

# HCBS Quality Measures Summit

June 17, 2014



# Data Element Uniformity and Cross Setting Quality Measures



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# Data Assessment Elements Goal

When we keep in mind the ultimate goal of  
quality care for all

and step back to look at the big picture of what's  
been done to prepare, it becomes clearer where  
the work converges; how much of the work is  
connected and has already been done to achieve  
quality care for all

*Achieving Uniformity to Facilitate Effective Communication for  
Better Care of Individuals and Communities*

# CARE: Background

- **2000: Benefits Improvement & Protection Act (BIPA)**
  - mandated standardized assessment items across the Medicare program, to supersede current items
- **2005: Deficit Reduction Act (DRA)**
  - Mandated the use of standardized assessments across acute and post-acute settings
  - Established Post-Acute Care Payment Reform Demonstration (PAC-PRD) which included a component testing the reliability of the standardized items when used in each Medicare setting
- **2006: Post-Acute Care Payment Reform Demonstration requirement:**
  - Data to meet federal HIT interoperability standards

# CARE: Concepts

## Guiding Principles and Goals:

### Assessment Data is:

- Standardized
- Reusable
- Informative
- Communicates in the same information across settings
- Ensures data transferability forward and backward allowing for interoperability

### Standardization:

- Reduces provider burden
- Increases reliability and validity
- Offers meaningful application to providers
- Facilitates patient centered care, care coordination, improved outcomes, and efficiency
- Fosters seamless care transitions
- Evaluates outcomes for patients that traverse settings
- Allows for measures to follow the patient
- Assesses quality across settings, and Inform payment modeling

# Current State

- Data, Document and Transmission: A value stream for convergence
  - **Patient and Resident Assessments uniform only at the provider- type level**
  - Communication **not standardized**
  - Care Communication: **Gap**
  - Providers **double document/triple document**
  - Assessment Data **not interoperable**
  - **Data elements** don't map exactly across settings
    - Reliance on cross walks
  - **Quality measures only measure quality in one setting**
  - Quality Measures lack harmonization

# Building the Future State

- Assessment Instrument/Data Sets **use uniform and standardized items**
- **Quality Measures are harmonized at the Data Element level**
- Providers/vendors have **public access to standards**
- **Data Elements are easily available with national standards** to support PAC health information technology (IT) and care communication
- **Transfer of Care Documents** are able to **incorporate uniform Data Elements** used in PAC/HCBS settings, if desired
- Quality Measures can evaluate quality across settings and longitudinally

# Keeping in Mind, the Ideal State

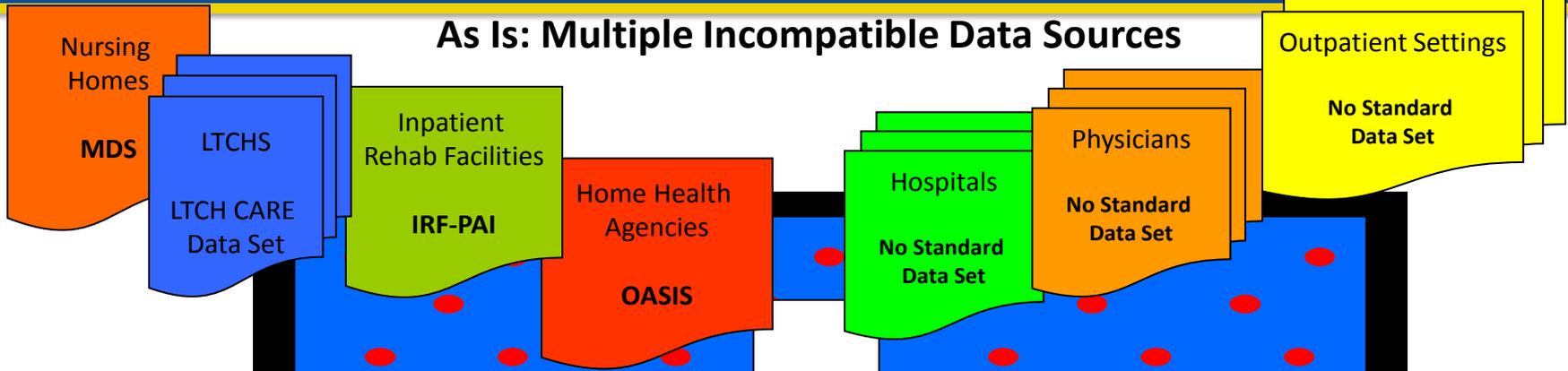
- Facilities are able to transmit electronic and interoperable Documents and Data Elements
- **Provides convergence** in language/terminology
- Data Elements used are **clinically relevant**
- Care is coordinated using **meaningful information** that is spoken and **understood by all**
- Measures **can evaluate quality across settings and evaluate intermittent and long term outcomes**
- **Measures follow the person**
- **Incorporates needs beyond healthcare system**

As Is

Transition

To Be

### As Is: Multiple Incompatible Data Sources



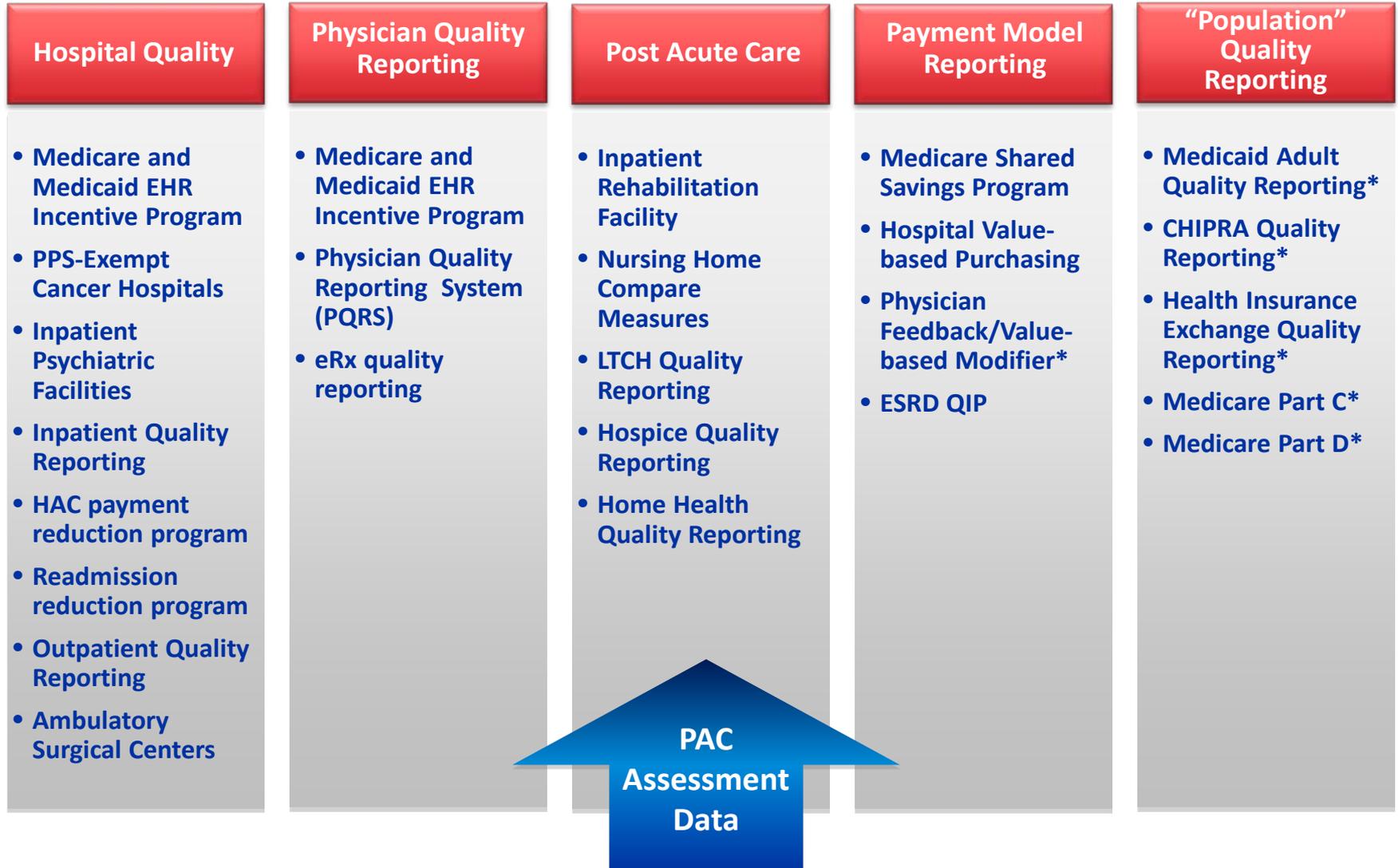
GOAL:

