costs and premiums • Healthcare system costs as a result of inefficiently delivered services, *particularly ER visits, poly-pharmacy, hospital admissions*

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MCC Framework Domains

HHS National Quality Strategy: 6 Priorities	Key Measurement Areas
Enable healthy living *(Optimize Function)*	• Quality of life/*patient family perceived burden of illness or pain* • Social support/*connectedness, to include ability to work* • Disparities/*social determinants* • Depression/substance abuse/*mental health*
Make care safer	• Preventable admissions and readmissions • Inappropriate medications, *proper medication protocol and adherence* • Reduce harm from unnecessary services
Prevention and treatment for leading causes of mortality	• Patient outcomes • *Missed prevention opportunities – primary, secondary, tertiary*

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Life-Course Theory

Life-course theory is based on two concepts:

- The impact of specific risk factors and determinants of health varies during the life course.
- Health and disease result from the accumulation of the effects of risk factors and determinants over the life course.

Combining the two components produces a life-course health "trajectory."

An individual's health trajectory may be affected by the dynamic interaction among social, biological, and environmental influences over time.

The theory underscores the importance of multiple risk and protective influences.

Institute of Medicine, *Child and Adolescent Health and Health Care Quality: Measuring What Matters,* Washington, DC: The National Academies Press, 2011.

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Workgroup Discussion and Questions

Discussion Questions

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- Is this work thoroughly aligned with the three-part aim of the NQS?
- Which of the metrics identified by the NPP have particular importance for dual eligible beneficiaries?
- In what ways does the life-course approach apply?
- How can this workgroup incorporate concepts proposed by the MCC work?

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Synthesize Strategic Approach to Performance Measurement

Initial Vision for High-Quality Care

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Individuals should have ~~reliable~~ timely access to a **person- and family-centered**, **culturally and professionally competent** support system that helps them reach their **personal goals** through ~~access to~~ the use of a range of appropriate **healthcare services and community resources**.

Guiding Principles

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- The population is defined by its heterogeneity and diversity; the group is best segmented by functional status or position on a trajectory spanning from health/wellness to disability/illness
- Culturally competent care must incorporate many dimensions, including race/ethnicity, age, function, language, level of health literacy, and accessibility of the environment for people with disability
- Attention must be paid to social factors that influence wellness, such as economic insecurity, access to affordable and healthy food, and the capacity of informal caregivers
- Strategy for performance measurement should emphasize:
  - data exchange through portable, interoperable electronic health records
  - gathering and sharing information with the beneficiary and caregivers
  - providing feedback to providers in order to facilitate continuous improvement
  - risk adjustment / stratification strategy to mitigate potential unintended consequences (e.g., adverse selection, overuse)
  - continuous care management
- Research needs and information gaps related to quality of care (e.g., high cost/high need patients, patient-reported outcomes, MCCs) should be identified and addressed

High-Leverage Improvement Opportunities

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- Care Coordination
  - Should take place across and within settings where care and community support is provided, across provider types, and across Medicare and Medicaid benefit structures
  - Include process measures, such as presence of a person-centered plan of care and medication reconciliation
  - Include measures of access to multi-disciplinary care team
  - Include measures related to advance planning and/or palliative care
  - Include measures related to medication management
- Quality of Life
  - Care and supports are provided to enhance quality of life and enable individual to reach his/her self-determined goals
  - Include measures of functional status, to be evaluated over time
  - Include measures of an individual's ability to participate in his/her community
- Screening and Assessment
  - Screening should be thorough and tailored to address the many complexities of the dual eligible beneficiary population to enable effective care
  - Assess home environment and availability of family and community supports
  - Screen for underlying mental and cognitive conditions, drug and alcohol history, HIV status, risk of falling, etc., and modify care plan as needed

Discussion Questions

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- Does the strategic approach to performance measurement seem complete?
  - Does the vision statement need refinement?
  - Do the guiding principles need further expansion or specification?
  - Are the high-impact areas for quality improvement sufficient?
- What early guidance has begun to emerge from the strategic approach to performance measurement?
- What short-term goals can be proposed to complement the long-term vision?

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Workgroup Discussion and Questions

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Opportunity for Public Comment

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Defining High-Need Population Subgroups

Homework Assignment

Identify the highest need sub-groups within the dual eligible population. What are the potential opportunities for increasing value and affordability through performance measurement?

- Are there prominent issues which are specific to one or more sub-groups? Measure set should account for population heterogeneity.
- Provide your rationale for selecting sub-groups as "highest need" and why you believe certain opportunities will lead to more efficient care.

Responses from workgroup members focused on these attributes:

- Disease burden: multiple chronic conditions, and/or specific conditions causing particular burden (serious mental illness, ESRD, HIV)
- Functional limitations: ADL impairments and/or cognitive impairment
- Social burden: racial/ethnic minority status, lowest income, homeless

Results suggest there is not an established taxonomy for classifying the population. Rather, combinations of particular risk factors lead to high levels of need in an additive manner.

Homework Results: High-Need Subgroups

Additive Effect

Limitations in one or more ADLs resulting from sensory and/or physical impairments

Mental health/substance use disorder

Cognitive impairment

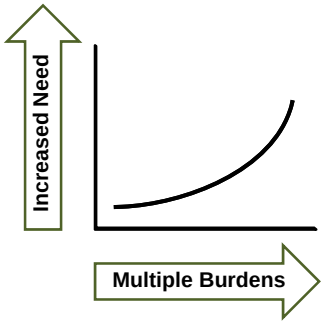
Intellectual disability/developmental disability

Social burden

Multiple chronic conditions

Frail elderly persons

Other?



Exact mathematical relationship is not known, and would vary by combination of factors, but the evidence demonstrates it is not linear.

Link to Affordability of Care

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- Major cost drivers: patient complexity leading to unnecessary ER use, hospitalization, institutionalization
- Most vulnerable beneficiaries tend to incur the highest costs
- Disability
  - associated with increased costs due to conditions related to the disability, their interaction with other conditions, and the lower socio-economic status of people with disabilities across the lifespan
  - Individuals with intellectual and developmental disabilities require a lifetime of services and supports
- Suggestions:
  - Promote prevention, early detection, and compliance with treatment
  - Improve connection to primary care (at a minimum), which should (ideally) serve as a medical home
  - Identify individuals who are less able to manage for themselves, such as individuals with MCCs, and mobilize appropriate support resources
  - Utilize multiple strategies to prevent individuals from being lost in the system
  - Reduce intensity of services and care settings where appropriate
  - Monitor medication access, use, adherence, and polypharmacy

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Workgroup Discussion and Questions

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Opportunity for Public Comment

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Applications of Quality Measurement

Medicare

CMS Quality Reporting and Public Reporting Overview

Edward Garcia, MHS
CMS/OCSQ/QMHAG

Shari Ling, MD
CMS/OCSQ/QMHAG

July 25, 2011

Objectives

1. **QRPR Objectives**
2. **Overview of ACA QRPR sections**
3. **Related initiatives**
4. **Unifying/Cross cutting opportunities**
5. **Opportunities for Multi-stakeholder Input**

1 Objectives for Quality Reporting & Public Reporting

Quality Reporting & Public Reporting will…	In order to…
Achieve high participation rates by providers	• Hold accountable for and assess the performance of all providers and to empower patients with this information
Align new Affordable Care Act reporting requirements with current HHS high priority conditions and topics	• Address and measure high priority conditions and priority topics in order to provide a comprehensive assessment of the quality of health care delivered
Increase the quality reporting of healthcare-associated infections by providers	• Reduce the number of healthcare-associated infections and improve the quality of care
Implement EHR reporting for quality reporting programs	• Improve quality of care through the meaningful use of EHRs
Assure patient focus by reporting outcome measures on Compare sites	• Improve the usefulness of the Compare websites by making them more person-centered and patient focused
Increase the transparency, availability and usefulness of quality data	• Empower the public with information to make informed decisions and drive quality improvement.

2 Quality Reporting & Public Reporting

2 Quality Reporting and Public Reporting: Prior to the Affordable Care Act

Setting	Quality Reporting	Public Reporting	Value-Based Purchasing
Hospital	Hospital IQR Voluntary 2003 MMA 2004 DRA Authorized 2005	Hospital Compare	
ESRD	Claims data Crown Web	Dialysis Facility Compare 2001	ESRD Quality Incentive Program 2008
Nursing Home	MDS	Nursing Home Compare 2002	
Home Health	OASIS	Home Health Compare 2003	
Eligible Professional	Physician Quality Reporting System	Provider Directory: PQRS participation	Resource Use Reports 2008
Eligible Professional	Electronic Prescribing Reporting Program	Provider Directory: eRX participation	
Hospital Outpatient	Hospital Outpatient Quality Reporting Program	Hospital Compare	
Medicare Advantage	Medicare Advantage	Medicare Plan Finder	Quality Bonus Payments
Hospital/EP	ARRA HITECH	Public reporting of participation TBD	
Medicaid	CHIPRA 2009		
Ambulatory Surgical Care Center	TRHCA Authorized 2008 but not implemented		

2 Quality Reporting & Public Reporting Affordable Care Act Sections

Provision	Description	Quality Reporting	Public Reporting	Other Requirements
2701	Medicaid Adult Health Quality Measures	State/population level	New CMS website	
10303	Developing Outcome Measures	Use in quality reporting programs	Add to Compare sites as appropriate	Develop 20 Outcome Measures
3014	Quality Measurement: Multi-stakeholder Group Input; Assessment & dissemination of quality measures	Provides input on measures to use in quality reporting programs	Provides input on measures to publicly report	Pre-rulemaking activities; Assess and disseminate QM.
3002/10327	Improvements to Physician Quality Reporting System	1 million eligible professionals	Physician Compare	Informal appeals; MOC; Integrate with ARRA-HITECH; Timely feedback reports
3004	Quality Reporting for LTCH Quality Reporting for IRFs Quality Reporting for Hospice	429 LTCH 1,182 IRFS 3,521 Hospice	Hospital Compare New CMS website New CMS website	
3005	Quality Reporting for PPS-Exempt Cancer Hospitals	11 cancer hospitals	Hospital Compare	
10322	Quality Reporting for Psychiatric Hospitals	2,000 psychiatric hospitals	Hospital Compare	
10331	Physician Compare	PQRS	Physician Compare	
3008	Payment Adjustment for conditions Acquired in Hospitals	4,000 hospitals	Hospital Compare	

2 Summary of Quality Reporting & Public Reporting Program ACA Requirements

Develop 20 Outcome Measures
- 10 acute & chronic by 3/2012
- 10 preventative & primary by 3/2013

Quality Measurement
- Multi-stakeholder input & Pre-rule making process
- Assessment & dissemination of quality measures

Improvements to 1 Existing Quality Reporting Program - PQRS
- Informal appeals
- MOC
- Integrate with ARRA HITECH
- Timely feedback reports

5 New Quality Reporting Programs
- LTCH
- IRFs
- Hospice
- Cancer Hospitals
- Psychiatric Hospitals

New Physician Compare
- Implement plan for making physician performance available to the public by 1 /1/13

Medicaid Adult Health Quality Measures
- Voluntary reporting at state level

Measures for payment policy
- Readmissions
- HACs

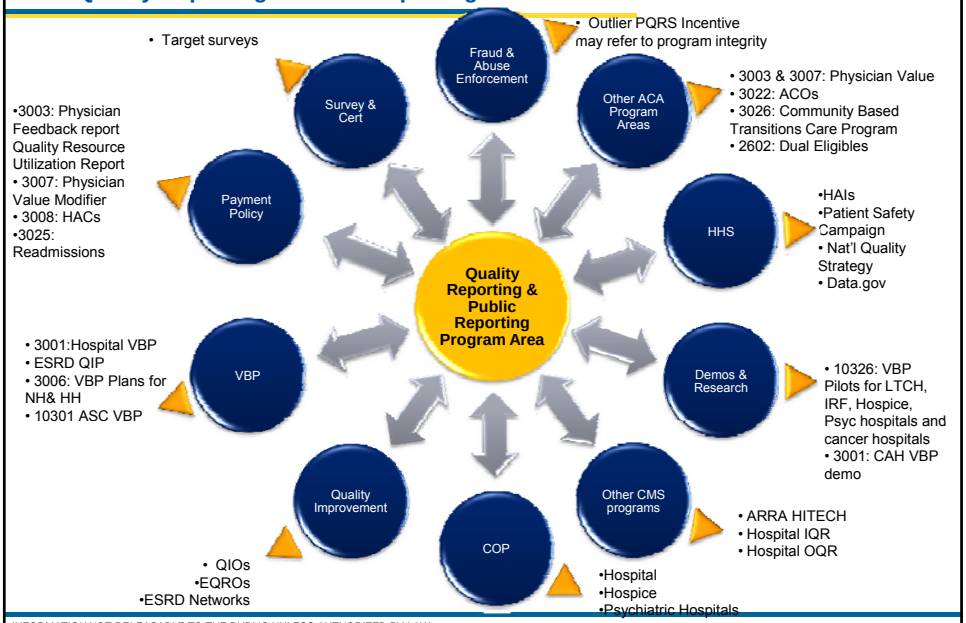
2 Quality Reporting & Public Reporting: Affordable Care Act Sections

Setting	Quality Reporting	Public Reporting	Value-Based Purchasing
Medicaid	State/population level	New CMS website	
PPS-Exempt Cancer Hospitals	11 cancer hospitals	Hospital Compare	Conduct pilot by 2016 (ACA 10326)
Long term care hospital	429 LTCH	Hospital Compare	Conduct pilot by 2016 (ACA 10326)
Inpatient Rehabilitation Facility	1,182 IRFS	New CMS website	Conduct pilot by 2016 (ACA 10326)
Hospice	3,521 Hospice	New CMS website	Conduct pilot by 2016 (ACA 10326)
Eligible Professional	Improvements to PQRS (ACA section 3002) Alignment of PQRS with ARRA HITECH quality measures	Physician Compare (ACA Sec.10331)	Physician feedback Reports (ACA section 3003) Physician Value Modifier (ACA Sec. 3007)
Nursing Home/Home Health/ASC			Develop Nursing Home , Home Health, and ASC VBP plan (ACA section 3006)
Psychiatric Hospitals	Quality reporting for Psychiatric hospitals (ACA section 10322)	Hospital Compare	Conduct pilot by 2016 (ACA 10326)
Hospital	Hospital Inpatient Quality Reporting	Hospital Compare	Hospital VBP (ACA Sec. 3001)

2 Quality Reporting & Public Reporting: CMS Measures

	2011 Current Measures Measures that are in use at this time by CMS in various programs and settings.	Future Measures Measures CMS is considering using or developing within the next few years, BUT MIGHT NOT SELECT FOR IMPLEMNETATION	Previously Used Measures These are fully developed measures that CMS no longer uses for a variety of reasons.	Archived Those measures, measure topics, or measure concepts that were considered for use at one time by CMS. These are kept in the inventory strictly for archival purposes.	Total Number of Measures
Hospital IP	121	254	7	140	522
Hospital OP	17	56	0	30	103
Ambulatory Care	160	248	43	98	549
Community	21	56	0	0	77
Dialysis Facility	57	12	0	68	137
Home Health	99	1	12	4	116
IRF	0	34	0	1	35
LTCH	0	35	0	1	36
Non-acute	0	0	0	21	21
Palliative Care	0	4	0	41	45
MA (Part C)	71	0	0	4	75
Nursing Home	21	19	32	0	72
Part D	25	16	0	9	50
SNP Only	5	0	0	0	5
Various Settings	0	2	0	0	2
Grand Total	597	737	94	417	1845

3 Related Initiatives that Depend on, or are Supported by Quality Reporting & Public Reporting



4 Unifying/Cross Cutting Opportunities

Measure alignment and simplification

Leverage existing data infrastructure and build new data infrastructure in an enterprise approach

Leverage the use of EHRs (PQRS integration with ARRA HITECH)

Develop Physician Quality Reporting Strategy that supports Physician VBP

- PQRS Improvements - 3002
- Physician QRUR - 3003
- Physician Value Modifier - 3007
- ACOs - 3022
- Physician Compare - 10331

4 Unifying/Cross Cutting Opportunities

Collaboration with other DHHS agencies

- AHRQ
  - Patient Safety – HACs 3008; Readmission & Patient Safety Organizations 3025
  - Quality measure development - 3013
  - Assessment of impact of quality measures - 3014
  - All patient data – Readmissions 3025
  - Develop Outcome measures - 10303
  - Adult Medicaid core measures - 2701
- ASPE
  - Multi-stakeholder Input - 3014
  - Dissemination of quality measures - 3014
  - Assessment of impact of quality measures - 3014
- CDC
  - QR for LTCH, IRF - 3004
  - HACs - 3008

5 Opportunities for Multi-stakeholder Group Input

Collaboration with Multi-Stakeholder Groups

- NQF-convened MAPs
  - Receiving input on alignment of physician quality measurement by October 1, 2011.
  - Receiving input on alignment of Post-Acute Care settings measurement
  - Receiving input on measures for implementation of PPS-exempt Cancer Hospitals and Hospice quality reporting programs.
  - Receiving input on measures for reducing readmissions and HACs.
  - Receiving input on measures applicable to the Dual Eligible population.
  - Receiving input annually by February 1 on measures being *considered* by the Secretary for implementation.

