QUALITY OVERVIEW

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The Institute of Medicine (IOM) of the National Academy of Sciences defines quality health care as “safe, effective, patient-centered, timely, efficient and equitable.”

The Agency for Healthcare Research and Quality (AHRQ), defines quality health care “as doing the right thing for the right patient, at the right time, in the right way to achieve the best possible results.”
Quality problems fall into three broad categories:

1. Underuse – medically necessary care not received
2. Misuse - each year, more than 100,000 Americans get the wrong care and are injured as a result
3. Overuse - care that is not needed or for which there is an equally effective alternative that costs less money or causes fewer side effects
Americans receive appropriate, evidence-based care when they need it only 55 percent of the time

As many as 91,000 Americans die each year because they don’t receive the right evidence-based care for such chronic conditions as high blood pressure, diabetes and heart disease

Nearly 90,000 people die every year, at least in part because of an infection contracted while in the hospital
HOW DO WE MEASURE QUALITY?

1. **Measure processes of care.** For example, is a patient with diabetes getting his eyes examined when he should?

2. **Measure outcomes of care.** Is a knee surgery patient walking well following physical therapy?

3. **Measure the experience of patients and their family members.**
The Health Plan Employer Data and Information Set (HEDIS®)

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

ORYXTM: a program for measuring the performance of hospitals, nursing homes, home care agencies and mental health care providers

The Medicare Health Outcomes Survey (HOS) is used to assess the physical and mental well-being of people enrolled in managed care plans.
QUALITY MEASURES

- Meaningful Measures
- Clearly Defined Performance Measures
- Mutually Agreed Upon Performance Measures
- Accurate And Reliable Data Collection
- Replicable Across Populations
QUALITY MEASURES

- Compliance with Regulatory Requirements
- Care Specific
- Timely Intake
- Timely Assessments
- Fall Prevention
QUALITY MEASURES
RESOURCE UTILIZATION

- Avoidable Hospitalizations
- Hospital Readmissions
- Emergency Room Utilization
- Outcome measures related to person-centered care planning and delivery
Basis for Pay for Performance
- Pay for Performance (P4P) is an incentive payment methodology in which a payer (usually a health plan) establishes a budget around selected quality and compliance benchmarks (criterion) and then rewards providers who meet or exceed the performance benchmarks through payment of financial incentives.

Value Based Purchasing (VBP)
- Value-based purchasing is a demand-side strategy to measure, report, and reward excellence in health care delivery. VBP aligns quality performance measures with reimbursement strategies.
TRIPLE AIM

- Improvement in the health of populations

- Improvement in the individual experience of care

- Reduction of the per capita costs of care
Questions?
CAADS
QUALITY IMPROVEMENT COMMITTEE

Lydia Missaelides
Executive Director
Definitions

- **Outcome**: Measured evidence of a desired change

- **Indicator**: Information that contributes to evidence of an outcome
Guiding Principles for Outcomes

1. Relevant to the setting and persons served

2. Measureable by use of a tool or counting
   - Measurement must be:
     - Standardized
     - Meaningful
     - If a frequency (count) must be easily available to obtain and count

3. Resources used must be proportional to value of measure (cost/benefit)

4. Standardized tools must also be:
   - Validated and reliable
   - Non-proprietary
   - Easy to use
   - Appropriate to population, age, and conditions
   - Culturally appropriate
## Indicator Example: Counting

<table>
<thead>
<tr>
<th>Indicator and why selected</th>
<th>Measured by</th>
<th>Frequency or percentage</th>
<th>Target</th>
</tr>
</thead>
</table>
| **Check for Excluded Providers** | Evidence of procedure for checking OIG’s Excluded Providers list | Numerator: # of times checked annually  
Denominator: calendar quarters (4) | Target = 100%  
4/4 |
| Regulatory: CMS requirement | http://exclusions.oig.hhs.gov/ | |
| **Turnover Rate** | Number of total staff compared to staff departures, excluding involuntary terminations, furloughs, and layoffs. | Numerator: Number of paid staff who leave in 12 months.  
Denominator: Number of staff positions during same period.  
Example: 2/8 = .25 x 100 = 25% turnover | Target = 20% (?) |
<table>
<thead>
<tr>
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<th>Measured by</th>
<th>Frequency or percentage</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Care plan developed with involvement by participant and/or caregiver.</strong></td>
<td>Care plans are reflective of the participant or caregiver stated values and desires as documented in the assessment process.</td>
<td><strong>Numerator:</strong> Number of care plans that document the inclusion of the participant (or caregivers) and their values and desires.</td>
<td><strong>Target = 100%</strong></td>
</tr>
<tr>
<td><strong>Regulatory:</strong> 1115 Waiver STC 96(c)</td>
<td>Best practice will include methods for asking about preferences and values beginning at intake. (“getting to know me or 20 questions”)</td>
<td><strong>Denominator:</strong> Total number of care plans.</td>
<td></td>
</tr>
<tr>
<td>SOP F WIC 14529(d)(2) T-22</td>
<td>“Tell me more” approach.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCR Section 54211(b)(2)</td>
<td>For non-verbal people, there are best practices for eliciting responses.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Participant Scorecard