Uniform Data Elements  
*Across Providers*  
Standardized  
Nationally Vetted

### To Be: Uniform Assessment Data Elements

- ✓ Enable Use/re-use of Data
  - Exchange Patient-Centered Health Info
  - Promote High Quality *Care*
  - Support Care Transitions
  - Reduce Burden
  - Expand QM Automation
  - Support Survey & Certification Process
  - Generate CMS Payment

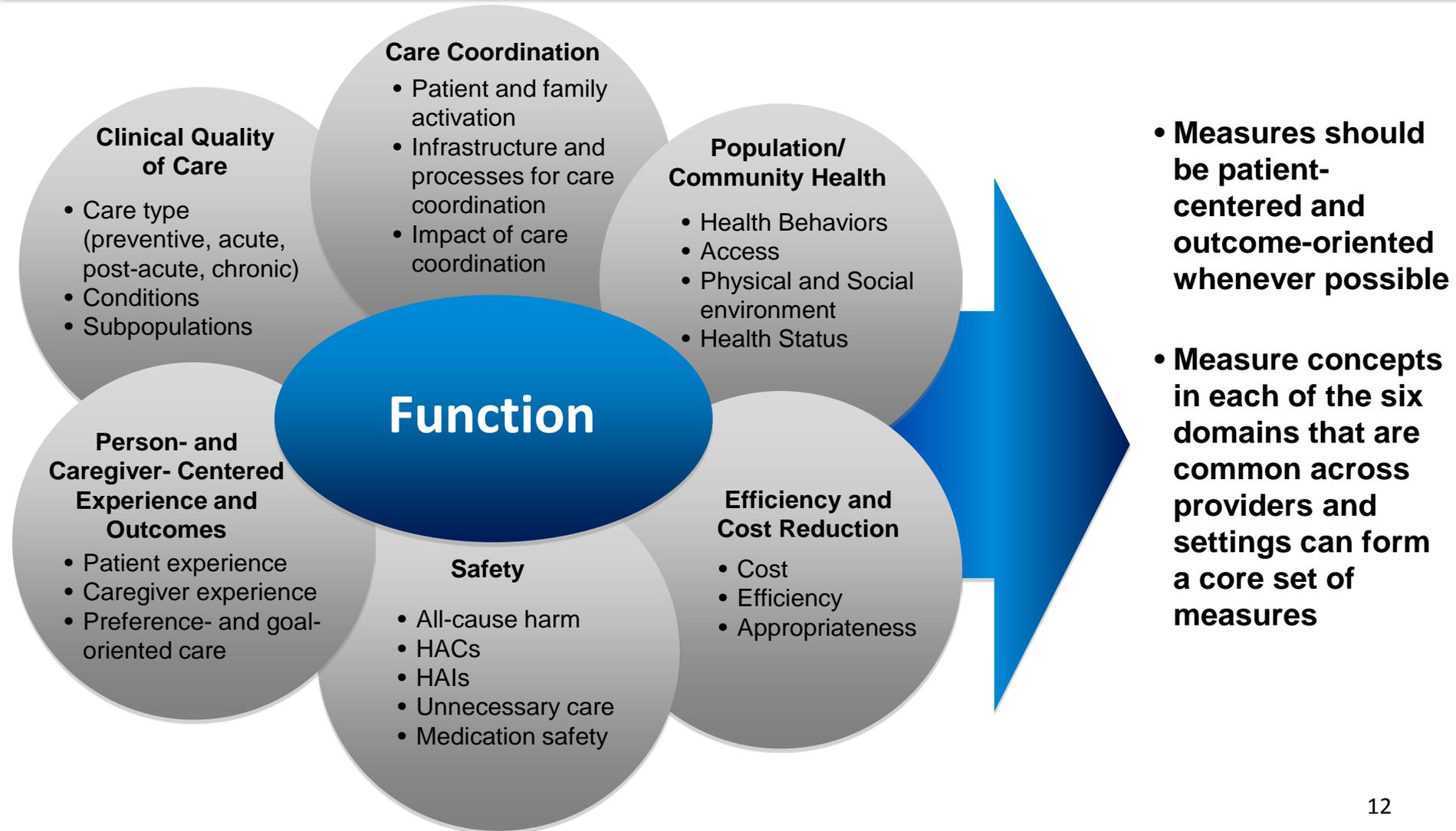
# CMS' Quality Reporting and Performance Programs



# CMS Vision for Quality Measurement

- Align measures with the **National Quality Strategy and Six Measure Domains**
- Implement measures that **fill critical gaps** within the six domains
- Develop parsimonious sets of measures - **core sets of measures**
- Remove measures that are no longer appropriate (e.g., topped out)
- Align measures with external stakeholders, including private payers and boards and specialty societies
- Continuously improve quality measurement over time
- **Align measures across CMS programs whenever and wherever possible**

# CMS Framework for Measurement



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

- Bi-partisan bill introduced in March, U.S. House & Senate
- Requires Standardized Patient Assessment Data that will enable Medicare to:
  1. Compare quality across PAC settings
  2. Improve hospital and PAC discharge planning
  3. Use this information to reform PAC payments (via site neutral or bundled payments or some other reform) while ensuring continued beneficiary access to the most appropriate setting of care.
- Patient Assessment Data Requirement for **Inpatient Hospitals** (medical condition, functional status, cognitive function, living situation, access to care at home, and any other indicators necessary for assessing patient need)

# Definitions of Concepts



**Section G****Functional Status****G0120. Bathing**

How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (**excludes** washing of back and hair). Code for **most dependent** in self-performance and support.