5 Opportunities for Multi-stakeholder Group Input

Collaboration with Multi-Stakeholder Groups

- Dual Eligibles MAP
  - What are the conditions/topics of greatest priority for measurement in this population?
  - What current measures could be considered as part of a “core set” for this population?
  - What are the major conditions and settings that are most important for duals?
  - What principles and criteria will guide measure selection for dual-MAP implementation?
  - How are the measures to be used?
  - What is the level of measurement to focus on?
  - Other thoughts?

An Update on Medicare Parts C & D Performance Measures

Liz Goldstein, Ph.D.
Director, Division of Consumer Assessment & Plan Performance

Medicare Drug Benefit and C & D Data Group
Center for Medicare, CMS

Session Overview

- Quality measurement
- Methodology for the Plan Ratings
- Quality bonus payments
- Future directions

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Quality Measurement

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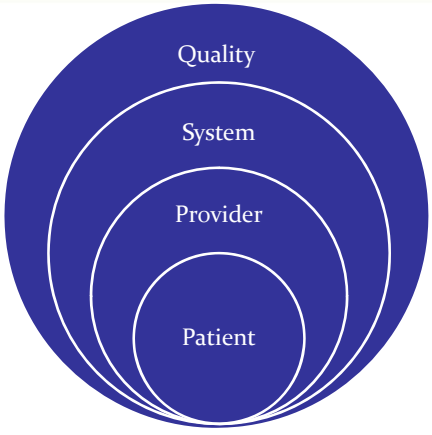
Quality is Multidimensional



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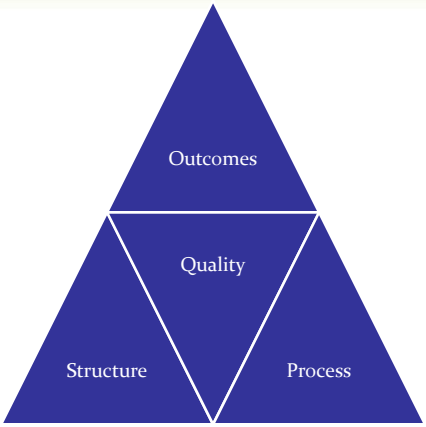
Measuring Quality



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Objectives of Plan Ratings

Public reporting	Technical assistance	Policy review
Basis for compliance and enforcement actions	Identifying audit candidates	Decisions for application approval and denials

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Methodology for the Plan Ratings

Five Levels of Plan Ratings

1. Data for each measure.
   - Contract's detailed data used to rate performance.
2. Individual measure level.
   - Star rating for each performance measure.

See Appendix 1 for List of Measures

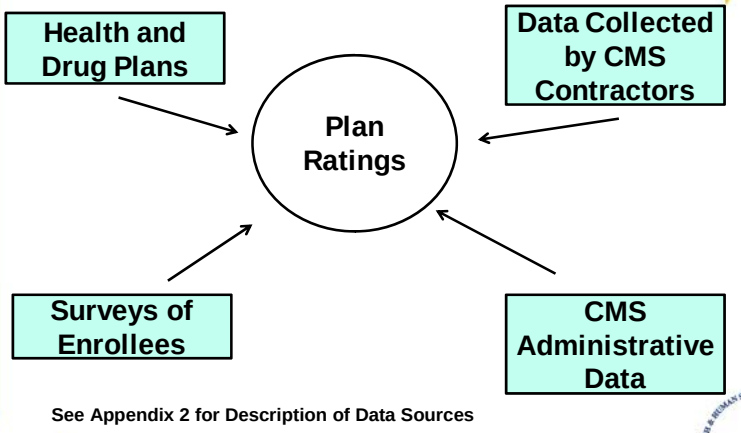
Five Levels of Plan Ratings (cont.)

3. Domain level.
   - Related measures are grouped together.
   - Stars based on averages of individual measures.
4. Summary ratings for Parts C and D.
   - Adjusted average of individual measure stars into a single rating.
   - Contracts are rewarded for high and stable performance.
   - ½ stars provide more differentiation.

Five Levels of Plan Ratings (cont.)

5. MA-PDs receive an Overall rating that summarizes quality and performance for all Part C and D measures combined.
   - Overall rating - adjusted average of both Part C and D individual measure stars into a single rating.
   - Contracts are rewarded for high and stable performance.
   - ½ stars provide more differentiation.

Data Sources for Plan Ratings



See Appendix 2 for Description of Data Sources

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CY2011 Plan Ratings

- Overall combined Part C and D Rating for MA-PDs available.
- Low performing icon displayed on Medicare Plan Finder (PF) for contracts with less than 3 stars for the Part C and/or D summary rating for the prior 3 years.
- Used minimum thresholds for CMS' assignment of 4 stars.
  - Other star assignments are based on the distribution of data.
- When a CMS standard is reached, a contract receives 3 or more stars (e.g., call center hold time).

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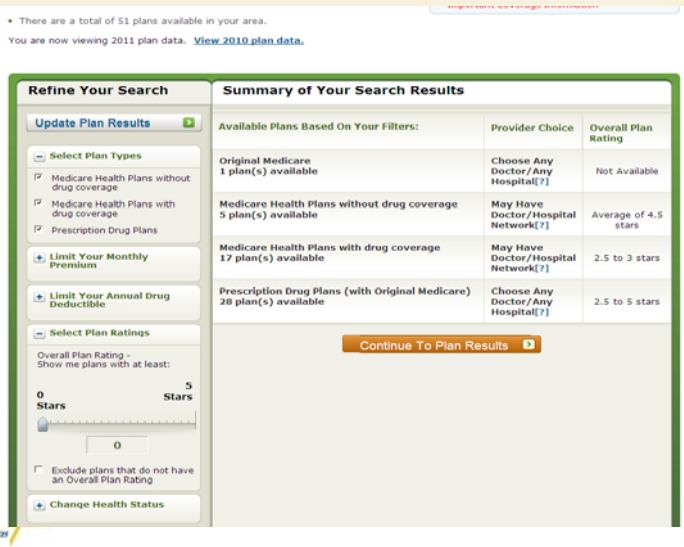
Plan Finder Website

Plan Ratings Filter



Sample Plan Comparison

Overall Plan Rating [?]		
3.5 out of 5 stars	3.5 out of 5 stars	3 out of 5 stars
Prescription Drug Plan Ratings		
Plan A (S****-***)	Plan B (S****-***)	Plan C (S****-***)
Summary Rating of Prescription Drug Plan Quality (?) View previous ratings for these plans		
3.5 out of 5 stars	3.5 out of 5 stars	3 out of 5 stars
Drug Plan Customer Service (?) Click to view data sources		
4 out of 5 stars	3 out of 5 stars	3 out of 5 stars
Time on Hold When Customer Calls Drug Plan (?)		
★★★★★	★★★★	★★★
Time on Hold When Pharmacist Calls Drug Plan (?)		
★★★★	★★★★★	★★★
Accuracy of Information Members Get When They Call the Drug Plan (?)		
★★★	★★	★★★★
Availability of TTY/TDD Services and Foreign Language Interpretation When Members Call the Drug Plan (?)		
★★★★	★★★	★★★

Quality Bonus Payments

Quality Bonus Payments

- The Affordable Care Act introduces Quality Bonus Payments (QBPs) into the MA program as part of the national strategy for implementing quality improvement in health care.
- Under the Affordable Care Act, beginning in 2012 all MA plans with a star rating of 4 or higher will qualify for a QBP.
  - MA plans earning either 4 or 5 stars will get the same percentage bonus.
  - MA plans earning less than 4 stars will get no bonus.

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QBP Demonstration

- However, CMS will test an alternative method for computing QBPs in a nationwide three-year demonstration.
- Evaluation will test whether providing scaled bonuses leads to more rapid and larger quality improvements in MA program quality scores.

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Special Enrollment Period

- CMS will establish a Special Enrollment Period (SEP) beginning in 2012 to allow MA beneficiaries to enroll in 5-star plans.
- Plans will be able to market year round.
- More detailed information on the SEP was provided in an HPMS memo and the 2012 Call Letter.

Future Directions

Future Directions

- Currently, 53 measures make up Plan Ratings.
- Due to the linkage of quality and payment, it is important to ensure a robust system of quality measurement.
- Future development of ratings is aligned with the Institute of Medicine (IOM)'s six aims for improving healthcare delivery:
  - safe, timely, effective, efficient, equitable, patient-centered.
- We will look towards consensus-building organizations for the development of measures and clinical criteria (e.g., clinical thresholds, inclusion/exclusion criteria, definition of numerator/denominator).

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Improvements to Plan Ratings

- Principles for adding measures over time include:
  - Mix of standards, process, outcomes, and patient experience measures/
  - Alignment across the public reporting and payment systems of Medicare and Medicaid.
  - Minimize the burden on providers to the extent possible.
  - Utilize measures nationally endorsed by a multi-stakeholder organization.

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Improvements to Plan Ratings (cont.)

- Principles for modifying calculation approaches include:
  - Scoring on overall achievement relative to a national or other appropriate benchmarks.
  - Scoring methodologies weighted towards outcome, patient experience, and functional status measures over time.
  - Reliable, straightforward, and stable scoring methodologies.

Considerations for Measures

- For <u>new</u> measures we consider:
  - Whether measure has been defined
  - Whether data are/will be collected in time
  - Whether there are concerns with reliability & validity of data
  - Value of proposed measure in improving star ratings, supporting IOM's six aims
- For <u>all</u> measures we consider:
  - Quality of data
  - Variation among plans
  - Measure's accuracy, validity, stability

Communications around Star Ratings

- Enhancements described in:
  - 2012 Call Letters and future Call Letters.
  - Part C and D 2012 rule.
  - HPMS memos.
  - User Group Calls.

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Potential Additional Measures for 2012 Plan Ratings

- All-Cause Readmission rates.
- Advising Smoker and Tobacco Users to Quit.
- Body Mass Index.
- Special Needs Plan (SNP)-specific measures.
- Voluntary Disenrollment Rates.
- Measures from the Hospital Inpatient Quality Reporting program.
- Part D transition process implementation.
- Part D medication adherence.

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Potential Enhancements for 2012 Plan Ratings

- Weighting of measures to provide more weight to outcome/clinical measures.
- Controlling for concentration of providers in a geographic area, such as through identification of Health Professional Shortage Areas (HPSAs).
- Rewarding contracts for quality improvement.
- Reducing overall and/or summary Plan Ratings for contracts with serious compliance issues.
- Addition of icon for high performing plans.

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Potential Additional Measures for 2013 Plan Ratings

- Survey measures of care coordination.
- Case-mix adjusted mortality rates.
- Preventable hospitalizations.
- Serious Reportable Adverse Events.
- Grievances.
- Use of highly rated hospitals by plan members.
- Medication therapy management (MTM) measures.
- Evaluation of a contract's Chronic Care Improvement Program (CCIP) and Quality Improvement Project (QIP).

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Appendix 1:
CY2011 Parts C and D
Domains and Measures

Part C Domain:
Staying Healthy: Screenings, Tests, and Vaccines

- Breast Cancer Screening
- Colorectal Cancer Screening
- Cardiovascular Care - Cholesterol Screening
- Diabetes Care - Cholesterol Screening
- Glaucoma Testing
- Appropriate Monitoring for Patients Taking Long Term Medications
- Annual Flu Vaccine
- Pneumonia Vaccine
- Improving or Maintaining Physical Health
- Improving or Maintaining Mental Health
- Osteoporosis Testing
- Monitoring Physical Activity
- Access to Primary Care Doctor Visits

Part C Domain:
Managing Chronic (Long-Lasting) Conditions

- Osteoporosis Management in Women who had a Fracture
- Diabetes Care – Eye Exam
- Diabetes Care – Kidney Disease Monitoring
- Diabetes Care – Blood Sugar Controlled
- Diabetes Care – Cholesterol Controlled
- Controlling Blood Pressure
- Rheumatoid Arthritis Management
- Testing to Confirm Chronic Obstructive Pulmonary Disease
- Improving Bladder Control
- Reducing the Risk of Falling

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Part C Domain:
Ratings of Health Plan Responsiveness and Care

- Getting Needed Care
- Doctors who Communicate Well
- Getting Appointments and Care Quickly
- Customer Service
- Overall Rating of Health Care Quality
- Overall Rating of Plan

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Part C Domain:
Health Plan Members' Complaints and Appeals

- Complaints about the Health Plan
- Plan Makes Timely Decisions about Appeals
- Reviewing Appeals Decisions
- Corrective Action Plans

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Part C Domain:
Health Plan's Telephone Customer Service

- Call Center - Hold Time
- Call Center - Information Accuracy
- Call Center - Foreign Language Interpreter and TTY/TDD availability

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Part D Domain:
Drug Plan Customer Service

- Call Center - Hold Time (Customer Calls to Drug Plan)
- Call Center - Hold Time (Pharmacist Calls to Drug Plan)
- Call Center - Information Accuracy (Drug Plan)
- Call Center - Foreign Language Interpreter and TTY/TDD availability (Drug Plan)
- Drug Plan's Timeliness in Giving a Decision for Members Who Make an Appeal
- Fairness of Drug Plan's Denials to Member Appeals, Based on an Independent Reviewer
- Drug Plan Provides Pharmacists with Up-to-Date and Complete Enrollment Information about Plan Members

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Part D Domain:
Drug Plan Member Complaints and Medicare Audit Findings

- Complaints about Joining and Leaving the Drug Plan
- All Other Complaints about the Drug Plan
- Beneficiary access problems Medicare Found During an Audit of the Plan

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Part D Domain:
Member Experience with Drug Plan

- Drug Plan Provides Information or Help When Members Need It
- Members' Overall Rating of Drug Plan
- Members' Ability to Get Prescriptions Filled Easily When Using the Drug Plan

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Part D Domain:
Drug Pricing and Patient Safety

- Completeness of the Drug Plan's Information on Members Who Need Extra Help
- Drug Plan Provides Accurate Price Information for Medicare's Plan Finder Website and Keeps Drug Prices Stable During the Year
- Drug Plan Members 65 and Older Who Receive Prescriptions for Certain Drugs with a High Risk of Side Effects, When There May Be Safer Drug Choices
- Using the Kind of Blood Pressure Medication That Is Recommended for People with Diabetes

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Appendix 2:
Description of Data Sources

Health and Drug Plans

	Healthcare Effectiveness Data and Information Set (HEDIS) 	Prescription Drug Event (PDE) 	Plan Finder (PF) Pricing Files 

Data Submitted	• Examples:
	  • Breast Cancer Screening.
	  • Osteoporosis Testing.
		• Use of high-risk medications.
		• Use of recommended BP medications in DM patients.
		• Accurate Price Information for Medicare's Plan Finder Web site and Stable Drug Prices.
			• Accurate Price Information for Medicare's Plan Finder Web site and Stable Drug Prices.

Data Time Period for 2011 Plan Ratings	CY2009 • Submitted to NCQA by June 30, 2010.	CY2009 • Submitted monthly, final due by June, 2010.	CY2009 • Pricing files submitted/posted. • Biweekly. • Corresponding PDE for comparison.
Data Checks	• NCQA approved auditors review data prior to submission.	• Final reconciliation process.	• CMS QA.

CMS Contractors

	Independent Review Entity (IRE)	Call Center 

Data Collected	• Parts C & D appeals:
	  • Measure of timeliness.
	  • Measure on fairness of decisions.
		• Parts C & D hold time.
		• Accuracy of CSR information.
		• Availability of interpreter and TTY/TDD services.

Data Time Period for 2011 Plan Ratings	• January 2009 – June 2010.	• February – June 2010.
Data Checks	• Contractor conducts QA checks. • Plans reconcile discrepancies via plan review.	• Contractor follows CMS approved protocols and ongoing monitoring of callers is conducted.

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Surveys of Enrollees

	Consumer Assessment of Healthcare Providers and Systems (CAHPS)	Medicare Health Outcome Survey (HOS)
Data Collected	• Example: Overall rating of health or drug plan.	• Example: Improving or maintaining physical health.
Data Time Period for 2011 Plan Ratings	• Data collection from February – June, 2010.	• Data collection from April – August, 2009.
Data Checks	• Oversight of mail & telephone operations, including silent telephone monitoring. • Data cleaning, including out-of-range checks.	• Oversight of approved vendors. • Data cleaning, including out-of-range checks.
Scientific Program Review	• Comprehensive evaluation conducted in 2007 as part of National Quality Forum Endorsement process. Received NQF endorsement July 1, 2007.	• Published, peer-reviewed, independent evaluation in 2003 conducted by a university affiliated research group found *HOS provides a rich and unique set of valid, reliable, and actionable data.*

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Administrative Data

	CMS Enrollment Data Files 	HPMS Complaint Tracking Module (CTM) 	CMS Audit Records 
Data Submitted	• Part D LIS match rate.	• Parts C & D complaint rates.	• Parts C & D audit measure.
Data Time Period for 2011 Plan Ratings	• LIS Match rate: 01/01/2010 – 6/30/2010.	1/01/2010 – 6/30/2010.	• CY2009 audits.
Data Checks	• Validation of CMS administrative records ongoing.	• SOP for plans to check and correct information module.	• Central and regional offices review ongoing. • Audit module in HPMS accessible by plans, may also respond to audit issues.

