Measure Applications Partnership Post-Acute/Long-Term Care Workgroup

Web Meeting

October 4, 2011

Agenda

10:30	Welcome
10:35	Finalize Core Measure Concepts for PAC/LTC Settings
10:55	Discuss Core Measure Concepts for LTCHs
11:05	Finalize Data Considerations
11:25	Next steps

Elements of a Coordination Strategy

- Measures and measurement issues
  - Measure selection criteria
  - Priority areas for measurement
  - Core measure sets for LTC (Nursing Home Compare) and PAC (Home Health Compare)
  - ➢ **Core measure concepts across PAC/LTC settings**
  - Identification of priority measure gap concepts
- ➢ **Data sources and HIT implications**
- Alignment
- Pathway for improving measure application

Finalize Core Measure Concepts Across PAC/LTC Settings

Short- and Long-Stay Nursing Facilities, Home Health Care, Inpatient Rehabilitation Facilities

Priority Areas for Measurement

- **Function**
  - Patient factors such as ADLs and stage of illness
  - Helps define population subsets for measurement
- **Goal Attainment**
  - Goals of care may be different across settings (e.g., improvement, maintenance, palliation)
- **Patient/Family Engagement**
- **Care Coordination**
  - Across settings of care and providers
  - Assessing how the system coordinates care
- **Safety**
  - Health risks
- **Cost/Access**
  - Total cost and attention to cost-shifting
  - Patients access to additional social supports (e.g., home and community based services)

Overall Themes of Survey Results

- Need to define terms
  - e.g., advance care planning, self care activation, avoidable, restorative, advanced illness
- Concerns about measure feasibility
  - Measure concepts that are difficult to quantify (e.g., shared decision making, quality of life)
  - Providers' ability to influence measure results (e.g., access to community supports)
- Individual measures addressing the measure concepts may need to vary based on stage of illness

Concepts with Strong Agreement

- Functional status assessment, maintenance, or improvement (100%)
- Establishment of patient goals (100%)
- Falls (100%)
- Infection rates (100%)
- Avoidable hospital readmissions (100%)
- Experience of care (94.8%)
- Inappropriate medication use (94.7%)
- Shared decision making in developing care plan (94.7%)

Concepts with Strong Agreement (cont.)

- Avoidable ED admissions (94.7%)
- Avoidable hospital admissions (94.7%)
- Advanced care planning (94.7%)
- Pressure ulcers (94.7%)
- Attainment of patient goals (89.5%)
- Adverse drug events (89.5%)
- Discharge planning (89.4%)

Concepts with Weak Agreement

- Unnecessary services (58.8%)
  - Difficult to define
  - Limited evidence-base to support measures
- Staffing turnover (61.1%)
  - Consider substituting with staffing level
  - Require improved data integrity and timeliness for measurement
  - Consider assessing the effectiveness of the providers practices to reduce the turnover rate
- Appropriate level of care selected (63.2%)
  - Difficult to measure
  - Needs to incorporate patient goals
  - Process measure, should focus on related outcome measures (e.g., avoidable ED/hospital admissions)

Concepts with Weak Agreement (cont.)

- Access to community supports (68.4%)
  - Providing information on community support may be better measure; rural areas may not have community supports
  - Not actionable by providers, should be assessed at community or national level
- Mental health assessment (68.4%)
  - Need to go beyond assessment, measure if assessment is being appropriately acted on
- Timeliness of initiation of care (73.7%)
  - Need to clarify; define as timeliness in next setting
- Restorative care management (73.7%)
  - Need to clarify
  - Not core, does not apply to all settings

Concepts with Moderate Agreement

- Family/caregiver preparedness and support (78.9%)
- Family/caregiver burden assessment (79%)
- Cognitive status assessment (79%)
  - Need to go beyond assessment; measure if assessment is being appropriately acted on
- Quality of life (79%)
- Self-care activation (83.4%)
  - Need to clarify the definition
  - Self-care activation may not apply to people with cognitive or mental impairment
- Advanced illness care management (84.2%)
  - Need to clarify the definition of advanced illness
  - Difficult to identify the population with advanced illness
  - Advanced illness population is heterogeneous, requiring different measures
  - Better used as an internal performance monitoring and improvement tool rather than for accountability purposes; prefer goal setting and goal attainment measures
- Timely and bi-directional communication during transitions (84.3%)