Enter Code

**A. Self-performance**

0. **Independent** - no help provided
1. **Supervision** - oversight help only
2. **Physical help limited to transfer only**
3. **Physical help in part of bathing activity**
4. **Total dependence**
8. **Activity itself did not occur** or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

Enter Code

**B. Support provided**

(Bathing support codes are as defined in item **G0110 column 2, ADL Support Provided**, above)

**G0300. Balance During Transitions and Walking**

After observing the resident, **code the following walking and transition items for most dependent**

**Coding:**

0. **Steady at all times**
1. **Not steady, but able to stabilize without staff assistance**
2. **Not steady, only able to stabilize with staff assistance**
8. **Activity did not occur**

**Enter Codes in Boxes****A. Moving from seated to standing position****B. Walking** (with assistive device if used)**C. Turning around** and facing the opposite direction while walking**D. Moving on and off toilet****E. Surface-to-surface transfer** (transfer between bed and chair or wheelchair)**G0400. Functional Limitation in Range of Motion**

**Code for limitation** that interfered with daily functions or placed resident at risk of injury

**Coding:**

0. **No impairment**
1. **Impairment on one side**
2. **Impairment on both sides**

**Enter Codes in Boxes****A. Upper extremity** (shoulder, elbow, wrist, hand)**B. Lower extremity** (hip, knee, ankle, foot)**G0600. Mobility Devices****Check all that were normally used****A. Cane/crutch****B. Walker****C. Wheelchair** (manual or electric)



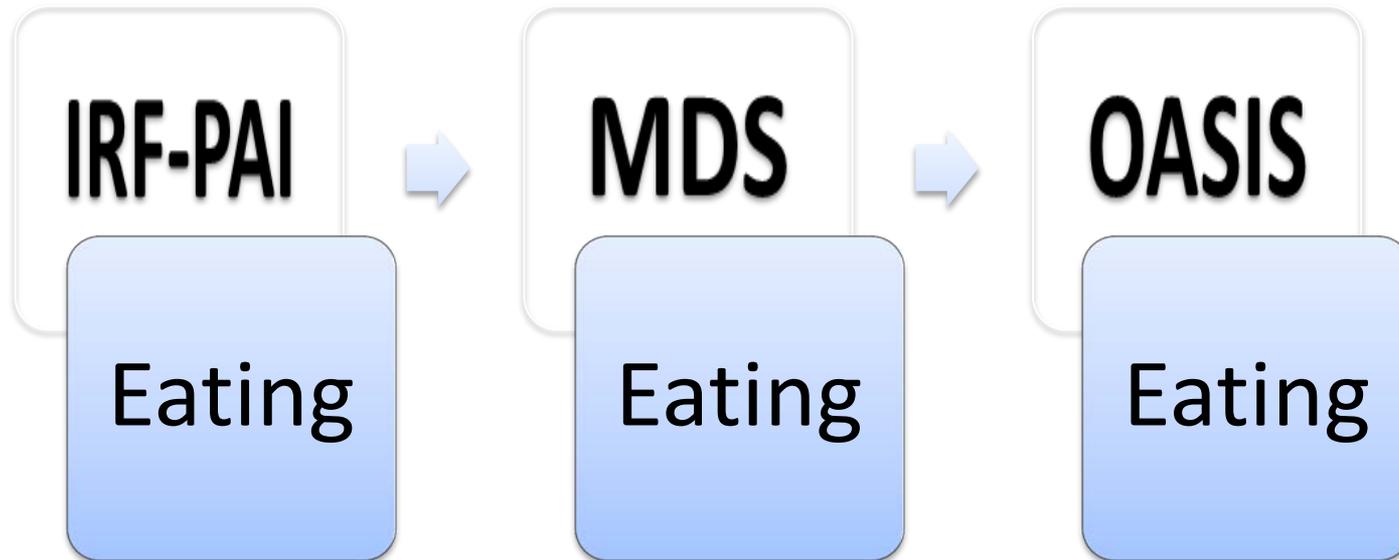
# Functional Status

- Function is a measurement area that touches on all 6 Priorities.
- Functional status is relevant to all settings:
  - High priority to consumers
  - Specialized area of care provided by post-acute care providers, including IRFs, LTCHs, SNFs, and HHAs
  - Long term outcomes link to function
- Functional Status data are collected by post acute care providers for payment and quality monitoring: IRFs (payment), SNFs (payment), LTCHs (risk adjustor for quality) and HHAs (payment and quality).
- However, functional status data are currently setting-specific and are not easily compared.

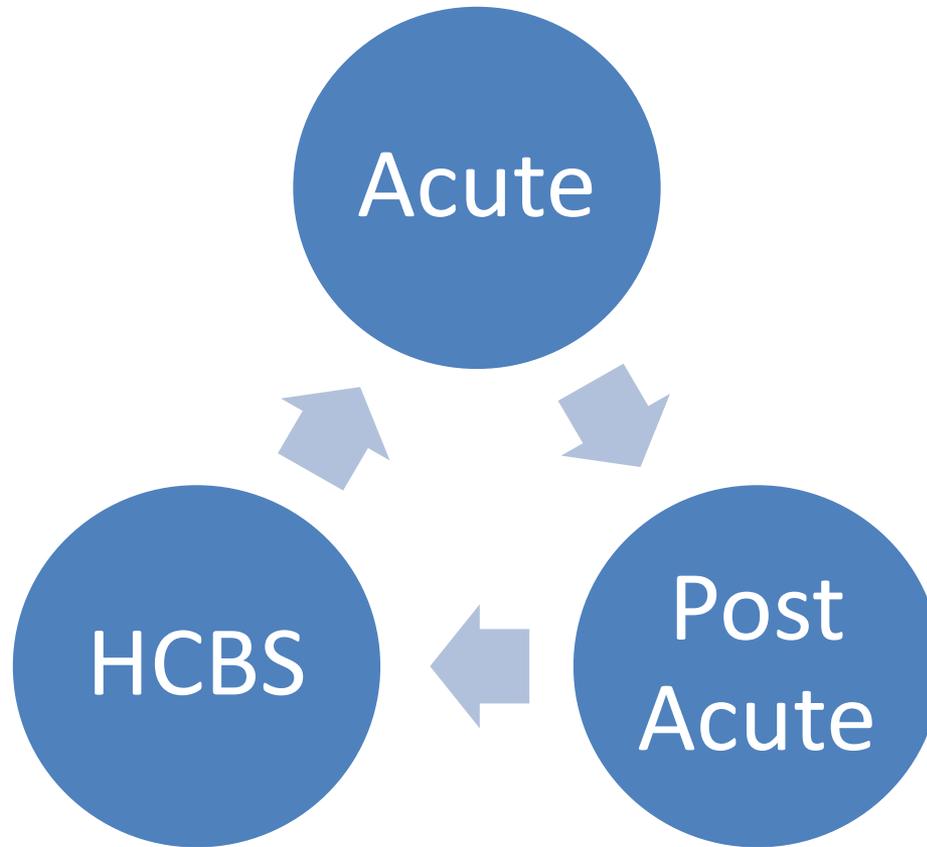
# Measures in Development

- **IRF** Functional Outcome Measure: Change in self-care score for medical rehabilitation patients.
- **IRF** Functional Outcome Measure: Change in mobility score for medical rehabilitation patients.
- **IRF** Functional Outcome Measure: Discharge mobility score for medical rehabilitation patients.
- **IRF** Functional Outcome Measure: Discharge self-care score for medical rehabilitation patients.
- Percent of **LTCH** patients with an admission and discharge functional assessment and a care plan that addresses function.
- **LTCH** Functional Outcome Measure: Change in mobility among patients requiring ventilator support.