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NQF
National Quality Forum

Applications of Quality Measurement

Medicaid

Awaiting slides from CMS

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www.qualityforum.org

Overview of the Medicaid Adult Quality Measures

MAP Dual-Eligible Beneficiaries Workgroup Meeting

July 25, 2011

Karen LLanos, MBA
Technical Director, Division of Quality, Evaluation, and Health Outcomes
Children and Adults Health Programs Group
Center for Medicaid, CHIP and Survey & Certification

Using Quality Measures For Accountability & Quality Improvement

- Assess national and State needs
- Design and evaluate interventions
- Evaluate progress and setbacks
- Foster competition among providers to offer the highest quality of care
- Inform choices of States and enrollees to obtain greater value for their dollars

The Affordable Care Act, Section 2701

- Identify and publish a recommended core set of health quality measures for Medicaid-eligible adults
  - Initial preliminary core set to be posted in Federal Register for public comment by January 1, 2011
  - Initial core set to be finalized and published by January 1, 2012

The Affordable Care Act, Section 2701

- By January 1, 2013
  - Develop a standardized reporting format for core set and procedures to encourage voluntary reporting by the States
  - Establish a Medicaid Quality Measurement Program to fund development, testing and validation of emerging and innovative evidence-based measures
- By September 30, 2014
  - HHS to collect, analyze, and make publically available the information reported by the States
- By January 1, 2015
  - Annually publish recommended changes to initial core set

CMS and AHRQ Collaboration

- CMS is partnering with the Agency for Healthcare Research and Quality (AHRQ)
  - AHRQ's Subcommittee to the National Advisory Council (SNAC)
  - Comprised of Medicaid medical directors, State officials, health policy researchers, measurement experts, etc.
- Two meetings
  - Meeting 1: October 2010
  - Meeting 2: August 2011

Understanding the Universe of Measures: *Creating a Measures Inventory*

- 1,000 measures were identified for evaluating the quality of care for adults:
  - Used by the Federal Government in various programs
  - National Quality Forum (NFQ) endorsed measures
  - Measures submitted by Medicaid medical directors who responded to a call for measures currently being used
  - Measures suggested by the SNAC co-chairs

Narrowing 1,000 Measures List:
First Meeting of SNAC (Oct. 2010)

- Divided into four work groups reflecting dimensions of health care related to adults in Medicaid:
  - Maternal/Reproductive Health
  - Overall Adult Health
  - Complex Health Care Needs
  - Mental Health and Substance Use
- Reviewed and prioritized measures based on several criteria

Selection Criteria

- Importance to measure and report
  - High impact
  - Opportunity for improvement
  - Evidence that supports the focus of measurement
- Scientific acceptability of measure properties (e.g., reliability and validity)
- Usability for public reporting and quality improvement
- Feasibility (including data or information showing measure can be implemented)

Desired Attributes of Core Set

- Population-centric
- Reflect priority issues for the populations
- Provide State-level information for public reporting and point to opportunities for quality improvement
- Usable with all insurance categories
- Parsimonious list
- Can meet other regulatory requirements where possible

Getting to the Draft List of 51…and Beyond

- Subcommittee identified 37 measures to be high-priority and cross-cutting
- 14 other measures added to achieve balance
- Draft list of 51 measures for initial core set posted in Federal Register for comment (Dec. 2010)
- Public comments covered three themes (decrease, align, and add other measures)
- August 2011 SNAC meeting to discuss public comments and make final recommendations to CMS

Questions for the Measurement Advisory Panel

- Which of the 51 measures are most relevant to dually-eligible enrollees?
- Are there critical services, quality issues or other measurement areas not represented on the draft list?
- Other feedback/guidance for CMS or the Subcommittee as we prepare for the August meeting?

Quality Measures Used in Home and Community Based Services:

MAP Dual Eligible Beneficiaries Workgroup Meeting

Anita Yuskauskas, Ph.D.
Technical Director, HCBS Quality
Disabled & Elderly Health Programs Group
CMCS

July 27, 2011

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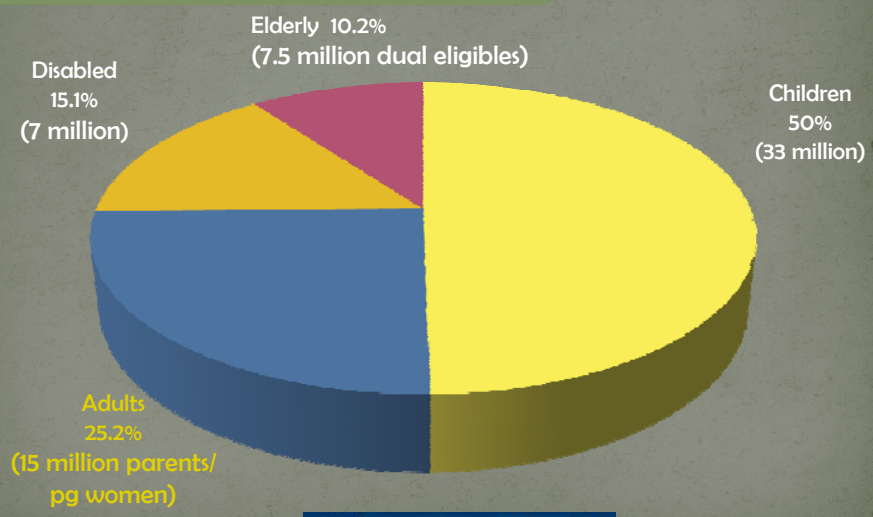
Our Beneficiaries – FY 2007



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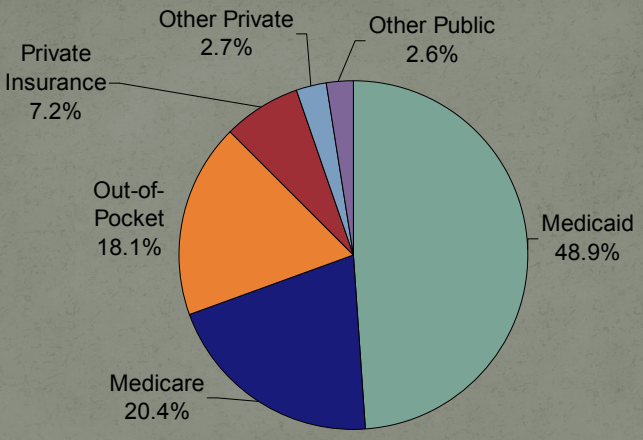
LTC Expenditures by Payer: United States, 2005



Source: Georgetown University Long-Term Care Financing Project

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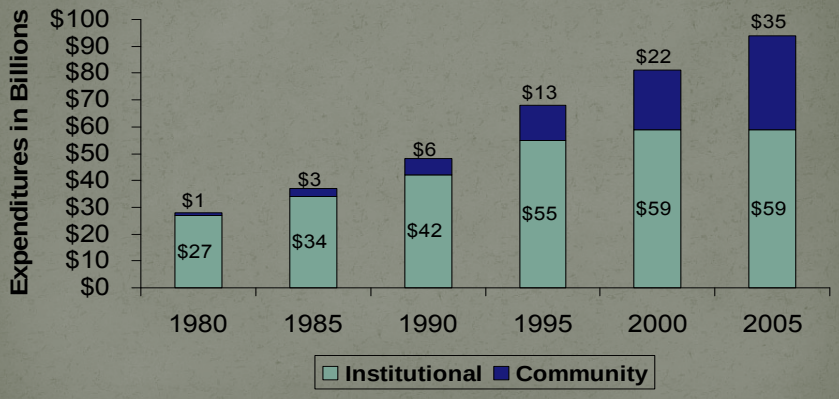
Medicaid Institutional and Community-Based Expenditures in 2005 Dollars: FFY 1980-2005



Source: CMS Form 64 Reports, adjusted for price increases based on the Skilled Nursing Facility Input Price Index.

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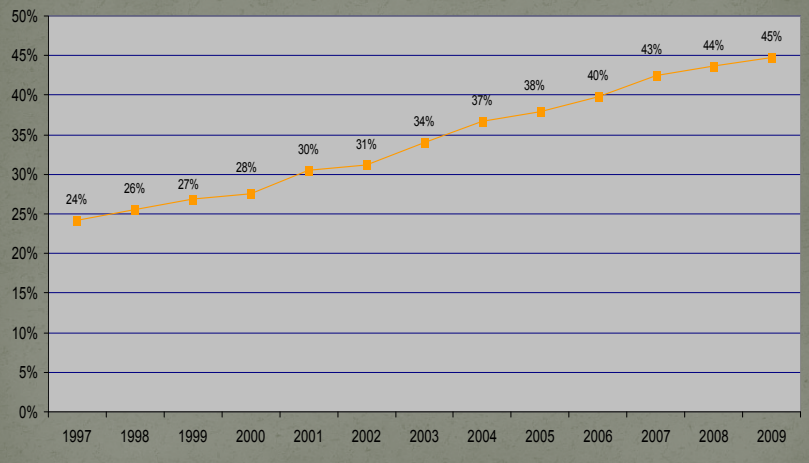
Chart 1: Percent of Medicaid Long-Term Care Expenditures for HCBS, FY 1997 - 2009



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Medicaid Vehicles for Delivering Home and Community Based Services

- Section 1915(c) Home and Community Based Services Waivers : 66% of all HCBS spending
- State Plan Personal Care Services & Home Health Services 31%
- Other: 3%
  - PACE
  - Section 1915(i) HCBS as a State Plan Option
  - Section 1915(j) Self-Directed Personal Assistance Services
  - Various managed care authorities
  - 1115 Demonstration Programs

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HCBS WAIVERS

National Overview

- **300+ Waiver Programs**
- **More than 1 million participants**
- **More than $23 Billion**

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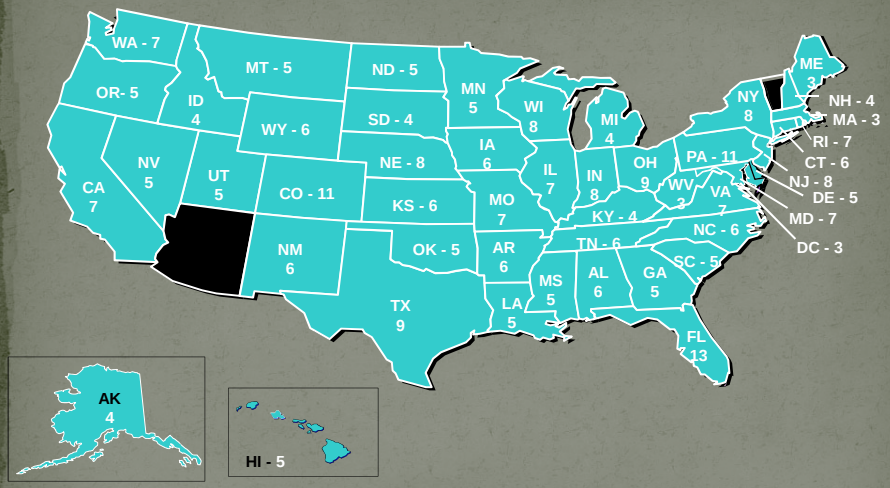
Number of Active HCBS Waivers Per State



Arizona and Vermont provide similar services as part of Research and Demonstration Waivers.
Source: Medstat review based on CMS Waiver and Grant Management Database (WGMD); CMS 64 Reports; and Medstat review of state and CMS Web sites

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THE QUALITY ARCHETYPE:

1. ARE PEOPLE BETTER OFF?

2. ARE WE PROVIDING QUALITY SERVICES?

3. ARE WE DOING WHAT WE'RE PAID TO DO?

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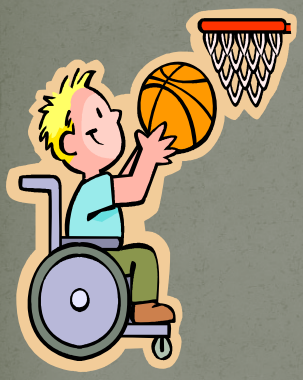
Are People Better Off?



Individual outcomes – the experience with and effect of programs - can be assessed using multiple data sources

- Claims data
- Assessment data
- Survey data
- Other administrative data, e.g. wages, critical incidents

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Are We Providing Quality Services?

- How are providers performing?
- Are they delivering:
  - The right services
  - Effective/proven services
  - Enough services
- How sufficient is the provider network?
- Are providers qualified?

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Is there fidelity & integrity between delivered services and funding requirements??

Process measures

- Most of the 1915c assurances apply here
- Sometimes called the "floor" or "foundation" of program quality
- Are our processes effective and efficient in achieving the intended outcomes?

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MEASUREMENT DRIVERS IN HCBS LTC

- Individual Service Recipients
- Tax Payers: State & Federal
- State Administering Agencies
- Congress , Legislators - Statute
- Providers
- Vendors of Measurement Sets, Accredita Instruments

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COMPLICATING FACTORS

- Wide Variety Of Diagnostic Categories in LTC
- No Standard "Treatment Intervention", i.e., service definitions & service delivery models
- Personal & social outcomes versus illness or disease outcomes
- Wide Range Of Settings
- Wide Range Of Service Provider Types And Qualifications
- Wide Range of Measurement Sets: No Standardization

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CURRENT & DEVELOPING MEASURES

CURRENT	DEVELOPING
• Quality of Life Surveys	• Access
• Assurance-Process-System Performance	• Care/Service Coordination
• Avoidable Hospitalization Composite	• Experience Survey (CAHPS trademark)
• Avoidable Incident Composite	• Functional Assessment
	• Evidence-based Practices
	• Disparity

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HCBS QUALITIES OF LIFE SURVEY MEASURES

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QUALITIES OF LIFE SURVEY MEASURES

- Cornerstone of measures in HCBS
- Various tested tools in the private sector, one in CMS (PES)
- Most states use at least one quality of life tool in their Waiver program
- MFP uses to assess transitions

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HCBS Q of L & EXPERIENCE SURVEY

Most Common Domains

- Access to Needed Services and Supports
- Safety
- Health/Access to Healthcare Services
- Community Inclusion
- Respect and Dignity
- Choice and Control
- Care/Support Coordination
- Cultural Competence

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Section 1915(c) HCBS QUALITY ASSURANCE MEASURES

(PROCESS, SURVEY & OUTCOME)

EXAMPLES

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Key Tenets of HCBS Quality

- **Continuous Quality Improvement - DDRI**
- **Evidence-based approach** for quality oversight and improvement based on statutory assurances
- State has lead responsibility for quality
- Provision of **technical assistance** support and materials to help states design and implement an evidence-based system

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COMPLIANCE & CONTINUOUS QUALITY IMPROVEMENT (CQI)

- COMPLIANCE: Statute requires state to abide by assurances (i.e., comply); waiver is a contract between State & CMS
- CQI: CQI recognizes problems and focuses on improvement
- INTEGRATION OF BOTH PROCESSES: CMS' process takes into account both discovery & remediation in assessing compliance

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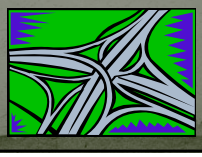

QUALITY OVERSIGHT: ROLES

CMS & THE STATE SHARE RESPONSIBILITY FOR QUALITY OVERSIGHT

• STATE ROLE	The State has first line s responsibility for designing, implementing, monitoring , remediating, and improving its own program
•CMS ROLE	CMS reviews evidence the State provides in order to verify implementation of approved QI strategy; decide State compliance based on submitted evidence
•NQE ROLE	The NQE provides technical assistance to States upon request, or as required by CMS, to design and implement QI strategies and prepare evidence for CMS Quality Reviews.