<table>
<thead>
<tr>
<th>PHYSICAL HEALTH STATUS</th>
<th>YOUR CENTER</th>
<th>ALL CENTERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Utilization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participants w/ ER Visits</td>
<td>13% (4/31)</td>
<td>20% (76/374)</td>
</tr>
<tr>
<td>Participants w/ Hospitalizations</td>
<td>15% (5/34)</td>
<td>21% (78/371)</td>
</tr>
<tr>
<td>Avg Dr Visits per Participant</td>
<td>1.25</td>
<td>3.35</td>
</tr>
<tr>
<td>Health Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swallowing Problem</td>
<td>13% (8/61)</td>
<td>12% (40/336)</td>
</tr>
<tr>
<td>Systolic BP&gt;140</td>
<td>6% (2/32)</td>
<td>23% (59/260)</td>
</tr>
<tr>
<td>Diastolic BP&gt;90</td>
<td>0% (0/28)</td>
<td>4% (10/254)</td>
</tr>
<tr>
<td>Moderate to High Pain (&gt;2)</td>
<td>67% (12/18)</td>
<td>19% (73/392)</td>
</tr>
<tr>
<td>Health Risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 or More Meds</td>
<td>42% (26/62)</td>
<td>25% (116/461)</td>
</tr>
<tr>
<td>High Risk of Falling</td>
<td>22% (15/69)</td>
<td>21% (94/441)</td>
</tr>
<tr>
<td>Nutritional Risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td>34% (22/64)</td>
<td>35% (147/419)</td>
</tr>
<tr>
<td>High</td>
<td>23% (15/64)</td>
<td>43% (179/419)</td>
</tr>
<tr>
<td><strong>PSYCHO-SOCIAL STATUS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Possible</td>
<td>37% (17/46)</td>
<td>31% (89/289)</td>
</tr>
<tr>
<td>Severe</td>
<td>4% (2/46)</td>
<td>5% (14/289)</td>
</tr>
<tr>
<td>Moderate to High Loneliness</td>
<td>39% (18/46)</td>
<td>33% (91/278)</td>
</tr>
</tbody>
</table>
Key Community Based Health Home System Outcome Results

For a 12-month cohort\(^1\) with 5 significant outliers removed (N=55):

1. Emergency Department visits were reduced by 23.6%

2. Hospital admissions were reduced by 24.1%

3. 30-day readmission rate was only 1.8% compared to national average of 20%\(^2\).

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\(^1\) Cohort included persons with 12 consecutive months of CBHH service during the years 2012-2014

Each person served as their own control, ie, pre and post CBHH intervention data were compared

CBHH Intervention Showed Hospital Admissions Reduced by 24.1%

Hospital Costs (in Millions)

- Hospital Admissions in the year prior to CBHH admission were **0.29** pmpy (approximately $11.9M† in costs)
- Hospital Admissions in the year subsequent to CBHH admission were **0.22** pmpy (approximately $8.9M‡ in costs)

$\text{Pre-CBHH} = \$11.9$

$\text{Post-CBHH} = \$8.9$

$\text{†Hospital Admissions pmpy (.29) x Membership (4,888) x Hospital Admit Cost ($8,378) \approx \$11.9M}$

$\text{‡Hospital Admissions pmpy (.22) x Membership (4,888) x Hospital Admit Cost ($8,378) \approx \$8.9M}$
1. Internal Continuous Quality Improvement (Plan, Do, Study Act)
2. Benchmarking across sites
3. Regulatory/contractual compliance
4. Value-based purchasing
5. Risk reduction
Related National Efforts

- National Adult Day Services Association
- National Quality Forum: HCBS quality measures
- CMS: TEFT HCBS assessment
- HSRI: National Core Indicators (NCI)
- HSRI: A-NCI (i.e., Aging NCI)
- ONC: eLTSS initiative (this is not measure related but will likely coincide)
- Academy Health: LTSS interest group (?)
- ACL Administration for Community Living