# Standardizing Function At The Item Level



# Longitudinal Measure Alignment



**CMS Vision: Align measures across CMS programs whenever and wherever possible.**

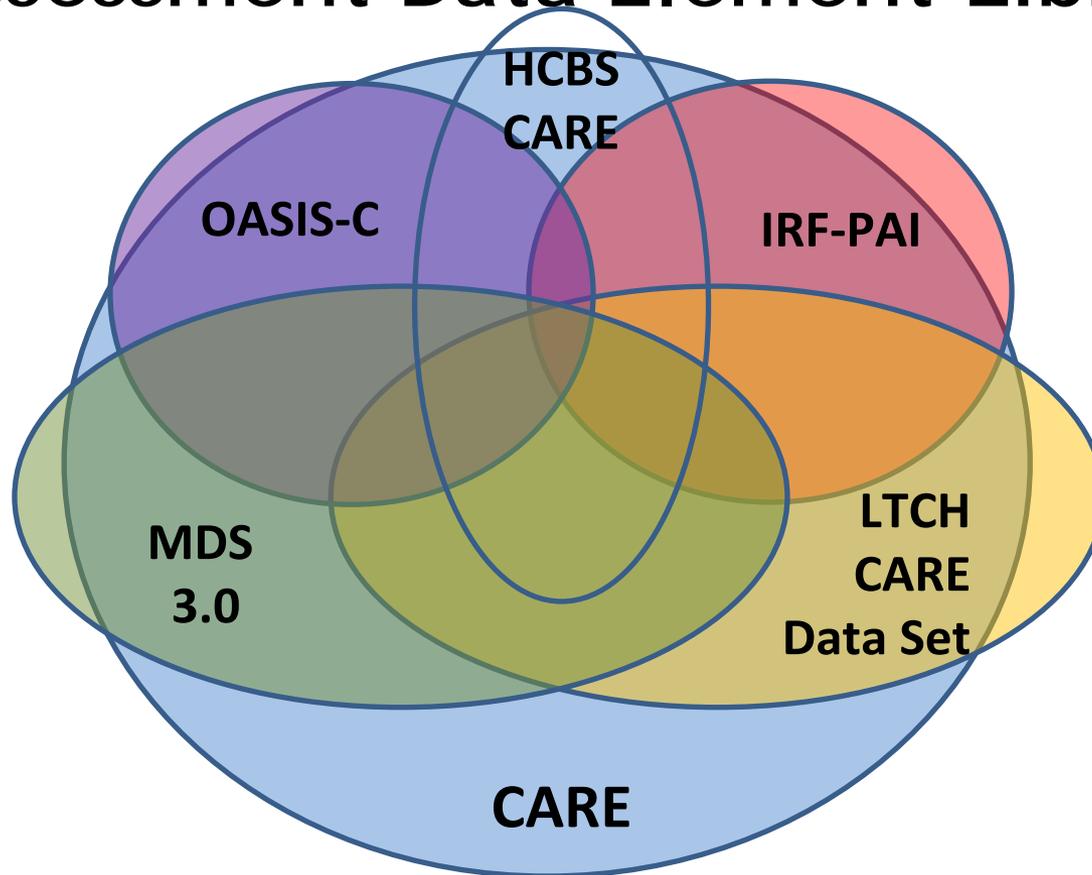
# Functional Status Quality Measures

- Data collection using the CARE Item Set occurred as part of the Post Acute Care Payment Reform Demonstration and included 206 acute and PAC providers

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/CARE-Item-Set-and-B-CARE.html>

# CMS Library Concept & CARE

## CMS Assessment Data Element Library

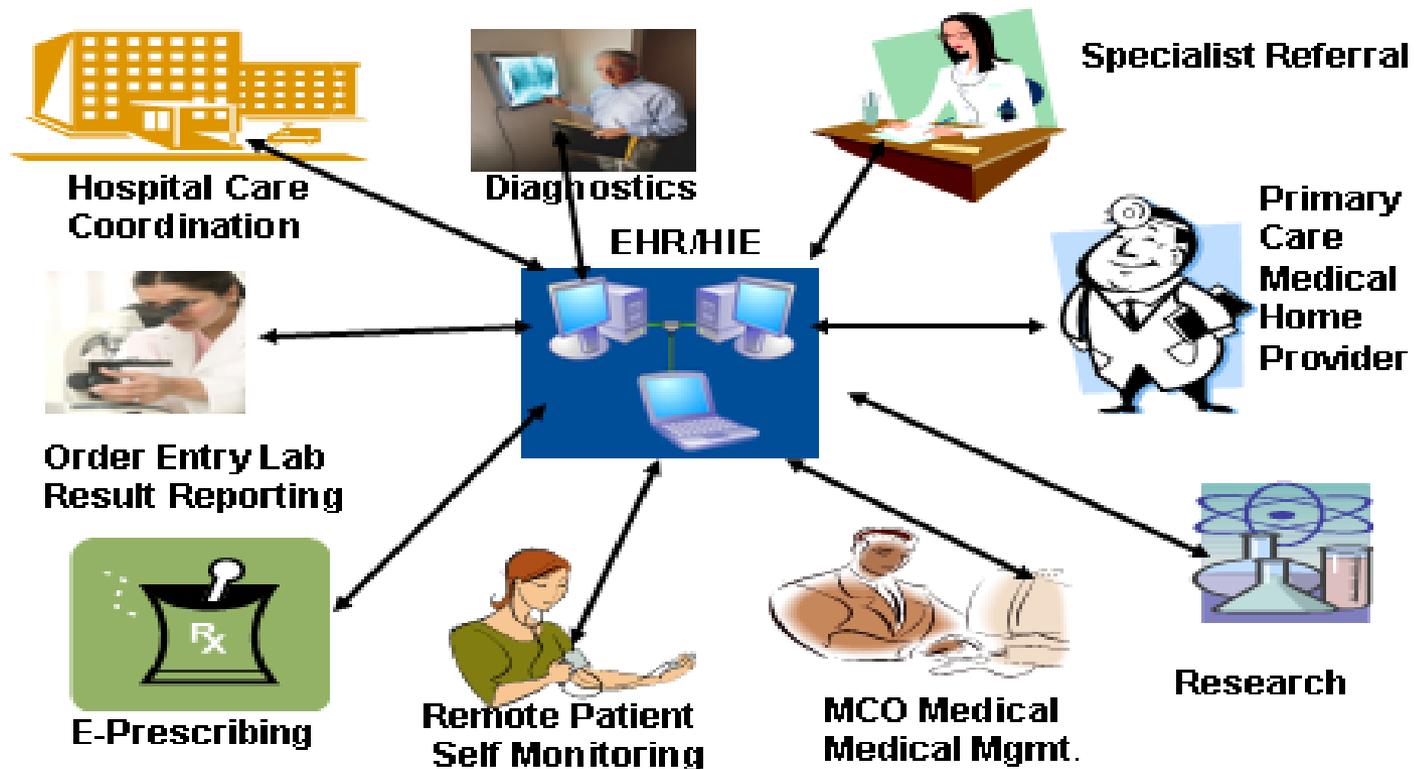


# CMS Vision for Quality Measurement

- Align measures with the **National Quality Strategy and Six Measure Domains**
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# CMS Vision for MU

## The E-Health Connected Medicaid Health System





# TEFT Grant Program – Addresses the Vision

## Four Components of TEFT

- Test an experience of care survey
- **Test a set of data elements from the functional domain in the Continuity Assessment Record & Evaluation (CARE)**
- Demonstrate personal health records with guidance from the Department of Defense (DoD)
- Identify, evaluate and harmonize standards for electronic long term services and supports (e-LTSS) records in conjunction with the Office of National Coordinator's (ONC) Standards and Interoperability (S&I) Framework