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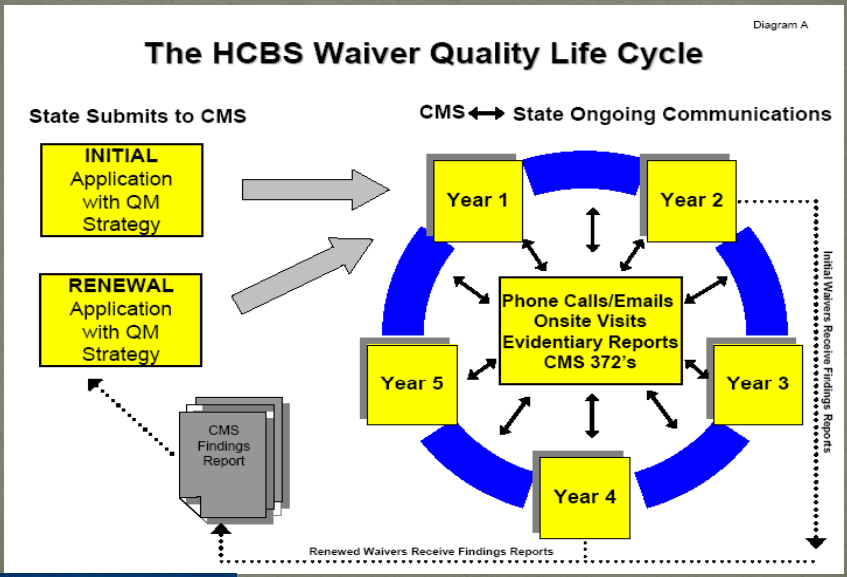
WAIVER QUALITY LIFECYCLE



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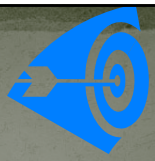
HCBS ASSURANCE RELATED MEASURES



- **Level of Care** – Persons enrolled in the Waiver have needs consistent with an institutional level of care
- **Service Plan** – Participants have a service plan that is appropriate to their needs and preferences, and receive services/supports specified in the service plan
- **Provider Qualifications** – Waiver providers are qualified to deliver services/supports
- **Health and Welfare** – Participants health and welfare are safeguarded.
- **Financial Accountability** – Claims for waiver services are paid according to state payment methodologies in the approved waiver.
- **Administrative Authority** – State Medicaid Agency is actively involved I the oversight of the waiver and is ultimately responsible for all facets of the Waiver Program.

Health and Welfare Assurance

Assurance: *The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation*

***Multiple performance measures highly recommended due to the multiple components of this subassurance*

Performance Measure Examples:

1. Number and percent of participant records reviewed where the participant (and/or family or legal guardian) received information/education about how to report abuse, neglect, exploitation and other critical incidents as specified in the approved waiver

Data Source:

- *Record review*

Health and Welfare Assurance, con't

Performance Measure Examples, con't:

2) Number and percent of participants (and/or family or legal guardians) reporting they received information/education in the prior year about how to report abuse, neglect, exploitation and other critical incidents as determined by the state

Data Source:

- *Waiver participant survey*

Note: PMs based on survey data should be used in conjunction with another performance measure assessing the same issue.

Health and Welfare Assurance, con't

Performance Measure Examples, con't:

3) Number and percent of critical incidents that were reported within required time frames as specified in the approved waiver

4) Number and percent of critical incident reviews/investigations that were initiated within required time frames as specified in the approved waiver

5) Number and percent of critical incident reviews/investigations that were completed within required time frames as specified in the approved waiver

6) Number and percent of critical incidents requiring review/investigation where the state adhered to the follow-up methods as specified in the approved waiver

Data Source:

- *Critical incident data*

Health and Welfare Assurance, con't

Performance Measure Examples, con't:

7)Number and percent of unexplained, suspicious and untimely deaths for which review/investigation resulted in the identification of preventable causes

Data Source:

- *Mortality review/investigation data*

8)Number and percent of restraint applications, seclusion, or other restrictive interventions that did not follow procedures as specified in the approved waiver

Data Sources:

- *Restraint, seclusion or other restrictive intervention reports*
- *Record review*

Health and Welfare Assurance, con't

Performance Measure Examples, con't:

9) Number and percent of participants reviewed who received the coordination and support to access health care services identified in their service plan

Data Source:

- *Record Review*

10) Number of medication errors (reported by type of error)

11) Number and percent of medication errors that resulted in a waiver participant requiring medical treatment

Data Sources:

- *Critical incident data*
- *Medication error data*

Health and Welfare Assurance, con't

Performance Measure Examples, con't:

12) Number of substantiated complaints

13. Number and percent of complaints addressed within required timeframe

Data Source:
- *Complaint data*

14) Number and percent of waiver participants receiving age-appropriate preventive health care

15) Number and percent of waiver participants who received physical exams in accordance with state Medicaid/waiver policy

16) Number and percent of waiver participants who received annual/semi-annual dental visits

Data Sources:
- *Record review*
- *Claims data*

Health and Welfare Assurance, con't

Performance Measure Examples, con't:

17) Number and percent of experience/satisfaction survey respondents who reported that people take their things without asking

18) Number and percent of experience/satisfaction survey respondents who reported that someone hit or hurt them physically

19) Number and percent of experience/satisfaction survey respondents who reported that staff yell or scream at them

20) Number and percent of experience/satisfaction survey respondents who reported they do not feel safe where they live

21) Number and percent of experience/satisfaction survey respondents who reported they are not treated with respect and dignity

Data Source:
- *Waiver participant survey*

Note: PMs based on survey data should be used in conjunction with another performance measure assessing the same issue.

Qualified Provider Subassurance a

Subassurance a: The State verifies that providers initially and continually meet required licensure and certification standards and adhere to other standards prior to their furnishing services

***Multiple performance measures highly recommended due to the multiple components of this subassurance*

Performance Measure Examples:

1) Number and percent of new provider applications, by provider type, for which the provider obtained appropriate licensure/certification in accordance with State law and waiver provider qualifications prior to service provision.

Data Sources:

- *Provider enrollment database*
- *Reports from licensure/certification entities*

Qualified Provider Subassurance a, con't

Performance Measure Examples, con't:

2) Number and percent of new provider applications for which appropriate background and registry checks, as required by the state/waiver, were conducted.

Data Sources:

- *Provider enrollment database*
- *Reports from licensure/certification entities*

3) Number and percent of providers, by provider type, continuing to meet applicable licensure/certification following initial enrollment.

Data Sources:

- *Provider performance review*
- *Reports/alerts from licensure certification entities*

4) Number and percent of agency providers whose direct support staff had timely criminal background and registry checks.

Data Sources:

- *Provider performance review*
- *Reports/alerts from licensure certification entities*

Qualified Provider Subassurance b

Subassurance b: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements

***Multiple performance measures highly recommended due to the multiple components of this subassurance*

Performance Measure Examples:

1) Number and percent non-licensed/non-certified provider applicants, by provider type, who met initial waiver provider qualifications.

Data Source:

- *Reports from entity enrolling non-licensed/non-certified providers*

Qualified Provider Subassurance b, con't

Performance Measure Examples, con't:

2) Number and percent of non-licensed/non-certified providers, by provider type, who continue to meet waiver provider qualifications.

Data Sources:

- *Provider performance review*
- *Reports from entity overseeing non-licensed/non-certified providers*

3) Number and percent of direct support applicants (staff) screened by the Financial Management Agency (for waiver participants self-directing) who passed background and registry checks and thus deemed eligible for hire.

Data Source:

- *FMS Reports*

TRANSITION INDICATORS

- Reinstitutionalization within 12 and 24 months
- Health Care Expenditures Per Month During the First 12 Months After Transition to the Community
- Quality of Care During the First 12 Months After Transition to the Community
- Admission to ER/hospital and/or office visits for pressure ulcers

CMS Centers for Medicare & Medicaid Services

HCBS BALANCING INDICATORS

Sustainability

- Global Budget
- Medicaid Expenditures
- Proportion of Medicaid HCBS Spending of the Total Medicaid LTC Spending
- Change in Per Capita Rate of Medicaid LTC Spending
- Shared Long-Term Supports and Services Mission/Vision Statement
- Quality of Long-Term Supports and Services Mission/Vision Statement

Self Determination & Person-Centeredness

- Availability of Options for Self-Determination

CMS Centers for Medicare & Medicaid Services

HCBS BALANCING INDICATORS

Coordination and Transparency

- Streamlined Access
- Service Coordination
- Coordination between HCBS and Institutional Care Entities

Community Integration and Inclusion

- Waiver Waitlist
- Coordination between Long-term Supports and Housing
- Employment Rates of Working-Age Adults with Disabilities

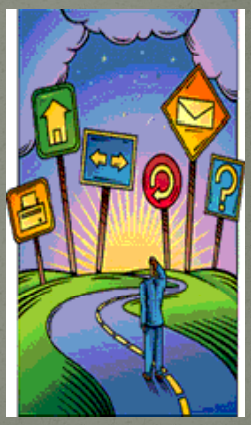
CMS Centers for Medicare & Medicaid Services

AVOIDABLE HOSPITALIZATION & INCIDENTS

AHRQ: THE DEFICIT REDUCTION ACT

CMS Centers for Medicare & Medicaid Services

QUESTIONS



Agency for Healthcare Research and Quality

Advancing Excellence in Health Care www.ahrq.gov

Performance Measurement, Medicaid and the Dual Eligible Population

D.E.B. Potter

Agency for Healthcare Research and Quality

Presentation to the Measures Applications Partnership Dual Eligible Beneficiaries Workgroup, NQF

Washington, DC July 25, 2011

Overview

- Environmental Scan of Medicaid Home and Community-based Services (HCBS) Measures
- Care Coordination Measures Atlas
- Indicators of Potentially Preventable Hospitalizations (PPH)
  - NQF Endorsed AHRQ Prevention Quality Indicators (PQIs)
  - Outcome Indicators for the HCBS Population
- CAHPS® - Person Reports of Experience with Care
- National Quality Report

Environmental Scan of HCBS Measures, 2009

- HCBS defined broadly
- All potential measures appropriate to any HCBS population
- Methods used
  - Literature and web searching
  - Input from Technical Expert Panel and stakeholders
  - *Federal Register* call for measures
    - 40+ states responded

Measures Identified

- 300+ measure sets identified
- Documented in the *HCBS Measure Scan* report available on AHRQ web site:

  http://www.ahrq.gov/research/ltcix.htm

Overall Findings

- Valid tested measures exist
- Wide range of domains identified
- Many measures submitted by States lack rigorous testing

Measures Domains Identified

- Change in daily activity function
- Availability of assistance with everyday activities when needed
- Employment
- Friendships
- Maintenance of family relationships
- Community inclusion
- School attendance
- Serious reportable events
- Avoidable hospitalizations
- Receipt of recommended preventive health care

Measures Domains (cont'd)

- Respectful treatment by direct service providers
- Opportunity to make choices about providers
- Opportunity to make choices about services
- Satisfaction with case management services
- Client perception of quality of care
- Residential experience (satisfaction and choice)
- Client report of abuse and neglect
- Availability of support for resilience and recovery

- Access to case management
- Receipt of all services in care plan
- Care coordination

HCBS Measure Gaps Identified

- National measures do not exist
- Not possible to compare
  - Across States or
  - Across HCBS subpopulations
- Existing data sources are limited

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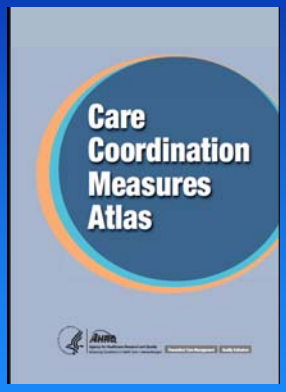
Care Coordination Measures Atlas

- Existing measures of care coordination
- Focus on ambulatory care
- Does not include commonly known endpoint metrics (e.g., ER use)
- 61 measure sets identified
- http://www.ahrq.gov/qual/careatlas/careatlas.pdf



Perspectives on Care Coordination - Measures Atlas

- Patient/family perspective
- Health care professional(s)
- System representative(s) perspective, e.g., accountable care organizations

Source: http://www.ahrq.gov/qual/careatlas/careatlas.pdf

Care Coordination Domains – Measures Atlas

Table 1. Mechanisms for Achieving Care Coordination (Domains)

COORDINATION ACTIVITIES
Establish Accountability or Negotiate Responsibility
Communicate
Facilitate Transitions
Assess Needs and Goals
Create a Proactive Plan of Care
Monitor, Follow Up, and Respond to Change
Support Self-Management Goals
Link to Community Resources
Align Resources with Patient and Population Needs
BROAD APPROACHES
Teamwork Focused on Coordination
Health Care Home
Care Management
Medication Management
Health IT-Enabled Coordination

Source: **http://www.ahrq.gov/qual/careatlas/careatlas.pdf**

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Underlying Framework of PPH Indicators

- Measures of population health
- Potentially preventable hospitalizations
- Adequacy of acute primary care
- Premise: access to good quality outpatient care (i.e., community based care)
- Area-based measures
- Derived from hospital discharge data
- AHRQ Prevention Quality Indicators (PQIs)
- Developed in 2002 and subsequently endorsed by NQF

PPH Indicators – AHRQ PQIs

PQI Number	Prevention Quality Indicators
1	Diabetes short-term complication admission rate
2	Perforated appendix admission rate
3	Diabetes long-term complication admission rate
5	Chronic obstructive pulmonary disease admission rate
7	Hypertension admission rate
8	Congestive heart failure admission rate
9	Low Birth Weight
10	Dehydration admission rate
11	Bacterial pneumonia admission rate
12	Urinary tract infection admission rate
13	Angina admission without procedure
14	Uncontrolled diabetes admission rate
15	Adult asthma admission rate
16	Rate of lower-extremity amputation among patients with diabetes

Source: **http://www.qualityindicators.ahrq.gov/**

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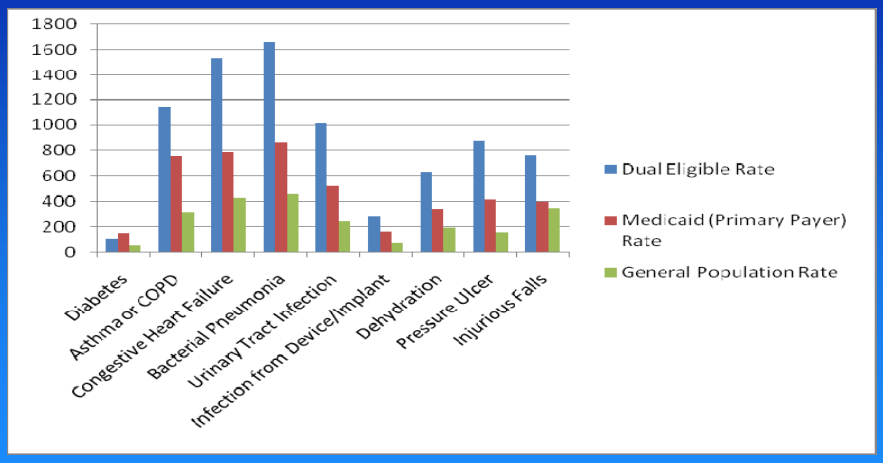
PPH Indicators for Medicaid HCBS Population

- Short-Term Complications of Diabetes (based on PQI 1)
- Asthma or Chronic Obstructive Pulmonary Disease (COPD) (based on PQIs 5 and 15)
- Congestive Heart Failure (based on PQI 8)
- Bacterial Pneumonia (based on PQI 11)
- Urinary Tract Infection (based on PQI 12)
- Dehydration (based on PQI 10)
- Infection from Device/Implant
- Pressure Ulcers
- Injurious Falls
- Composite: Ambulatory Care Sensitive Conditions (ACSC) Chronic Conditions
- Composite: ACSC Acute Conditions
- Composite: ACSC Overall (chronic or acute conditions)

Source: Schultz et al., Development of Quality Indicators for HCBS Population: Technical Report, AHRQ, forthcoming.

Comparisons of PPH Rates for Dual Eligibles, Medicaid and General Population (per 100,000 Population), 2005



Source: Schultz et al., Development of Quality Indicators for HCBS Population: Technical Report, Table 6, AHRQ, forthcoming. Numerator Data: AHRQ State Inpatient Database (SID) (37 states included), 2005. Denominator Data: U.S. Census Bureau, American Community Survey, 2006-2008.