Additional Considerations for Core Concepts

- Include measures that identify cost-drivers
  - Risk-adjusted cost per hospitalization
  - Risk-adjusted cost per level of goal attainment for comparable episodes of care
- Avoidable mortality
- Consider adding measures that address public health or prevention (e.g., immunizations)
- Pain and symptom management

Core Concepts Applicable to LTCHs

- Function
  - Cognitive Status Assessment
- Goal Attainment
  - Establishment of patient goals
  - Attainment of patient goals- focus on monitoring and readjusting goals
  - Advanced care planning
- Patient/Family Engagement
  - Experience of care
  - Family/caregiver burden assessment (for those discharged home)
  - Family/caregiver preparedness and support (for those discharged home)
- Care Coordination
  - Discharge planning
  - Timely and bi-direction communication during transitions
- Safety
  - Pressure Ulcers
  - Falls
  - Adverse drug events
  - Infection rates
  - Avoidable ED admissions, hospital admissions, readmissions- focus on unplanned admissions

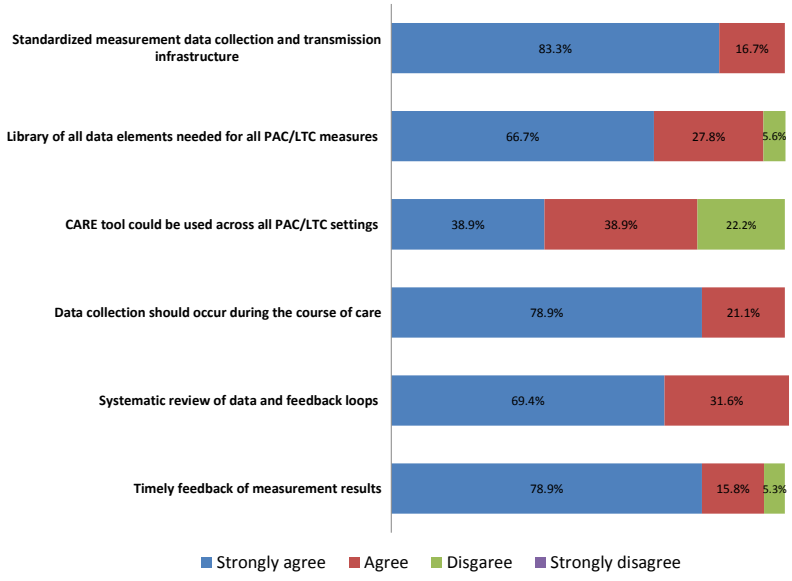
Discussion

Data Considerations

Data Considerations

- A **standardized measurement data collection and transmission infrastructure** is needed across all payers and settings to support data flow and reduce data collection burden.
- A **library of all data elements needed for all PAC/LTC measures** should be created and maintained.
- The **CARE tool could be used across all PAC/LTC settings** to support the development of a library of standardized data elements, to standardize data collection, and to facilitate the flow of information across settings.
- **Data collection should occur during the course of care**, when possible, to minimize burden and maximize the use of data in clinical decision making.
- **Systematic review of data and feedback loops** should be implemented to ensure data integrity and to inform continuous improvement of data validity and measure specifications.
- **Timely feedback of measurement results** is imperative to support improvement, inform purchaser and consumer decision making, and monitor cost shifting.

Survey Results



Comments on the CARE Tool

- Ensure that the tool replaces, not duplicates, current tools
- Field-testing and evaluation to demonstrate broad applicability
- Should be HIT enabled
  - Interoperable with EHRs and other settings
  - Rapid information exchange needed for care coordination and communication
  - Efficient alternative methods for providers without EHR
- Ability to generate care plans and link to decision support tools

Discussion

Next Steps

- Week of October 17: Draft PAC-LTC coordination strategy report to PAC-LTC Workgroup and Coordinating Committee
- November 1-2: Coordinating Committee review of PAC-LTC coordination strategy report; comments from PAC-LTC Workgroup due
- Mid-November: Public comment on PAC-LTC coordination strategy report