# Expansion of CARE to CB-LTSS

## Goals for expanding CARE items to CB-LTSS:

- Standardizes assessment concepts across populations and settings of care
- Supports person centered care through transitions
- Facilitates quality monitoring across providers and settings
- Leverages existing standards developed for the interoperable exchange of CARE items, specifically function
- Achieves other administrative benefits such as
  - Aligns with Balancing Incentive Program (BIP) requirements
  - Reduces costs to develop assessment tools
  - Reduces data collection burden
  - Increases ability to report data to CMS
  - Supports bundled payment initiatives

# Resources

- Data collection using the CARE Item Set occurred as part of the Post Acute Care Payment Reform Demonstration and included 206 acute and PAC providers  
<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/CARE-Item-Set-and-B-CARE.html>
- [link to the page that has details on the IRF and LTCH measures](#)
- <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Grant-Programs/TEFT-Program-.html>



# 1915(c) Waiver Quality Requirements



**Dianne Kayala, Technical Director**



Division of Long Term Services and Supports  
Disabled and Elderly Health Programs Group  
Center for Medicaid and CHIP Services



# HCBS Statutory Requirements

- 1915(c) HCBS Assurances/Expectations
  - Administrative Oversight
  - Level of Care
  - Provider Qualifications
  - Service Planning
  - Health and Welfare
  - Fiscal Accountability
- Form the basis for HCBS quality monitoring
  - States define performance measures for each area

# Improvements Made in 2014

Collaboration with State Associations, states and NQE resulted in March 12, 2014 Bulletin:

Key Changes:

1. Health and welfare monitoring and outcomes are emphasized;
2. Although states must continue to remediate issues, the reporting on individual remediation to CMS will not be required except in substantiated instances of abuse, neglect or exploitation; and
3. States' quality improvement projects/remediation will be required when the threshold of compliance with a measure is at or below 85%.
4. Quality measures of multiple 1915(c) waivers may be combined when waivers are similar

# For Further Information

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# National Core Indicators

Jamie Kendall, Director Special Projects

Center on Aging and Disability Policy

Administration for Community Living

June 17, 2014



# NCI Overview

- Provides information to appraise service system performance, including the extent to which critical outcomes are being achieved.
- Provides an universal evaluation tool that measures whether or not services improve the lives of consumers and allow them to stay in their homes and communities longer.
- Very few tools available that are designed to both measure the consumers' quality of life and help state leaders compare their state's systems performance against other states' performance.
- NCI is a quality benchmarking tool that provides a voice for the consumer and caregiver. It is the only known tool that is validated for id-dd populations including non verbal and populations with cognitive disability (because proxy is allowed).
- NCI is a good tool through state system changes and reforms, including those moving to MLTSS.

# NCI Overview

- NCI is a performance measurement system that enable states to make policy and funding decisions to support practices that work for people.
- Launched in 1997 in 13 participating states now has 40 states (including D.C.) and 22 sub-state regions and
- counties participate
- Data collected annually on 12,000-20,000 people and includes 17-year database
- Collaboration between NASDDDS – HSRI – participating state DD agencies
- Expanding to physical disabilities and aging populations with NASUAD and HSRI – piloting in three states

# NCI Data Sources and Uses

## Sources:

- Consumer and Family Surveys
- Collects information on performance management

## Uses:

- Quality Assurance and Service Improvement
- Meet CMS Waiver Reporting Requirements
- Compare performance to other states
- Public Accountability – to elected officials, stakeholders and the public

# Resources

Interactive Website:

[www.nationalcoreindicators.org](http://www.nationalcoreindicators.org)

NCI for Aging and Physical Disabilities:

<http://www.nasuad.org/initiatives/national-core-indicators-aging-and-disabilities>

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# **MLTSS Measures**

Debbie Dombrowski, Technical Director  
CMCS/DEHPG



# Development

- Used contract resources, Mathematica and NCQA, to develop a set of technical specifications for three groups of measures tailored to LTSS delivered in managed care plans
- Convened a technical expert panel comprised of a wide group of stakeholders to determine which measures to use and what elements should be included in the measures
  - June and August 2013

# Revision of Existing Measures

- Revised existing HEDIS and PQRS measures to be more encompassing of enrollees using LTSS

NCQA Measures	PQRS Measures
Functional Status Assessment	Screening for Clinical Depression and Follow up Plan
Pain Assessment	Reducing Falls Risk: Screening, Assessment, and Plan of Care
Medication Review	
Medication Reconciliation Post-Discharge	
Cervical Cancer Screening	
Chlamydia Screening in Women	

# Creation of New Measures

Assessment & Care Planning	Institution Utilization and Transition
Assessment Composite	Admission to an Institution from the Community
Care Plan Composite	Successful Discharge to the Community after Short-Term Institution Stay
Share Care Plan	Successful Discharge to the Community after Long-Term Institution Stay
Assessment Update	
Care Plan Update	
Re-assessment & Care Plan Update after Discharge	

# Next Steps

- Some revision of existing measures can be used currently, but most measures need testing prior to use
- Working with MMCO and DQEHO to contract with a vendor to test the measures
  - Use of these measures in any standard way is at least 2 years out

# Contact Information

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- Amy Gentile
- [Amy.Gentile@cms.hhs.gov](mailto:Amy.Gentile@cms.hhs.gov)

# MLTSS Resources from ASPE DALTCP Recently Posted on the Web

## ☐ Reports:

- "Quality in Managed Long-Term Services and Supports Programs"  
<http://aspe.hhs.gov/daltcp/reports/2013/LTSSqual.shtml>
- "Environmental Scan of MLTSS Quality Requirements in MCO Contracts"  
<http://aspe.hhs.gov/daltcp/reports/2013/MCOcontr.shtml>

## ☐ Research Briefs:

- "Did They or Didn't They?: A Brief Review of Service Delivery Verification in MLTSS"  
<http://aspe.hhs.gov/daltcp/reports/2013/verifyRB.shtml>
- "Addressing Critical Incidents in the MLTSS Environment: Research Brief"  
<http://aspe.hhs.gov/daltcp/reports/2013/CritIncidRB.shtml>
- "Performance Measures in MLTSS Programs: Research Brief"  
<http://aspe.hhs.gov/daltcp/reports/2013/PerfMeaRB.shtml>

☐ ASPE POC: Pam Doty





U.S. Department of Health and Human Services



Agency for Healthcare Research and Quality

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# Quality Indicators for the Medicaid HCBS Population

**D.E.B. Potter**

Presentation at the HCBS Quality Measures Summit, June 17, 2014

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# Background

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- Outgrowth of AHRQ's work mandated by the Deficit Reduction Act (DRA), Section 6086(b)
- Now a three way partnership between:
  - ▶ AHRQ
  - ▶ CMS CMCS DEHPG
  - ▶ CMS FCHCO
- Measures focus on ambulatory care sensitive (ACS) condition admissions



# Current Efforts Focus on Four HCBS Measures

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## **PQI 92 Prevention Quality Chronic Composite (for HCBS):**

- ▶ PQI #1 Diabetes Short-Term Complications Admission Rate
- ▶ PQI #3 Diabetes Long-Term Complications Admission Rate
- ▶ PQI #5 COPD or Asthma in Older Adults Admission Rate
- ▶ PQI #7 Hypertension Admission Rate
- ▶ PQI #8 Heart Failure Admission Rate
- ▶ PQI #13 Angina Without Procedure Admission Rate
- ▶ PQI #14 Uncontrolled Diabetes Admission Rate
- ▶ PQI #15 Asthma in Younger Adults Admission Rate
- ▶ PQI #16 Lower-Extremity Amputation among Patients with Diabetes Rate