PPH Indicators for HCBS Data Sources

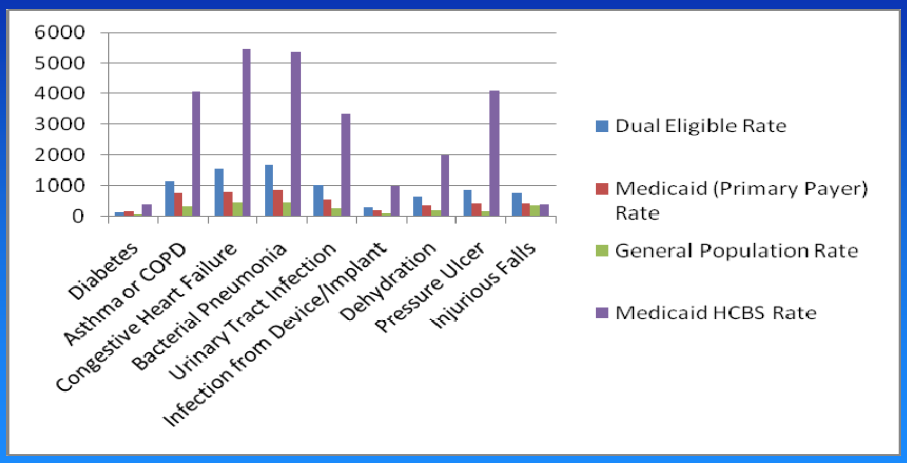
- Derived from hospital inpatient claims data and Medicaid and Medicare enrollment information from CMS
- Numerator data
  - Medicaid-only population from Medicaid Analytic eXtract (MAX) 2005
  - Dual-eligible population from Medicare Provider Analysis and Review file (MedPAR) 2005
- Denominator data (the HCBS Population)
  - From MAX 2005 and MedPAR FY04 (Q3-Q4), FY05 (Q1-Q2)

PPH Indicators for HCBS Denominator Issues

- Calculated quarterly to account for part-year eligibility (but annualized rates reported)
- Exclusions:
  - Individuals in a managed acute care plan
    - State of Arizona excluded due to managed acute care for all Medicaid beneficiaries under 1115 waiver
  - Individuals in a managed long-term care (LTC) plan
  - Individuals who show only institutional care use during a quarter
  - Under age 18
  - States of Wisconsin, Washington, and Maine due to missing data on HCBS use
- Resulting population used in national denominator: 1.6 million

Source: MAX 2005 data

PPH Rates for HCBS Pop. Compared to Dual Eligibles, Medicaid and General Population (per 100,000 Population), 2005



Source: Schultz et al., Development of Quality Indicators for HCBS Population: Technical Report, Table 6, AHRQ, forthcoming. HCBS Data Sources Medicaid MAX and Medicare MedPAR data, 2005. Other numerator data: AHRQ State Inpatient Database (SID) (37 states included), 2005. Other denominator data: U.S. Census Bureau, American Community Survey, 2006-2008.

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Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

- Surveys & related tools used to assess consumers' experiences with health care
- CAHPS® surveys for various settings:
  - Health Plan Survey (commercial insurance, Medicaid & Medicare plans) (children & adults)
  - Managed behavioral healthcare organizations
  - Dental plans
  - Medical groups, physician offices, & clinics
  - American Indian Survey
  - Home Health Care

CAHPS® Surveys (cont'd)

- CAHPS® facility surveys:
  - Hospital Survey
  - In-Center Hemodialysis Survey
  - Nursing Home Surveys, includes QoL metrics
- CAHPS® in development
  - Person Centered Medical Home (PCMH)
  - HCBS CAHPS®
- CAHPS® supplemental item sets:
  - Children with Chronic Conditions
  - People with Mobility Impairments (PWMI)
  - Health Literacy
- National Benchmarking Database

CAHPS® Clinician & Group Survey to Measure the Medical Home – In Development

The Patient-Centered Medical Home (PCMH) Survey domains:

- Access
- Communication
- Coordination
  - Care from other providers
  - Care from others on the care team
- Comprehensiveness
- Shared decision making
- Whole person orientation
- Self-management support
  - Chronic disease management
  - Health promotion

Source: https://www.cahps.ahrq.gov/content/products/CG/PROD_CG_PCMH.asp?p=1021&s=213

Care Coordination – Post Discharge Hospital Items - Hospital CAHPS®

WHEN YOU LEFT THE HOSPITAL

18. After you left the hospital, did you go directly to your own home, to someone else's home, or to another health facility?

- [1] ☐ Own home
- [2] ☐ Someone else's home
- [3] ☐ Another health facility → **If Another, Go to Question 21**

19. During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?

- [1] ☐ Yes
- [2] ☐ No

20. During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?

- [1] ☐ Yes
- [2] ☐ No

Source: http://www.hcahpsonline.org/surveyinstrument.aspx

Care Coordination - Medication Management Hospital Items – HCAHPS®

12. During this hospital stay, did you need medicine for pain?

- [1] ☐ Yes
- [2] ☐ No → **If No, Go to Question 15**

13. During this hospital stay, how often was your pain well controlled?

- [1] ☐ Never
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ Always

14. During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?

- [1] ☐ Never
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ Always

15. During this hospital stay, were you given any medicine that you had not taken before?

- [1] ☐ Yes
- [2] ☐ No → **If No, Go to Question 18**

16. Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?

- [1] ☐ Never
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ Always

17. Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?

- [1] ☐ Never
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ Always

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National Quality Report - State Snapshot Reports

- State-specific hospital outcome measures by primary payer
- Based on the AHRQ Inpatient Quality Indicators (IQIs) and the Patient safety Indicators (PSIs)
- 6 mortality measures
- 6 safety measures
- 4 birth/ OB measures

NQR Display for State-Specific Hospital Outcome Measures – CA Medicaid

State Hospital Care Measures for Medicaid Compared to the U.S.
These AHRQ Inpatient Quality Indicators and Patient Safety Indicators refer to inpatient deaths and potentially avoidable complications.

Hospital Care Measures	CA Rate (Medicaid)	US Rate (Medicaid)	CA Compared to US (Medicaid)	Relative Rate: CA Medicaid to Private	Relative Rate: US Medicaid to Private	Comparative Rate: CA to US Medicaid to Private
Hospital Mortality						
Deaths per 1,000 admissions with abdominal aortic aneurysm (AAA) repair	DSU	85.29	DNC	DNC	↓	DNC
Deaths per 1,000 admissions with coronary artery bypass surgery (CABG), age 40 and over	30.35	28.97	■	=	↓	■
Deaths per 1,000 discharges for acute myocardial infarction (AMI)	83.52	75.25	■	=	↓	■
Deaths per 1,000 adult admissions with congestive heart failure (CHF)	28.11	29.83	■	=	↑	■
Deaths per 1,000 adult admissions with pneumonia	45.22	41.37	■	=	=	■
Deaths per 1,000 adults with percutaneous transluminal coronary angioplasty (PTCA), age 40 and over	16.89	12.60	▼	↓	↓	■
Hospital Safety						
Deaths per 1,000 admissions in low-mortality DRGs	0.67	0.46	■	=	=	▼
Iatrogenic pneumothorax per 1,000 discharges	0.74	0.79	■	=	=	■
Selected infections due to medical care per 1,000 discharges	2.74	2.58	■	↓	↓	■
Postoperative septicemia per 1,000 elective surgical discharges of 4 or more days	20.06	16.36	▼	↓	↓	▼
Postoperative abdominal wound dehiscence per 1,000 discharges	3.41	4.10	■	↓	↓	▼
Hospital Birth/ Obstetrics						
Birth trauma injury to neonate per 1,000 selected live births	1.36	1.51	■	=	↑	■
Obstetric trauma per 1,000 instrument-assisted deliveries	101.81	114.06	▲	↑	↑	■
Obstetric trauma per 1,000 vaginal deliveries without instrument assistance	25.95	25.98	■	↑	↑	▼
Obstetric trauma per 1,000 Cesarean deliveries	2.63	3.29	▲	↑	↑	■

Relative Rates:
↓ indicates that Medicaid discharges receive poorer quality of care or have worse outcomes than privately-insured discharges.
↑ indicates that Medicaid discharges receive better quality of care or have better outcomes than privately-insured discharges.
= indicates that Medicaid discharges receive the same quality of care and have similar outcomes as privately-insured discharges.

Questions?

NQF
National Quality Forum

Applications of Quality Measurement

Integrated Models

Quality Measurement in the PACE Model

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National PACE Association
Geriatrics Section, Boston University Medical Center

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PACE

- Program of All-Inclusive Care for the Elderly
  - Focus on Frail, Disabled, Medically and Socially Complex Elders
  - Comprehensive
  - Integrated
  - Community-Based

PACE Eligibility

- Age 55 +
- Nursing Home Certified
- PACE Service Area
- "Able to Live Safely in the Community" with PACE Care Plan
- Must Enroll All Eligible Applicants
- *95% Dually Eligible*

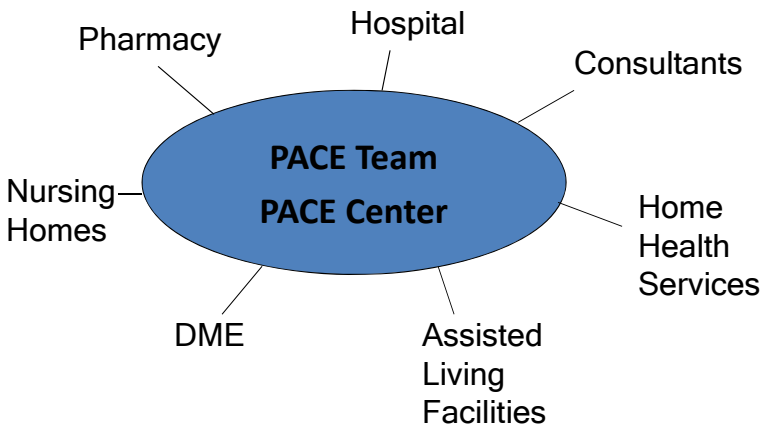
PACE Enrollees

- Mean Age: 78
- 75% Women
- Average # Basic ADL Deficits: 3.5
- 63% Have Cognitive Impairment
- Average Life Expectancy: 4.5 years

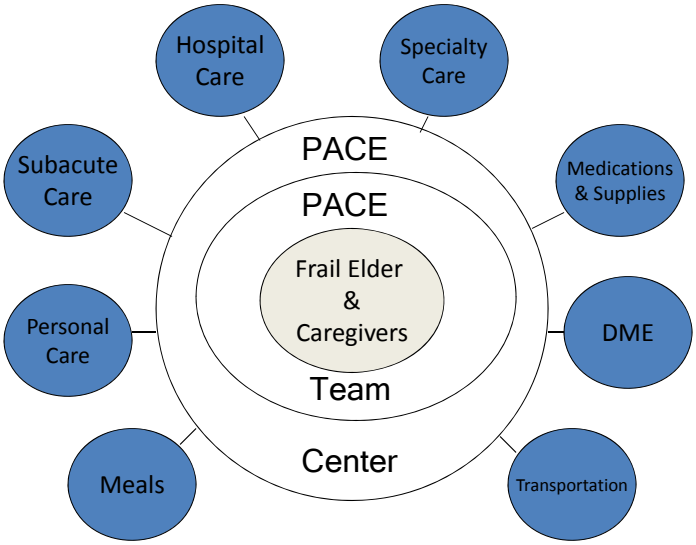
PACE Nationally

- 76 PACE Organizations
- 30 States
- 22,000 PACE Participants
- 100 to 2000 Participants per program

PACE Network



PACE Integration & Coordination



PACE Interdisciplinary Team

- Primary Care
  - MD
  - NP
- Nursing
  - Day Center Nurses
  - Home Care Nurses
- Rehabilitation
  - Physical Therapy
  - Occupational Therapy
- Social Work
- Activities
- Nutrition
- Pharmacy
- Transportation
- Personal Care

PACE Center

- Social Center
- Observation & Care Environment
- Full-Service Clinic
- Team Base

PACE Financing

- Medicare Capitation
  - Part C Medicare Advantage Risk Adjustment
  - PACE Frailty Factor
  - Part D Bid Process
- Medicaid Capitation
  - Methodology Varies State to State
  - Reflects Cost of Comparable Population

PACE Financing

- Responsible for All Costs
  - Inpatient
  - Outpatient
  - Pharmacy
  - Long-Term Care
- No Carve-Outs
- No Cost-Shifting
- No Restrictions on Services

Performance Measurement in PACE

- CMS Reporting Requirements
- Primary Care Model Practices
- Outcome Measures Initiative

CMS Reporting Requirements: Level 1

- Grievances
- Appeals
- Enrollments & Disenrollments
- 30-day Hospital Readmissions
- ED Utilization
- Unusual Incidents
  - Falls, Suicides, Infectious Disease Outbreaks, Medication Errors, Restraint Use
- Deaths

CMS Reporting Requirements: Level 2

Incident	Reporting Threshold
Unexpected deaths	
Suicide attempts	
Elder abuse	
Falls	Death, hospitalization 5+ days, or permanent loss of function
Traumatic injuries	Death, hospitalization 5+ days, or permanent loss of function
Medication-related occurrences	Death, hospitalization 5+ days, or permanent loss of function
Adverse outcomes of treatment	Death, hospitalization 5+ days, or permanent loss of function
Burns	Death, hospitalization, 3rd degree > 10% body area
Restraint use	Death, hospitalization, permanent loss of function
Elopement	Death, hospitalization, permanent loss of function
MVA	Death, hospitalization, permanent loss of function
Equipment-related occurrences	Death, hospitalization, permanent loss of function

Model Practices

- Based on Existing Guidelines
  - Chronic Medical Conditions
    - Diabetes, Chronic Heart Failure, Chronic Kidney Disease
  - Preventive Heath
- Stratified by Goals of Care
  - Longevity
  - Function
  - Palliative

PACE

NPA Primary Care Committee
2008 Chronic Heart Failure Model Practice

ACC-Recommended Intervention for CHF[1]	Goal: Longevity	Goal: Function	Goal: Palliative	Who?	When?
Diagnostic Evaluation:					
• Echocardiogram/determine EF	Yes	Yes	Consider	PCP	Initially
• Identify etiology (CAD, HTN, PVD, DM, valvular, cardiomyopathy)	Yes	Yes	No		
• Identify AHA stage	Yes	Yes	Yes to guide rx		
Recommended Medications for Systolic CHF (EF<40%)*:				PCP/ PharmD	Re-assess q 6 mos
• Aspirin	Yes	Yes	No		
• ACEI/ARB	Yes, if Cr<3, no allergy, ADR	Yes, if Cr<3, no allergy, ADR	Consider		
• Hydralazine and Isosorbide	Yes, if unable to take ACEI/ARB	Yes, if unable to take ACEI/ARB	Consider		
• Diuretics	Yes	Yes	Yes		
• Beta-blocker if not contraindicated	Yes, as pulse and BP permit	Yes	Consider		
• Spironolactone (AHA Stage D)	Yes if indicated	Consider	No		
• Digoxin (for symptom relief in advanced CHF)	Yes if indicated	Consider	Consider		
• Amlodipine (if need Ca channel blocker for angina, BP control)	Yes if indicated	Consider	Consider		
• Antiarrhythmic rx (if indicated)	Yes if indicated	Consider	Consider		
• Warfarin (if atrial fibrillation, INR 2-3)	Yes if indicated	Consider	No		
Other Recommended Medical Interventions:				PCP	q 6-12 months
• Tobacco cessation counseling	Yes	Consider	No		
• Oxygen (if indicated)	Yes	Yes	Yes		
• BP goal ≤130/80	Yes	Consider	No		
• AICD (if indicated)	Yes	No	No		
• Dual chamber pacer (if indicated)	Yes	No	No		
Participant/Caregiver Education				RN	At diagnosis and as status changes
• Cause/prognosis of CHF	Yes	Yes	Yes		
• Warning signs – when to call nurse (swelling, SOB, fatigue, weakness, anorexia, chest pain, nausea, lightheadedness)	Yes	Yes	Yes		
• Effects of meds, diet, activity	Yes	Yes	No		
• Weigh weekly, notify RN	Yes	Consider			
Monitoring of Fluid Status				RN PCP	Weekly-monthly
• Record weekly weights	Yes	Yes	Consider		
• Weight gain/loss of 3 lb in one week reported to PCP immediately (+CF evaluates/adjusts medications if needed)	Yes	Yes	Consider		
Diet				RD PCP	When diagnosed, then review annually
• Diet counseling with participant and caregiver	Yes	Consider	No		
• Low salt diet: Mild: 3-4 gm/Day *or* Severe: 2 gm/Day	Consider	Consider	No		
• Fluid restriction: 2 L/Day	Consider	Consider	No		
Exercise/Cardiac Rehab	Yes	Consider	No	PT	
Potential Quality Indicators				Quality Manager Medical Director	Selected measures quarterly-annually
• Assessment of LV function	Yes	Consider	No		
• ACEI/ARB use unless contraindicated	Yes	Yes	No		
• Cessation assistance offered to smokers	Yes	Consider	No		
• Pt/CG education on CHF	Yes	Yes	Yes		
• Advance planning	Yes	Yes	Yes		
• Decreased admissions for CHF	Yes	Yes	Yes		
• No 30-Day re-admissions for CHF	Yes	Yes	Yes		

PACE Outcome Measures

- Work in progress
  - Identify existing measures relevant to PACE population
  - Establish clear definitions, inclusion/exclusion criteria, benchmarks
  - Agree on common data set
- Effort led by NPA Measures Advisory Committee
  - PACE Executive Directors, Medical Directors, Quality Directors
- Vetted through NPA Quality Consortium
  - One representative from each PACE Organization

PACE OUTCOME MEASURES			
Health		**Preventive Care**	
1	Acute care hospital inpatient days/1000 participants/annum	9	Percentage of eligible participants who received flu immunization
2	Acute psychiatric hospital inpatient days/1000 participants/annum	10	Percentage of eligible participants who received pneumococcal immunization
3	Long-term hospital inpatient days/1000 participants/annum	**End-of-life Care**	
4	Emergency Department (ED) visits/1000 participants/annum	11	Percentage of participants for whom advance care planning is documented within 90 days of enrollment
5	30-Day All Cause Acute Hospital Readmission Rate	**Effectiveness of Chronic Disease Management**	
6	Percentage of participants residing in long term nursing facility for 90 or more days as of the last day of the quarterly reporting period	12	Percentage of participants with a diagnosis of congestive heart failure who are hospitalized with a primary or secondary discharge diagnosis of heart failure during reporting period
Care Planning		13	30-day readmission rate (all cause) for participants having primary or secondary discharge diagnosis of heart failure
7	Percentage of participants for whom care plans were initially developed or revised during six month period preceding reporting date	14	Percentage of diabetic participants who received Hemoglobin A_1C testing in prior year
8	Percentage of care plans developed or updated during the quarter that document participant involvement in care planning process	15	Percentage of diabetic participants who received a retinal eye exam in prior year
		16	Percentage of diabetic participants who received a comprehensive foot exam in prior year

Challenges

- Define Goals of the Model
- Align Performance Measures with Goals
- Capture Non-Traditional Domains
  - Patient-Centered Goals
  - Autonomy, Self-Efficacy, Self-Determination
  - Meaning, Purpose, Connection
  - Caregiver, Household, Community Benefits
- Broaden Definition of Health

Questions? Comments?