## ● **PQI 91 Prevention Quality Acute Composite (for HCBS):**

- ▶ PQI #10 Dehydration Admission Rate
- ▶ PQI #11 Bacterial Pneumonia Admission Rate
- ▶ PQI #12 Urinary Tract Infection Admission Rate

## ● **PQI 90 Prevention Quality Overall Composite (for HCBS):**

- ▶ All of the above individual PQI's

## ● **Hospitalization due to pressure ulcers (PU) (Stage III or IV, present on admission)(PSI #03)**



# Other Similar (PQI) Measures Used in Medicaid Populations

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- Medicaid Adult Core Measure Set includes:
  - ▶ PQI #1 Diabetes Short-Term Complications Admission Rate
  - ▶ PQI #5 COPD or Asthma in Older Adults Admission Rate
  - ▶ PQI #8 Heart Failure Admission Rate
  - ▶ PQI #15 Asthma in Younger Adults Admission Rate
- Evaluation of State Demonstrations to Integrate Care for Dual Eligible Individuals:
  - ▶ PQI 90 Prevention Quality Overall Composite
  - ▶ PQI 92 Prevention Quality Chronic Composite
- At least one state uses in their Dual's Financial Alignment Initiative:
  - ▶ PQI #5 COPD or Asthma in Older Adults Admission Rate
  - ▶ PQI #8 Heart Failure Admission Rate
- Medicaid Health Homes Core Measure Set:
  - ▶ "Ambulatory Care - Sensitive Condition Admissions"



# Overview of HCBS Measure Development

Date	Measure Development Efforts
2002	Original PQI's developed by AHRQ
2009/10	AHRQ adapts PQI's for use with FFS HCBS population
2010/11	AHRQ uses HCBS measures to assess health & welfare of HCBS populations (performance measurement at the national level)
2012	Findings published
2012/13	Initial risk adjustment methods developed for FFS HCBS measures (performance measurement at the state level)
2013	Risk adjusted measures used in preliminary MFP evaluations
2014/15	Finalize risk adjustments for FFS HCBS measures (include comorbidity indicators for mental illness, substance abuse disorders and disability)
2015/16	Adapt measures for use in managed care plans that serve HCBS populations (performance measurement at the health plan level)
2016/17	HCBS measures submitted to NQF for endorsement



# HCBS Measure Resources

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- Environmental Scan of Measures for Medicaid Title XIX Home and Community-Based Services (Galantowicz), AHRQ Pub. No. 10-0042-EF, June 2010, <http://www.ahrq.gov/professionals/systems/long-term-care/resources/hcbs/hcbsreport/index.html>
- Development of Quality Indicators for Home and Community-Based Services Population: AHRQ Quality Indicators Technical Report (Schultz, Davies & McDonald), June 2012 (contact D.E.B. Potter; server being migrated)
- Assessing the Health and Welfare of the HCBS Population: Findings Report (Konetzka, Potter & Karon), AHRQ Pub. No. 11(12)-0017-EF, June, 2012, <http://www.ahrq.gov/professionals/systems/long-term-care/resources/hcbs/hcbsfindings/index.html>
- Users of Medicaid Home and Community-Based Services Are Especially Vulnerable To Costly Avoidable Hospital Admissions (Konetzka, Karon & Potter), *Health Aff*, June 2012 (with on-line Appendix) (AHRQ Pub. No. 12-R077).
- Development and Testing of Risk-Adjusted Composite Measures for Populations Using Home- and Community-Based Services, Final Report (Phase I), September 27, 2013, prepared for CMS, CMCS, DEHPG by MPR contract No. HHSM-500-2010-00026I/HHSM-500-T0010, MPR Ref No: 40137.A10 (not released publically, circulated w/i HHS; current COR, Effie George).



# Additional Measure Resources

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- AHRQ's Prevention Quality Indicators (PQI's), [http://www.qualityindicators.ahrq.gov/Modules/pqi\\_resources.aspx](http://www.qualityindicators.ahrq.gov/Modules/pqi_resources.aspx)
- CMS Measures Management System Blueprint (the Blueprint) v 10.1, <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/MeasuresManagementSystemBlueprint.html>
- AHRQ's National Quality Measures Clearinghouse, <http://www.qualitymeasures.ahrq.gov/>
- HHS Measures Inventory, <http://www.qualitymeasures.ahrq.gov/hhs/index.aspx>
- CMS Measures Inventory, <http://cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/CMS-Measures-Inventory.html>
- NQF Measures Inventory, [http://www.qualityforum.org/Measures\\_Reports\\_Tools.aspx](http://www.qualityforum.org/Measures_Reports_Tools.aspx)





The Office of the National Coordinator for  
Health Information Technology



# Introduction to S&I Framework's electronic Long-term Services & Support (eLTSS) Initiative

June 17, 2014

Becky Angeles

eLTSS Initiative Project Manager

On-behalf of the Office of Standards & Technology

Office of the National Coordinator

Putting the **I** in **HealthIT**  
[www.HealthIT.gov](http://www.HealthIT.gov)



- Introduction to ONC Standards & Interoperability Framework
- Introduction to new eLTSS Initiative
- Next Steps

# What is the S&I Framework?

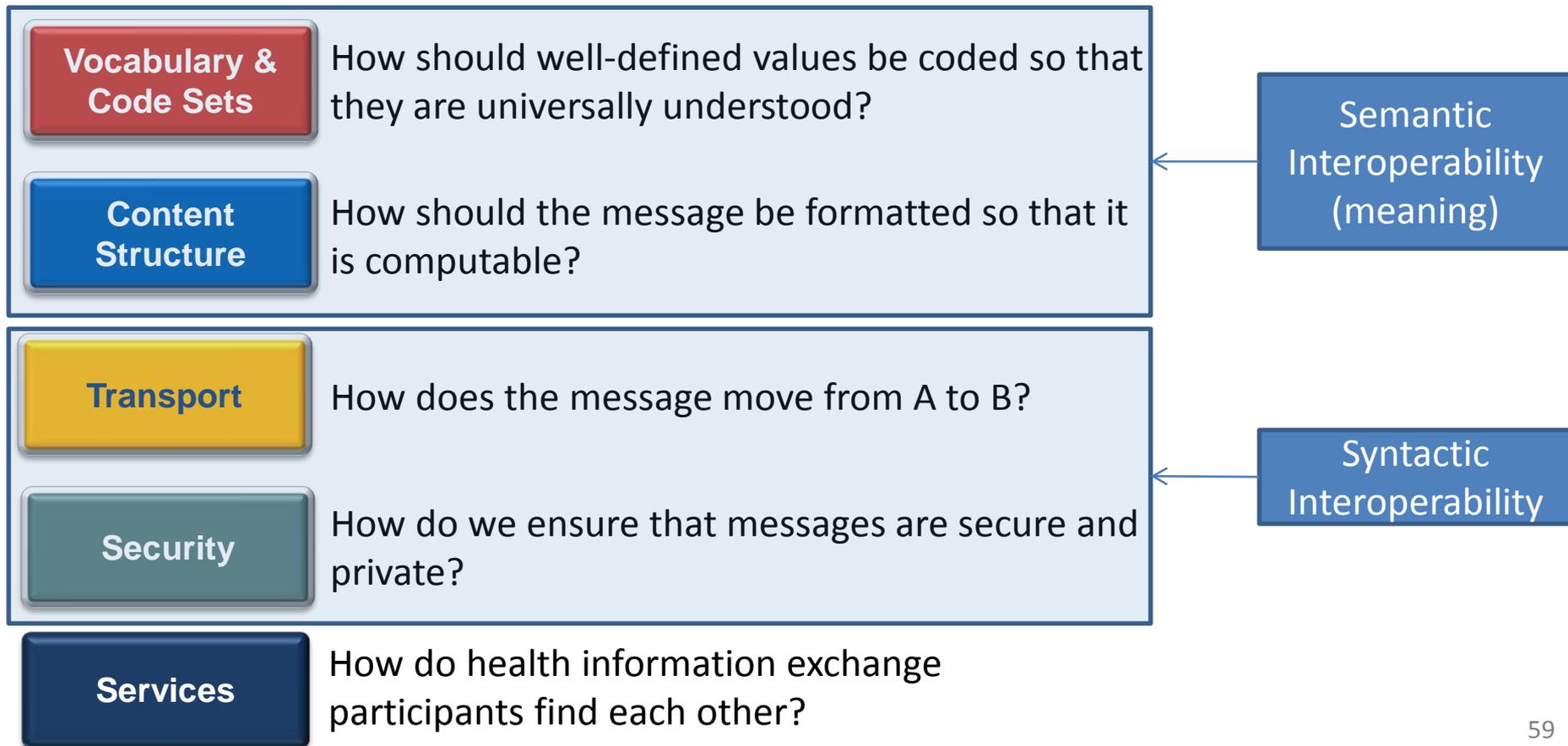
- The Standards and Interoperability (S&I) Framework represents one investment and approach adopted by ONC to fulfill its charge of prescribing health IT standards and specifications to support national health outcomes and healthcare priorities
- Consists of a collaborative community of participants from the public and private sectors who are focused on providing the tools, services and guidance to facilitate the functional exchange of health information
- Uses a set of **integrated functions, processes, and tools** that enable execution of specific value-creating initiatives



- Standards provide a common language and set of expectations that enable interoperability between systems and/or devices
- Health IT standards permit data (or electronic information) to be shared between clinician, lab, hospital, pharmacy, and patient regardless of application
- Standards are typically developed, adopted and/or maintained by Standard Development Organizations (SDOs)
  - S&I Framework serves as a community forum to identify or create standards which are then presented to an SDO for accreditation and publication

# Standard Interoperability “Building Blocks”

Interoperability is about using technology to exchange key pieces of information securely. The goal is to obtain and share the right information in the right context. In order to exchange this information for healthcare, there is an ONC defined framework for a set of building blocks that support system interoperability:



Building Blocks	Sample Standards	S&I Initiative(s)
<b>Vocabulary</b>	LOINC, SNOMED, RxNORM, ICD-10	Health eDecisions (HeD) Structured Data Capture (SDC) Clinical Quality Framework (CQF)
<b>Content</b>	CCDA, HQMF, QRDA, FHIR, ISO/IEC 11179, ISO/IEC 19763, HL7 2.5.1	HeD, SDC, CQF Transitions of Care (ToC) Longitudinal Coordination of Care (LCC) BlueButton+ <a href="#">eLTSS (NEW*)</a>
<b>Transport</b>	DIRECT, SOAP, REST, OpenID, OAuth	Electronic Submission of Medical Documentation (esMD) DIRECT, ToC, SDC, BlueButton+, <a href="#">eLTSS (NEW*)</a>
<b>Security</b>	DIRECT, OpenID, OAuth, NSTIC, X.509	esMD, Data Provenance Data Segmentation for Privacy (DS4P) DIRECT
<b>Services</b>	DNS+LDAP	Lab Orders & Lab Results Interfaces Data Access Framework (DAF) BlueButton+ API

Phase	Planned Activities
<b>Pre-Discovery</b>	<ul style="list-style-type: none"><li>• Development of Initiative Synopsis</li><li>• Development of Initiative Charter</li><li>• Definition of Goals &amp; Initiative Outcomes</li></ul>
<b>Discovery</b>	<ul style="list-style-type: none"><li>• Creation/Validation of Use Cases, User Stories &amp; Functional Requirements</li><li>• Identification of interoperability gaps, barriers, obstacles and costs</li><li>• Review of Vocabulary</li></ul>
<b>Implementation</b>	<ul style="list-style-type: none"><li>• Creation of aligned specification</li><li>• Documentation of relevant specifications and reference implementations such as guides, design documents, etc.</li><li>• Validation of Vocabulary</li><li>• Development of testing tools and reference implementation tools</li></ul>
<b>Pilot</b>	<ul style="list-style-type: none"><li>• Validation of aligned specifications, testing tools, and reference implementation tools</li><li>• Revision of documentation and tools</li></ul>
<b>Evaluation</b>	<ul style="list-style-type: none"><li>• Measurement of initiative success against goals and outcomes</li><li>• Identification of best practices and lessons learned from pilots for wider scale deployment</li><li>• Identification of hard and soft policy tools that could be considered for wider scale deployments</li></ul>

- In March 2014 CMS awarded planning and demonstration grants to qualified states for Testing Experience and Functional Tools (TEFT) in Medicaid community-based long term services & supports (LTSS)
- Total grant program ~\$42M, up to 4 years
- Purpose is to provide national measures and valuable feedback on how HIT can be implemented in this component of the Medicaid system
- 8 of 9 states confirmed to participate in S&I Framework:
  - AZ, CO, CT, GA, KY, LA, MD, MN

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Grant-Programs/TEFT-Program-.html>

# Role of S&I Framework in TEFT Program

Focus on two of four components:

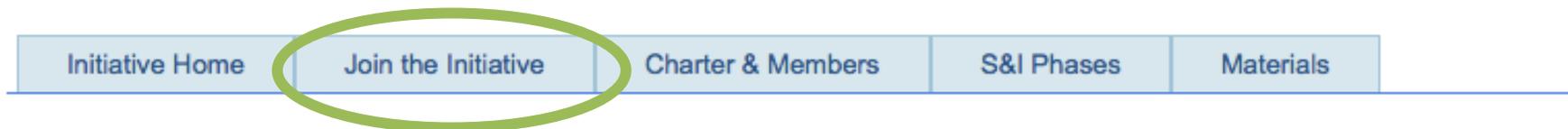
1. Test a beneficiary experience survey within multiple CB-LTSS programs for validity and reliability
2. Test a modified set of CARE functional assessment measures for use with beneficiaries of CB-LTSS programs
3. Demonstrate use of PHR systems with beneficiaries of CB-LTSS\*
4. Identify, evaluate and harmonize an e-LTSS standard in conjunction with the ONC S&I Framework

\* States participating in the PHR demonstrations must also participate in e-LTSS S&I Process

- eLTSS Initiative will be launched as new workgroup under the existing S&I Longitudinal Coordination of Care (LCC) Initiative
- CMS TEFT grantees will be invited to participate in eLTSS Initiative as part of their grant program requirements
- eLTSS Initiative will also be open for other stakeholder groups to participate:
  - Other States and State Medicaid Offices
  - LTSS system vendors
  - Other HIT systems
  - LTSS Providers and Facilities
  - Consumer Engagement Organizations
- Timeline: eLTSS Initiative will launch Fall 2014 and will run for duration of CMS TEFT grant program (3 years)

- To join the LCC Initiative and upcoming eLTSS Workgroup, go here:  
<http://wiki.siframework.org/Longitudinal+CC+WG+Committed+Member+Guidance> .

## Longitudinal Coordination of Care (LCC)



- Joining the initiative ensures that you are included on initiative communications and announcements. You may join as an Interested Party or a Committed Member. (More information about these two options is on the Join page.)
- Thank you! Your commitment and participation are critical to our success.