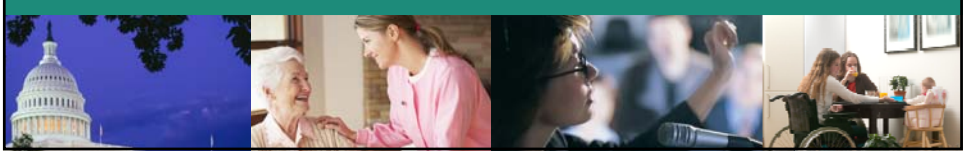
Experience of the SNP Alliance

Integrated SNPs and Performance Measurement

Rich Bringewatt

Chair, The SNP Alliance, and President, National Health Policy Group

July 26, 2011



Special Needs Plans

A Platform for Integration

1. State integration demonstration programs served as prototype for Congressional intent of SNP legislation.
2. Over 90% of ALL SNP beneficiaries are dually eligible.
3. D-SNPs have Congressional contracting mandate.
4. More beneficiaries enrolled in fully integrated SNPs than any other dual integration program.
5. Legacy plans provide evidence of success.
6. Emergent demand for rapid system transformation.
   a. Poor, frail, disabled, chronically beneficiaries are healthcare's most vulnerable, high-cost and fast-growing service group.
   b. Current operating methods are fundamentally flawed.
   c. Revenue limitations require significant improvement in cost and quality performance.
   d. SNPs have limitations (as all other integration options) but offer practical, nationwide platform for system transformation.

The Endgame of Integration

Adopt performance measures in light of what is to be achieved.

Duals require their ***care to be integrated*.**

- **Empowered consumers** through integrated enrollment and member materials, simplified access to care, and informed beneficiaries and families as partners.
- **Enriched medical homes** to address issues of frailty, disability, co-morbidity, multiple medication usage, and the volatile, complex and ongoing nature of care through interdisciplinary care teams, principal care leadership, and extended care pathways that lower the morbidity curve and natural illness/disability trajectory.
- **Integrated care networks** where providers serving the same person, either at the same time or in sequence to one another, offer safe and effective care transitions and care continuity through aligned relationships and person-centered care plans.
- **System management methods** that monitor and optimize *total* quality and cost performance as a person's care needs evolve over time and across care settings.

The Endgame of Integration

Adopt performance measures in light of what is to be achieved.

Duals require Medicare & Medicaid ***programs to be integrated.***

- **Unified program administration** with aligned goals, objectives and priorities.
- **Align program requirements** including for Conditions of Participation (CoPs) for component providers and model of care guidance for integrated plans.
- **Global capitation** using aligned, risk-adjusted payment methods and incentives.
- **System-oriented performance measures and methods** that recognize the systemic, interrelated medical and non-medical aspects of care that involve multiple service providers.

Barrier 1: Financial Incentives and Program Requirements do not Align with Integration Performance Measurement

1. Medicare and Medicaid have different goals, objectives and values that impede the performance in integrated plans.
2. Medicare and Medicaid have different payment methods and incentives that impede integrated care performance.
3. MA-SNP Model of Care requirements and S&P Measures are not aligned, e.g. different care management concepts.
4. STAR bonus payments do not contain incentives for integrating care or for addressing frailty, disability, co-morbidity or other important dual conditions such as AIDS.
5. Conditions of Participation (CoPs) requirements and component-based regulations in FFS impede care integration.

Barrier 2: Current Integration Related Measures and Methods Themselves are Not Fully Aligned

1. States and CMS have different reporting requirements. For example, states and CMS have different care management interests and even require different reporting methods for the same measures, e.g. HEDIS measures.
2. NCQA criteria for approval of SNPs are not fully aligned with their Structure and Process measures and methods.
3. CMS and states have unaligned QI requirements for SNPs (CCIP, QI Program plan, PIP, etc.) that sometimes conflict.
4. The overall layering of multiple component measures and methods for different interests reinforces fragmentation.

Barrier 3: Measures and Methods are not Adequately Aligned with the Interrelated Care Needs of High-risk Duals

1. STAR measures are not aligned with interrelated care needs of key populations; e.g., frail elders, adults with disabilities, persons with AIDS, etc. Some inappropriate; others missing.
2. HEDIS focused on prevention and illness treatment, not ongoing care management of complex chronic conditions.
3. CHAPS measures discount dual satisfaction scores.
4. The validity and reliability of self-report measures for HOS and CHAPS is questionable for cognitively impaired, persons with memory problems, mentally ill, and behavioral health.
5. Large and growing number of measures and methods is producing major data burden and threatening plan viability.

Integration Related S&P Measures

Issue 1: *Care Transitions Measures* Need Refinement

1. Existing measures give major focus to measuring planned vs unplanned transitions rather than identifying and reducing adverse consequences of care transitions.
2. Same rules for all types of conditions do not allow plans to tailor interventions to needs, e.g. frail with pneumonia and relatively well with hip fracture have different needs.
3. Major focus on documentation of process and not enough focus on enabling plans and providers to improve results, such as consumers receiving conflicting advice, inadequate information regarding other treatments, different approaches to assessment/care planning, adverse drug events from multiple prescribers and pharmacies, etc.

Integration Related S&P Measures

Issue 2: *Complex Care Management* Measures Need Refinement

1. Major focus on how many of 15 CM functions (e.g. assess health status) are performed without weighting of functions or differentiating how well they are performed, or the need for tailoring approach to different target populations.
2. Little focus on aligning medical and mental/behavior health.
3. No reference to interdisciplinary care teams, a key factor in the SNP Model of Care requirements.
4. Nothing on aligning assessment and care planning functions among related primary, acute and long-term care providers who serve the same persons as their condition evolves over time and across care settings.

Integration Related S&P Measures

3: *Coordination of Medicare and Medicaid* Measures Need Refinement

1. Focus is on *coordinating unaligned* functions rather than the degree to which enrollment, evidence of coverage, member communication, grievance and appeals, etc. are *simplified and integrated*.
2. Focus on *documenting* SNPs are *working* on State relationships rather than *alignment* of Medicare and Medicaid relationships.
3. Focus on access to pieces of care within network rather than the nature of the relationships among network providers who serve the same person as their condition evolves over time and across care settings.
4. No measurement of degrees of integration or meaningful measurement differences for FIDESNPs and SNPs with limited Medicaid contract.

Stratification/Case Mix Adjustment

Indicators To be Considered by the SNP Alliance through Annual Survey

1. Alliance conducts annual survey of members (10 Legacy Integration Plans as subgroup) re: targeting, hospitalization rates, emergency room visits, physician visits, long-term nursing home stays, pharmacy, etc.
2. Exploring stratification/case mix of 2011 survey data:
   a. Age, sex, institutional status, welfare status and risk scores from CMS-HCC payment methodology.
   b. Average number of ADLs from HOS survey.
   c. Rural and urban status from MSA data.
   d. Presence of mental illness treatment code in past year.
   e. Mix of 10 most prevalent conditions in Medicare population.

The SNP Alliance

Overall Recommendations

1. Reduce data burden; only focus on few measures that really matter.
2. Focus on system rather than component parts; quality dependent on relationships among related problems and care providers.
3. Align Model of Care, Conditions of Participation, financial incentives and other program requirements with performance measurement.
4. Align all Medicare and Medicaid performance measures and methods: HEDIS, HOS, CHAPS, QIPs, PIPs, CCIPs, etc.
5. Resolve self-report problems for high-risk beneficiaries.
6. Modify STARS to support targeting of duals with complex conditions.
7. Stratify or risk-adjust performance findings to target populations. Don't apply one set of measures and benchmarks to everyone.
8. Move to outcome methods ASAP.
9. Empower practitioners to make quality care decisions rather than become skilled documentation and compliance specialists.
10. Be weary of unintended consequences.

The Measurement Landscape for Integrated Models
The View From a FIDESNP

MAP Dual Eligible Beneficiaries Workgroup Meeting
July 25-26, 2011
Washington, DC

Larry Gottlieb, MD, MPP
Chief Quality Officer
Commonwealth Care Alliance

Key Challenges

1. Population-Measure Mismatch
   - Domains: critical domains unmeasured, other domains over-measured
   - Methods: Some required tools not validated, inflexible procedures
2. Population-Benchmark Mismatch
   - No stratification
   - Inadequate adjustment
3. Patient-Measure Mismatch
   - Most measures not patient-centered
4. Non-aligned Requirements
5. Measurement and Reporting Burden

Population-Measure Mismatch
CCA Domains of Quality

Domain	Many	Some	Few-None
1. Access to Care		✓	
2. Evidence-Based Medical Care	✓		
3. Consistent Care			✓
4. Coordinated Care			✓
5. Continuity of Care			✓
6. Compassionate Care			✓
7. Culturally Competent Care			✓
8. Care in the Community	✓		
9. Member Empowerment			✓
10. Member Health Status	✓		
11. Member Satisfaction	✓		
12. Provider Satisfaction			✓
13. Provider Competency		✓	

Population-Measure Mismatch
Methods

1. Some required tools not valid(ated) for our populations
   - Frail elderly
   - Cognitively impaired
   - Mentally ill
   - Low functioning mental status
   - Non-English speaking
2. Inflexible procedures
   - CAHPS biased towards less integrated practice interactions
     - CCA provides both health plan and direct care services
     - Our members are confused by CAHPS
   - Simple, minor adjustments not permitted by CMS
     - Refuse requests to allow first survey to include foreign language version
     - Refuse request for minor changes to clear up confusion

Population-Benchmark Mismatch
No stratification - inadequate adjustment

"Risk" adjustment is not indicated to control for variations in system performance

- It buries the deficiencies and opportunities that you want to highlight
  - ✓ Performance variation due to variations in access
  - ✓ Performance variation due to variations in health literacy

Benchmarking against improvement, compared to self or to like others, (in addition to absolute level of performance) is indicated

Population-Benchmark Mismatch
No stratification or adjustment

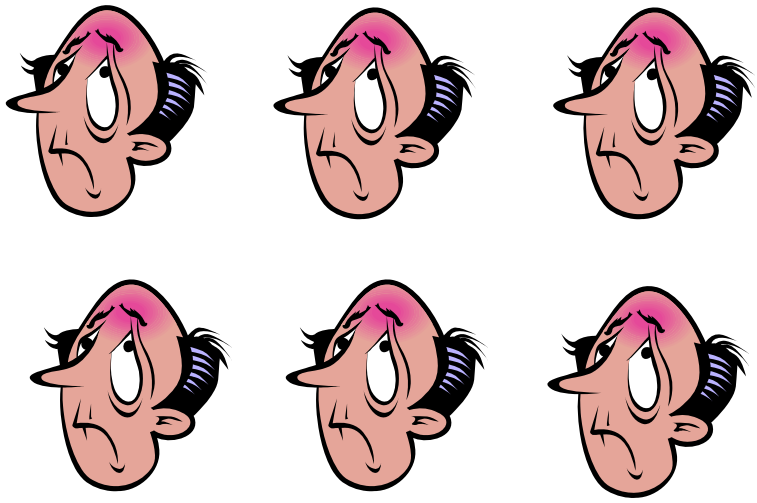
Adjustment or stratification is needed to control for variations in:

- Response "bias" in patient reported measures
  - ✓ CAHPS
  - ✓ HOS
- Risks and/or Benefits in "evidence-based" quality measures
  - ✓ Colorectal cancer screening in frail elderly
  - ✓ Blood pressure and glycemic control
  - ✓ Glaucoma testing in SPMI population
  - ✓ Osteoporosis screening in long-term nursing home residents

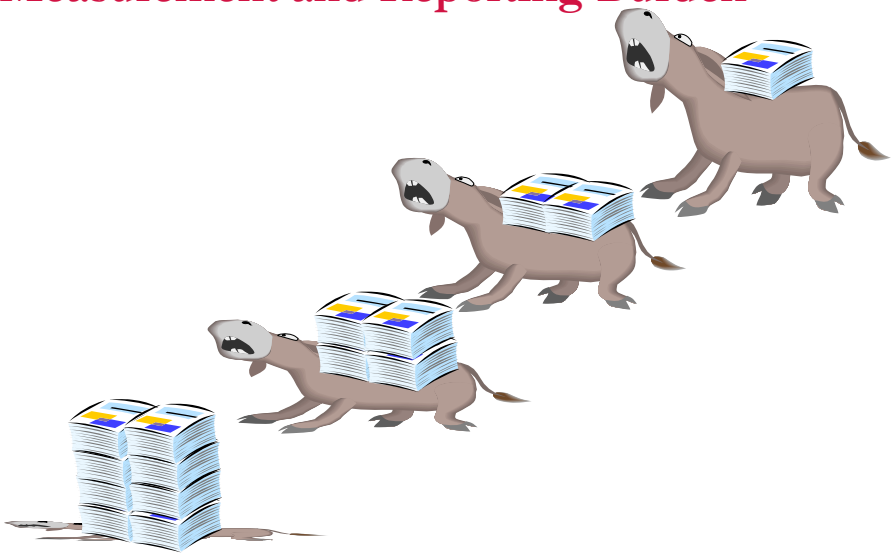
Patient-Measure Mismatch
Measures are not patient-centered

- This is a deficiency of almost all evidence-based disease-specific quality of care measures
- Do not consider individual patient values:
  - Risk tolerance
  - Costs of interventions: personal, financial
  - Outcome objectives: short and long-term

Non-aligned Requirements



Measurement and Reporting Burden



Questions and Discussion

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Data Sources and Alignment of the Data Platform

Data, Measurement, and Health IT Are Inextricably Linked

- **Data Sources** — Capture the right data
- **Performance Measures** — Calculate the performance measure
- **EHRs and HIT tools** — Provide real-time information to the clinician with decision support
- **E-Infra structure** — Publicly report for secondary uses: accountability, payment, public health, and comparative effectiveness

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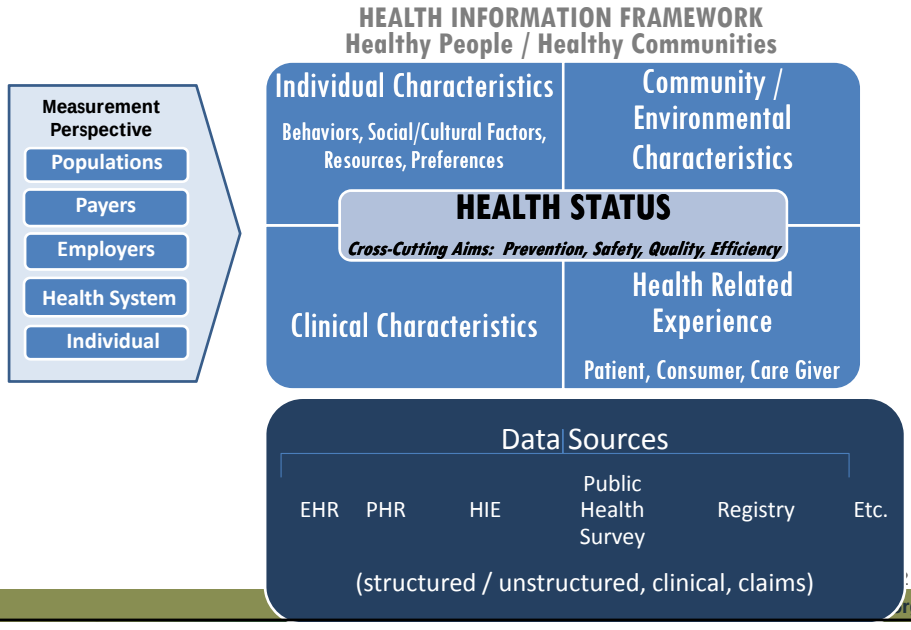
Performance Measures and Information Requirements



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Workgroup Discussion and Questions

Discussion Questions

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- In your experience, what are the strengths and limitations of the current data environment?
- How can the workgroup's proposed vision and measurement strategy capitalize on emerging principles of information exchange?
- What data limitations are due to policy and which are due to technical barriers?

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Opportunity for Public Comment

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Summary of Day 1 and Look Forward to Day 2

Themes from Day One

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- National Quality Strategy & Multiple Chronic Conditions
  - Agreement with the stretch goals
  - Need to address mental health and substance beyond prevention
  - *Many insights from Vision and Principles discussion below apply here too*
- Strategic Approach to Measurement: Must Strike a Balance
  - Health care including long term care, plus social and community needs, must be addressed to improve patient-centered health outcomes (WHO definition of health)
  - Recognize
    - Vulnerabilities: disparities, housing, transportation, education
    - Affordability, efficiency, sustainability
    - Coordination across provider types and teams
- Highest Need Populations
  - Consider individuals in residential facilities
  - Multiplier impact varies, greatest for: mental health, substance abuse, cognitive impairment, pain

Themes from Day One, continued

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- Medicare, Medicaid, Integrated Programs
  - *Many* measure sets available, most limited by provider type or care location
  - Need coordinated, parsimonious measure set(s) that fit the defined population
  - Clarify unit of analysis: individual, provider / facility, care team, system-ness (local, states / CMS?)
  - No common data set, start by linking federal data sets (in process)
  - Many 'mismatches' in current measurement and reporting requirements and population needs

Themes from Day One, continued

- Health Information Framework and Data Needs
  - Current data sources are inaccurate in many cases
  - Claims is insufficient, but still a needed data source
  - Two-way data sharing is needed to support patient-centered, coordinated care
  - Messaging about the intention and use of measures is important
  - Balance: keep the vision of what is desired, while learning from practical examples of what to replicate and pitfalls to avoid

Expectations for Day 2

- Digging into available measures
  - Presentation from NQF Performance Measures Department staff
  - Small group activity related to assessing the appropriateness of available measures for use with the dual eligible population
- Identification of gaps in endorsed measures, measure development gaps, and opportunities to address them
- Refinement of strategy and overarching recommendations
- Agreement on the group's input to the MAP Coordinating Committee

Measure Applications Partnership

Dual Eligible Beneficiaries Workgroup

In-Person Meeting

July 25-26, 2011

Agenda: July 26

9:00 am	Recap of Day 1
9:30 am	NQF-endorsed measures for high-leverage quality improvement opportunities
10:30 am	Small group activity: assessing available measures
11:30 am	Report out from small groups
12:30 pm	Working lunch
1:00 pm	Looking beyond endorsed measures
2:30 pm	Refine recommendations and path forward
3:30 pm	Summation
3:45 pm	Adjourn

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NQF-Endorsed Measures for High-Leverage Quality Improvement Opportunities

NQF's Mission

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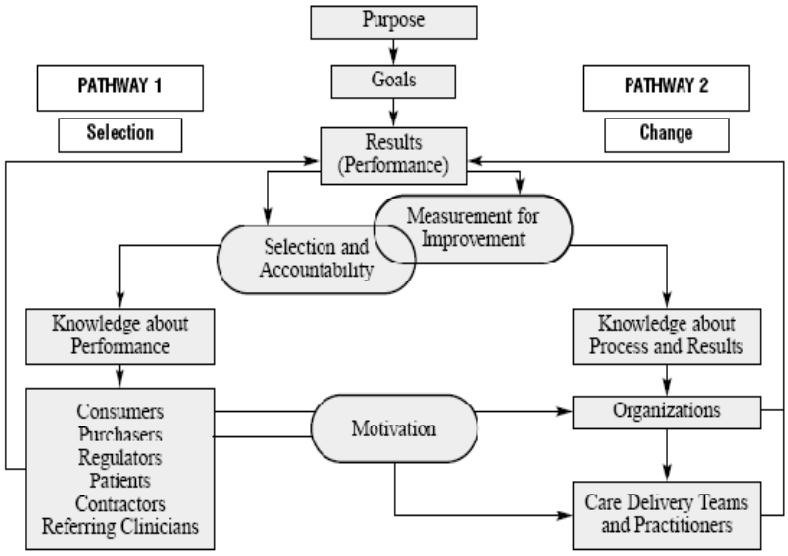
To improve the quality of American healthcare by:

- Building consensus on national priorities and goals for performance improvement and working in partnership to achieve them
- Endorsing national consensus standards for measuring and publicly reporting on performance
- Promoting the attainment of national goals through education and outreach programs

Measurement & Improvement Paths



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NQF, 2002

www.qualityforum.org

Quality Measurement in Evolution

- Drive toward higher performance
- Shift toward composite measures
- Measure disparities in all we do
- Harmonize measures across sites and providers
- Promote shared accountability and measurement across patient-focused episodes of care:
  - Outcome measures
  - Appropriateness measures
  - Cost/resource use measures coupled with quality, including overuse

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Disparities Measurement

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- Assessment of quality and safety by race, ethnicity, primary language and SES status needs to become a routine part of performance measurement
- Explore direct methods for collecting race, ethnicity, primary language, and SES data in an efficient, effective, patient-centered manner or consider indirect methods
- Identify measures that are “disparity-sensitive” that should be routinely stratified: prevalence, impact of the condition, impact of the quality process, quality gap

Integrated Framework for Measurement

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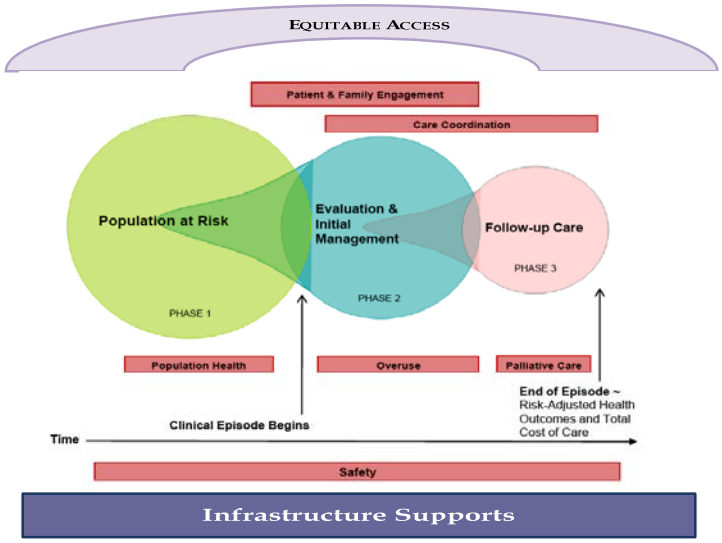

Patient-Focused Episodes of Care Model

- Patient-focused orientation
  - Follows the natural trajectory of care over time
- Directed at value
  - Quality, costs, and patient preferences
- Emphasizes care coordination
  - Care transitions and hand-offs
- Promotes shared accountability
  - Individual, team, system
- Addresses shared decision making
  - Attention to patient preferences
- Supports fundamental payment reform
  - Bundled payment for the episode of care

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Episodes Model Measurement Domains

- Patient-level outcomes (better health)
  - Morbidity and mortality
  - Avoidance of complications (e.g., HAIs)
  - Functional status and health-related quality of life
  - Patient experience of care
- Processes of care (better care)
  - Technical
  - Care coordination and transitions
  - Alignment with patients' preferences
- Cost and resource use (overuse, waste, misuse)
  - Total cost of care across the episode
  - Indirect costs

NQF Evaluation Criteria

- **Importance to measure and report**
  - What is the level of evidence for the measures?
  - Is there an opportunity for improvement?
  - Relation to a priority area or high impact area of care?
- **Scientific acceptability of the measurement properties**
  - What is reliability and validity of the measure?
- **Usability**
  - Are the measure results meaningful and understandable to intended audiences and useful for both public reporting and informing quality improvement?
- **Feasibility**
  - Can the measure be implemented without undue burden, capture with electronic data/EHRs?
- **Assess competing and related measures**

Care Coordination – Previous NQF Work

- In 2006, endorsed a definition of and framework for care coordination.
  - Care coordination is a function that helps ensure that the patient's needs and preferences for health services and information sharing across people, functions, and sites are met over time. Coordination maximizes the value of services delivered to patients by facilitating beneficial, efficient, safe, and high-quality patient experiences and improved healthcare outcomes.
  - Identified five key domains: Healthcare "Home," Proactive Plan of Care and Follow-up, Communication, Information Systems, and Transitions or Handoffs.
- In 2010, endorsed 25 care coordination practices and 10 performance measures

Care Coordination

- 59 endorsed measures fall within this topic area

Examples:

- # 228: 3-Item Care Transition Measure (University of Colorado Health Sciences Center)
- #554: Medication Reconciliation Post-Discharge (MRP) (NCQA)

Quality of Life

- Targeted area across all NQF projects
- 68 endorsed measures fall within this topic area
  - functional status,
  - pain management,
  - palliative care and end-of-life care, and
  - safety

Examples:

- #260: Assessment of Health-related Quality of Life (Physical & Mental Functioning) (RAND)
- #429: Change in Basic Mobility as Measured by the AM-PAC (CREcare)

Assessment and Screening

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- Targeted area across all NQF projects
- Did not include population-level measures of prevalence; focused on clinician- or hospital-level
- 68 endorsed measures fall within this topic area

Examples:

- #35: Fall Risk Management in Older Adults (NCQA)
- #110: Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use (CQAIMH)

Behavioral Health and Substance Use

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- Previous work by NQF:
  - Endorsed evidence-based practices on substance use
  - Multiple projects on behavioral/mental health (including substance use)
- 36 endorsed measures fall within this topic area

Examples:

- #710: Depression Remission at Six Months (MN Community Measurement)
- # 711: Depression Remission at Twelve Months (MN Community Measurement)

Relevant Upcoming NQF Projects

- Care Coordination (2 phases)
  - Phase I: Foundational work focused on implementation and methodological issues that limit measurement and quality improvement of care coordination
  - Phase II: Endorsement Maintenance
- Population Health
  - Framework Paper on Approaching Population Health Measurement and Evaluation
  - Followed by a focused project on population health endorsement maintenance
  - Prevention Endorsement Maintenance
- Behavioral/Mental Health

Workgroup Discussion and Questions

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Small Group Activity

Measure Selection Criteria Development

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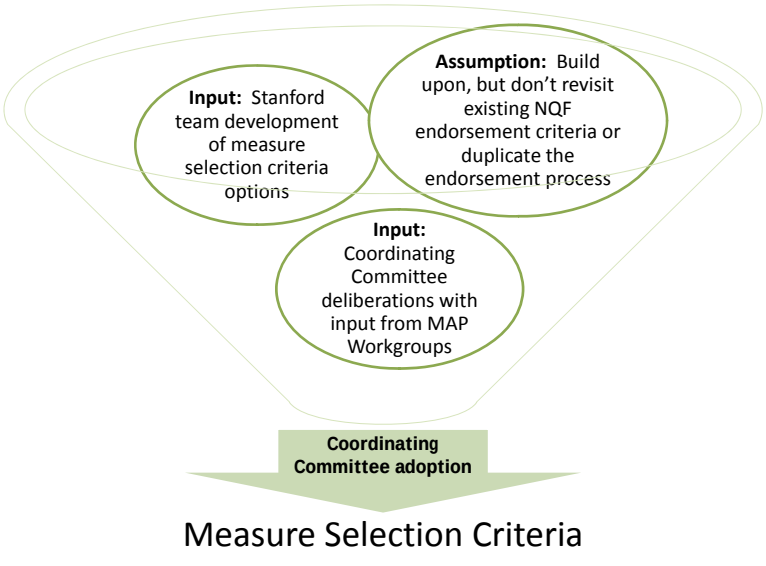

Criteria for Individual Measure Selection

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1. Measures addresses National Quality Strategy priorities and high-leverage measurement areas
2. Measure meets NQF endorsement criteria
3. Measure promotes parsimony through applicability to multiple populations and providers
4. Measures enables longitudinal assessment of patient-focused episode of care
5. Measure is ready for implementation in the context of a specific program
6. Measure is proximal to outcomes

Each criterion is weighted equally and scored on a scale of high-medium-low

Instructions for Small Group Activity

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- 4 Groups: Care Coordination, Quality of Life, Screening and Assessment, Mental Health and Substance Use
- Identify a group member who will be responsible for reporting out to the larger group. A staff member will join each group to provide guidance and take notes.
- Each group will receive a list of endorsed measures that most closely apply to its category, based on scores assigned by NQF staff
- **Discuss the pros and cons of using the selected measures to assess the care experience of dual eligible beneficiaries**
- **What are the characteristics of a measure that make it appropriate or inappropriate?**
- **Select the metrics you feel are the best examples and describe why**
- **Would a measure or measures from your sample list be adequate to assess performance in the specified area? If not, document the gaps.**

Group Assignments

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Care Coordination	Quality of Life	Screening and Assessment	Mental Health and Substance Use
Counsell	Burrows	Murray	Beale
Dunford	Claypool	Linebach	Cuello
Hansen	Lind	Polakoff	Gottlieb
James	Nemore	Potter	Kivlahan
Meklir	Powell	Preston	Stuart
Tyler	Zlotnik	Reinhard	Vandivort
STAFF: Stollenwerk	STAFF: Valuck	STAFF: Hwang	STAFF: Lash

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Report Out from Small Group Activity

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Workgroup Discussion and Questions

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Opportunity for Public Comment

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Looking Beyond Endorsed Measures

Measure Development and Endorsement Gaps

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- Measure Development Gaps
  - Many concepts one might wish to evaluate have not been developed as standardized performance measures
  - Metrics may exist in other forms, such as consumer surveys or assessments, for which performance measures would need to be developed and tested
- Measure Endorsement Gaps
  - A desired measure or measure set that has been fully developed and tested but not yet endorsed by NQF is considered in an "endorsement gap"
  - Under certain circumstances, such a measure may be eligible for expedited review

Mental Health and Substance Use Measures

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- SAMHSA recently released National Framework for Quality Improvement in Behavioral Health Care, aligned with NQS
- Includes opportunities for success and illustrative measures across six priority statements, such as:
  - Use of recovery measures
  - Percentage of adults reporting binge drinking in the past 30 days
  - Percentage of individuals receiving information to make informed decisions about treatment options
  - Percentage of individuals with severe mental illness who report social supports/social connectedness
  - Percentage of adults screened for depression and receiving a documented follow-up plan, or screened for risky alcohol use and if positive, receiving brief counseling

Mental Health and Substance Use Quality Indicators

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1	Safety	Appropriate monitoring of metabolic/cardiovascular side effects for individuals receiving antipsychotic medication	Process
2	Effectiveness	Meaningful use of disease registries and evidence-based decision support for (at least two) behavioral health conditions	Structure
3a	Effectiveness	Depression screening and follow-up	Process
3b	Effectiveness	Use of standardized assessment tools (for example, PHQ-9) for depression	Process
3c	Effectiveness	Depression remission at 6 months	Outcome
3d	Effectiveness	Depression remission at 12 months	Outcome
4	Effectiveness	Screening, brief intervention, and referral for alcohol abuse	Process
5	Effectiveness	Appropriate number of visits after initiating ADHD treatment	Process

Harold Alan Pincus, Brigitta Spaeth-Rublee and Katherine E. Watkins. The Case for Measuring Quality in Mental Health and Substance Abuse Care. *Health Affairs*, 30, no.4 (2011): 730-736.

Mental Health and Substance Use Quality Indicators

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6	Patient-Centeredness	Experience of care/satisfaction with care/recovery consumer survey items	Process/ Outcome
7	Timeliness	Initiation and engagement in alcohol and drug dependence treatment within 14 days, 30 days	Process
8	Efficiency	30-day rehospitalization for individuals hospitalized for a mental health or substance use condition	Process/ Outcome
9a	Equity	Items 1, 3-8 analyzed for disparities with regard to race/ethnicity, sex, and age	Process/ Outcome
9b	Equity	General medical quality indicators for chronic conditions such as diabetes, cardiovascular disease, and preventive care analyzed for population denominators with mental illness comorbidity	Process/ Outcome
10	Equity	Availability and distribution materials for shared decision-making, self-management, and recovery that are culturally relevant to populations in community being served	Structure

ACOVE Measures

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- RAND Health researchers developed ACOVE, the first set of quality measures specific to the vulnerable older adult population
- ACOVE measures aim to comprehensively evaluate the medical care provided to older persons with illness living in the community who are at increased risk of decline.
- Released in 2007, ACOVE 3:
  - Contains 392 quality indicators
  - Covers 26 different conditions
  - Includes 14 different types of care processes (e.g., taking a medical history or performing a physical exam)
  - Covers all four domains of care:
    - Screening and prevention (31% of QIs)
    - Diagnosis (20%)
    - Treatment (35%)
    - Follow-up and continuity (14%)

http://www.rand.org/health/projects/acove/acove3.html

Multidimensional Prognostic Index (MPI)

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- The MPI, calculated from information collected in a standardized comprehensive geriatric assessment, is effective in predicting the short- and long-term mortality risk among hospitalized elderly patients with dementia.
- The MPI has 8 domains and a total of 63 items

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2864495/

SF Questionnaires

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- The SF-36, SF-12, and SF-8 are multipurpose surveys that measure eight domains of health:
  - physical functioning
  - role limitations due to physical health
  - bodily pain
  - general health perceptions
  - vitality
  - social functioning
  - role limitations due to emotional problems
  - mental health
- The SF yields scale scores for each of these eight health domains, and two summary measures of physical and mental health: the Physical Component Summary (PCS) and Mental Component Summary (MCS)
- Available in standard (4-week) recall, acute (1-week) recall, and 24-hour recall
- VR-12 and VR-36 are similar instruments used in the Veterans Health System

http://www.iqola.org/instruments.aspx

Supports Intensity Scale

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- The Supports Intensity Scale (SIS) is an assessment tool that evaluates practical support requirements of a person with an intellectual disability.
- The SIS measures support requirements in 57 life activities and 28 behavioral and medical areas. The assessment is done through an interview with the individual and those who know the person well.
- SIS measures support needs in the areas of home living, community living, lifelong learning, employment, health and safety, social activities, and protection and advocacy.
- The scale ranks each activity according to *frequency* (none, at least once a month), *amount* (none, less than 30 minutes), and *type* of support (monitoring, verbal gesturing).
- Finally, a Supports Intensity Level is determined based on the Total Support Needs Index, which is a standard score generated from scores on all the items tested by the scale.

http://www.siswebsite.org/page.ww?section=Product+Info&name=Product+Info

World Health Organization QoL Measures

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- WHOQOL-DIS is an assessment of quality of life in physically or intellectually disabled people
  - This 12-item module can be used in conjunction with the World Health Organization Quality of Life Questionnaire (WHOQOL-100) or the shorter 26-item WHOQOL-BREF
  - Developed cross-culturally and tested in 12 locations worldwide

http://www.springerlink.com/content/9834t28641737x02/

PEONIES

- PEONIES stands for “Personal Experience Outcomes iNtegrated Interview and Evaluation System”
- Personal experience outcomes are the dreams, desires, hopes, wishes, goals, and preferences that each person has for him/herself
- Achievement of these personally desired outcomes are the essence of quality of life
- Developed by Sara Karon, PhD and other researchers at the University of Wisconsin—Madison, with extensive input from professional and consumer stakeholders
- Promotes use of **consumer-defined outcomes** in Medicaid’s managed long-term care services, including care planning, quality improvement, and quality assurance activities
- It is a single approach to measuring quality that can be used **across populations and across long-term care programs**
- PEONIES facilitates **individualized approaches to care planning and a standardized, reliable way to measure quality at the aggregate level**

http://www.chsra.wisc.edu/peonies/peonies_index.html

Personal Experience Outcomes Areas

CHOICE

- ❑ I decide where and with whom I live.
- ❑ I make decisions regarding my supports and services.
- ❑ I decide how I spend my day.

HEALTH AND SAFETY

- ❑ I have the best possible health.
- ❑ I feel safe.
- ❑ I am free from abuse and neglect.

PERSONAL EXPERIENCE

- ❑ I have relationships with family and friends I care about.
- ❑ I do things that are important to me.
- ❑ I am involved in my community.
- ❑ My life is stable.
- ❑ I am respected and treated fairly.
- ❑ I have privacy.

Using PEONIES

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- PEONIES uses semi-structured interviews to identify:
  - the outcomes desired by the individual in each area
  - whether those outcomes currently are achieved and if not, why not
  - the types of supports need to help the person maintain or achieve each outcome
  - the status of those necessary supports
- State's external quality review organization measures the above items during the plans' annual review process
- 25-30 consumers per managed care plan are sampled for assessment with the PEONIES tool
- When necessary, information is obtained from proxies and confirmed with the individual to the extent possible
- Interview conducted in person, lasts roughly 60 minutes
- Each Family Care and Wisconsin Partnership Program site receives a summary of the interview information results
- PEONIES could be automated and used more widely than it is currently, such as to assess nursing home residents

uSPEQ ® Consumer Experience Survey

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- The uSPEQ ® tool can be universally applied across the domain of health and human services organizations serving multiple patient/client/consumer populations
- Anonymous survey of consumers, some items are standardized and field-tested, others can be customized
- Four domains: access to services, the service process, how the program meets a person's needs, outcomes
- Grew out of work on performance indicators conducted by CARF International, an accreditor of health and human service providers
- The Veterans Health Administration will use uSPEQ to gather input from veterans regarding their satisfaction with VA's rehabilitation programs

http://www.uspeq.org/

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Workgroup Discussion and Questions

Discussion Questions

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- Could the measures and/or instruments presented fill any of the gaps identified by the workgroup?
- What other measures or measure sets should the group consider to fill gaps?
- How could point-in-time assessments be best translated into performance measures?
- What are the implications of considering a proprietary measure or tool for use?

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Opportunity for Public Comment

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Refine Recommendations and Path Forward

Input to MAP Coordinating Committee

- Final strategy and overarching recommendations
- Which example measures are most illustrative for use in the Interim Report?
  - Does the measure fit the vision and strategic approach to performance measurement?
  - Is the measure endorsed?
  - Is there an appropriate data source?
- Does the group have questions or a need for guidance from the Coordinating Committee?

Questions to Pose for Public Comment

A month-long public comment period will occur in October, following submission of the interim report to HHS.

What questions would the workgroup like to pose to external stakeholders during the public comment process?

1.

2.

3.

4.

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Workgroup Discussion and Questions

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Opportunity for Public Comment

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Summation

Flow of Information to Inform Reports

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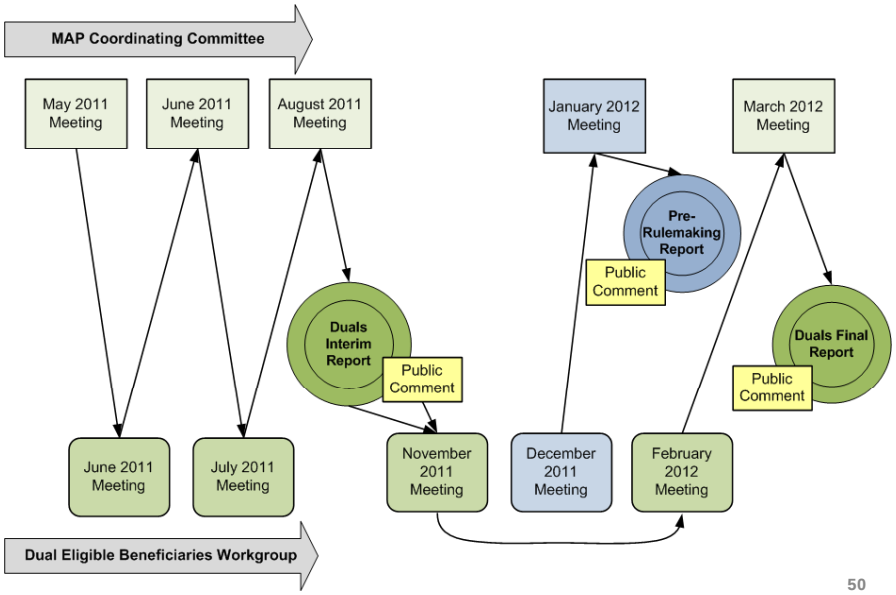

Next Meeting

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Dual Eligible Beneficiaries Workgroup
In-Person Meeting #3

November 15, 2011
Washington, DC

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Appendix

Dual Eligible Beneficiaries Workgroup Charge

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To advise the MAP Coordinating Committee on performance measures to assess and improve the quality of care delivered to Medicare/Medicaid dual eligible beneficiaries. The Workgroup will:

- Develop a strategy for performance measurement for this unique population and identify the quality improvement opportunities with the largest potential impact
- Identify a core set of current measures that address the identified quality issues and apply to both specific (e.g., Special Needs Plans, PACE) and broader care models (e.g., traditional FFS, ACOs, medical homes)
- Identify gaps in available measures for the dual eligible population, and propose modifications and/or new measure concepts to fill those gaps
- Advise the Coordinating Committee on a coordination strategy for measuring readmissions and healthcare-acquired conditions across public and private payers and on pre-rulemaking input to HHS on the selection of measures for various care settings

MAP Two-Tiered Structure

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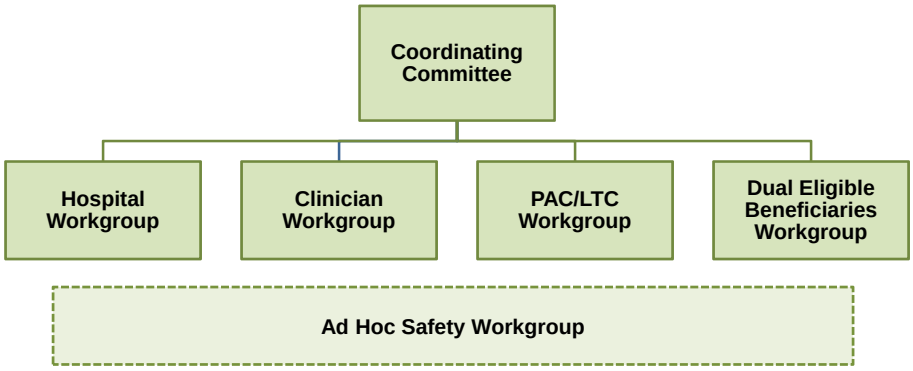

Dual Eligible Beneficiaries Workgroup Membership

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Chair	Alice Lind, MPH, BSN

Organizational Members	American Association on Intellectual and Developmental Disabilities	**Representatives**	Margaret Nygren, EdD
	American Federation of State, County and Municipal Employees		Sally Tyler, MPA
	American Geriatrics Society		Jennie Chin Hansen, RN, MS, FAAN
	American Medical Directors Association		David Polakoff, MD, MsC
	Better Health Greater Cleveland		Patrick Murray, MD, MS
	Center for Medicare Advocacy		Patricia Nemore, JD
	National Health Law Program		Leonardo Cuello, JD
	Humana, Inc.		Thomas James, III, MD
	LA Care Health Plan		Laura Linebach, RN, BSN, MBA
	National Association of Public Hospitals and Health Systems		Steven Counsell, MD
	National Association of Social Workers		Joan Levy Zlotnik, PhD, ACSW
	National PACE Association		Adam Burrows, MD

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Dual Eligible Beneficiaries Workgroup Membership

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Subject Matter Experts	Mady Chalk, PhD, MSW	Substance Abuse
	James Dunford, MD	Emergency Medical Services
	Lawrence Gottlieb, MD, MPP	Disability
	Juliana Preston, MPA	Measure Methodologist
	Susan Reinhard, PhD, RN, FAAN	Home and Community-Based Services
	Rhonda Robinson Beale, MD	Mental Health
	Gail Stuart, PhD, RN	Nursing

Federal Government Members	Agency for Healthcare Research and Quality	**Representatives**	D.E.B. Potter, MS
	CMS Medicare-Medicaid Coordination Office		Cheryl Powell
	Health Resources and Services Administration		Samantha Meklir, MPP
	HHS Office on Disability		Henry Claypool
	Substance Abuse and Mental Health Services Administration		Rita Vandivort-Warren, MSW
	Veterans Health Administration		Daniel Kivlahan, PhD

Coordinating Committee Co-Chairs	George Isham, MD, MS
	Beth McGlynn, PhD, MPP

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Membership Terms

NQF National Quality Forum

Chair	Term Length
Alice Lind, MPH, BSN	3

Organizational Members	Term Length
American Association on Intellectual and Developmental Disabilities	3
American Federation of State, County and Municipal Employees	1
American Geriatrics Society	2
American Medical Directors Association	2
Better Health Greater Cleveland	1
Center for Medicare Advocacy	1
National Health Law Program	3
Humana, Inc.	2
LA Care Health Plan	3
National Association of Public Hospitals and Health Systems	1
National Association of Social Workers	2
National PACE Association	1

Subject Matter Experts	Term Length
Mady Chalk, PhD, MSW	2
James Dunford, MD	2
Lawrence Gottlieb, MD, MPP	1
Juliana Preston, MPA	3
Susan Reinhard, PhD, RN, FAAN	3
Rhonda Robinson Beale, MD	3
Gail Stuart, PhD, RN	2

Federal Government Members	Term Length
Agency for Healthcare Research and Quality	1
CMS Medicare-Medicaid Coordination Office	1
Health Resources and Services Administration	3
HHS Office on Disability	2
Substance Abuse and Mental Health Services Administration	3
Veterans Health Administration	2

Suggested Measures and Measure Concepts: Care Coordination

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- ✓ Primary care visit within two weeks (and/or 30 days) of hospital discharge
- ✓ CAHPS ® Clinician Group Survey to Measure the Medical Home
- ✓ Physician Orders for Life-Sustaining Treatment (POLST) / Advance directives
- ✓ Medication reconciliation/review
- ✓ Improving or maintaining physical health (HOS)
- ✓ Access to primary care
- ✓ Integrated bio-psycho-social supports
- ✓ Established care team
- ✓ Shared problem list/plan of care with joint decision-making and frequent review
- ✓ Interagency discharge planning/Transitions
- ✓ Notification of Medicaid case manager within two days of hospital admission
- ✓ Connection to informal caregiver
- ✓ Caregiver counseling and support with financial, legal, medical affairs
- ✓ Pharmacist consult to increase adherence, reduce polypharmacy, and drug-drug interactions
- ✓ Transportation access

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Suggested Measures and Measure Concepts: Quality of Life

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- ✓ Depression remission at 6 and 12 months
- ✓ Change in daily activity function
- ✓ Long-stay residents whose need for help with ADLs has increased
- ✓ World Health Organization Quality of Life module for persons with disability (WHOQOL-DIS)
- ✓ CAHPS ® Nursing Home Survey
- ✓ SNF master patient index MPI 3.0
- ✓ Timeliness of services
- ✓ Tracking functional status at home
- ✓ Economic indicators
- ✓ Unplanned hospital or psych admissions
- ✓ Stress
- ✓ Community integration
- ✓ Involvement of informal caregivers
- ✓ Ability for surrogate decision-making
- ✓ Safety
- ✓ Ability to have choice /self-determination
- ✓ Palliative care / Pain management / Comfort
- ✓ Patient experience of care
- ✓ Person-centered planning and goal-setting
- ✓ Mobility
- ✓ Quality-Adjusted Life Years
- ✓ Access to community-based treatment and recovery services
- ✓ Living in the least restrictive/most independent environment
- ✓ Reduced delirium

Suggested Measures and Measure Concepts: Screening and Assessment

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- ✓ Fall risk screening (HRA/SF-12) and management
- ✓ Bio-psycho-social needs (MDS 3.0)
- ✓ Screening and brief intervention for substance use at least annually
- ✓ PHQ-2 or PHQ-9 (depression)
- ✓ GAD-7 (anxiety)
- ✓ Improving or maintaining mental health (HOS)
- ✓ Supports Intensity Scale (SIS) for ID/DD
- ✓ Screening and assessment for medical conditions, including preventive care
- ✓ HIV screening
- ✓ Family and community support
- ✓ Adaptive behavior scales
- ✓ Reduced need for crisis intervention and/or ER visits
- ✓ Access to medication
- ✓ Medication side effects
- ✓ Treatment preferences
- ✓ Advance directives
- ✓ Routinely assess skin condition and hydration for institutional residents
- ✓ Assess institutional residents for possible HCBS placement
- ✓ Screen for dementia in older adults
- ✓ Literacy screening for ability to understand written directions
- ✓ Screening for peritoneal dialysis and/or kidney transplant in ESRD population

Other Suggested Measures and Measure Concepts:

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- ✓ CAHPS ® for Medicaid HCBS
- ✓ ACOVE for vulnerable older adults
- ✓ Diabetes management
- ✓ Annual flu shot
- ✓ Skilled workforce
- ✓ Maintenance of outcomes
- ✓ Absence of medical and psychiatric adverse events
- ✓ Review of medical history for signs of abuse or negligence
- ✓ Use of “Project RED” concepts
- ✓ Home visits
- ✓ Effective care – USPSTF A and B recommendations
- ✓ Use of telemedicine and emerging technologies to promote self-care
- ✓ Chronic disease self-management
- ✓ Social services contacts/referrals
- ✓ Availability of caregiver respite
- ✓ Certification of provider ability to offer “Health Care Services for Individuals with Disabilities”
- ✓ Employment
- ✓ Cultural competency