- CMS TEFT Leads:
  - Anita Yuskauskas ([Anita.Yuskauskas@cms.hhs.gov](mailto:Anita.Yuskauskas@cms.hhs.gov))
  - Anca Tabakova ([anca.tabakova@cms.hhs.gov](mailto:anca.tabakova@cms.hhs.gov))
- ONC Leads:
  - Mera Choi ([mera.choi@hhs.gov](mailto:mera.choi@hhs.gov))
  - Farrah Darbouze ([farrah.darbouze@hhs.gov](mailto:farrah.darbouze@hhs.gov))
  - Elizabeth Palena-Hall ([elizabeth.palenahall@hhs.gov](mailto:elizabeth.palenahall@hhs.gov) )
- Initiative Coordinator
  - Evelyn Gallego ([evelyn.gallego@siframework.org](mailto:evelyn.gallego@siframework.org))
- Project Management
  - Use Case Lead: Becky Angeles ([becky.angeles@esacinc.com](mailto:becky.angeles@esacinc.com))
  - Pilots Lead: Lynette Elliott ([lynette.elliott@esacinc.com](mailto:lynette.elliott@esacinc.com))

**LCC Wiki Site:** <http://wiki.siframework.org/Longitudinal+Coordination+of+Care>





The Office of the National Coordinator for  
Health Information Technology



# Examining Voluntary Certification: Long-Term and Post-Acute Care and Behavioral Health

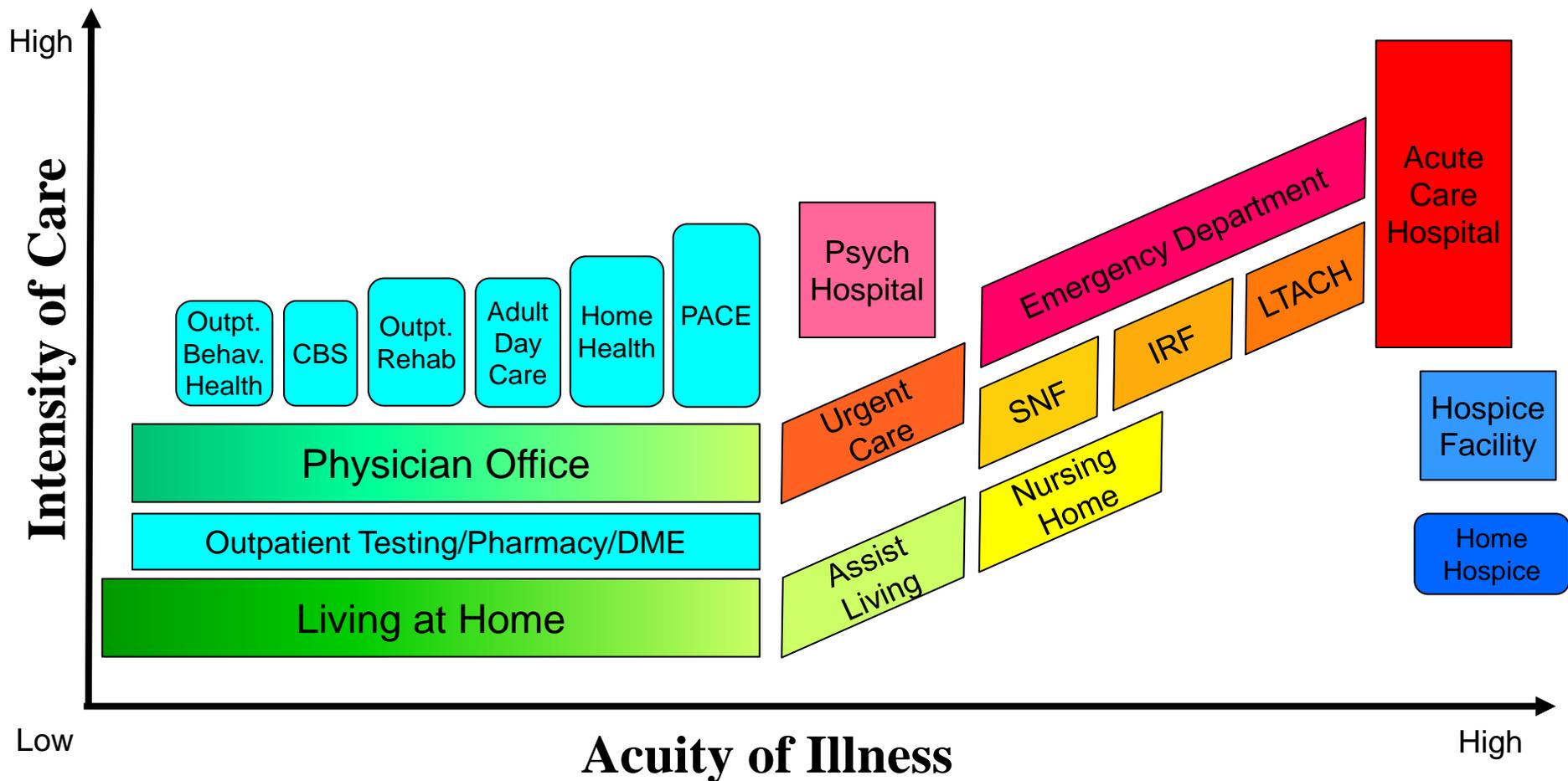
Liz Palena Hall  
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June 17th, 2014

Putting the **I** in Health**IT**  
[www.HealthIT.gov](http://www.HealthIT.gov)



# Challenge : The Spectrum of Care is Vast... as are the Barriers to Care Coordination



Adapted from Derr and Wolf, 2012

- **Support Other Settings of Care:** Current certified EHR technology supports health care providers seeking to achieve meaningful use, but certain criteria may be applicable to other settings of care and could improve the transfer and use of information across systems
- **Improved Communication / Modular Approach:** Tailoring certification criteria by setting/functionality would open critical communication lines between MU eligible and MU-ineligible care providers
- **Increasing Interoperability:** Alignment among federal programs around data and standards relevant to LTPAC settings would increase interoperability and improve provider workflow and patient care

# Health IT Policy Committee Recommendations on Voluntary Certification for LTPAC and BH

**Transitions of Care** - align and update ONC certification criteria consistent with Meaningful Use  
**Privacy and Security** - align and update ONC certification criteria consistent with Meaningful Use  
**Data Segmentation / Consent Management**

- For MU 3, include document level sequester send and receive functionality in voluntary certification program for BH providers, include functionality as voluntary certification criterion for other CEHRT
- Additional pilots and guidance needed to clarify recipient response
- Health IT Standards Committee should address the maturity/feasibility of the DS4P standard or other standards for BH voluntary certification and general EHR certification, and level of granularity

**LTPAC Patient Assessments** - support the use of standards for a subset of patient assessment data to enable reuse for clinical and administrative purposes

**BH Patient Assessments** - future work needed to identify standards to support BH patient assessments

**Trend Tracking** - track national trends in LTPAC and BH health IT adoption, including use by functionality and by certification criteria; utilize EHR adoption definitions consistent with those used in ONC/CMS initiatives.

**\*\* Quality Measurement** - No final recommendation at this time. QM WG believes draft recommendations are not ready for the short-term, but could serve as a foundation for more exploratory work.

## ONC Reports:

- Strategy and Principles to Accelerate HIE

[http://www.healthit.gov/sites/default/files/acceleratinghieprinciples\\_strategy.pdf](http://www.healthit.gov/sites/default/files/acceleratinghieprinciples_strategy.pdf)

- A 10 Year Vision to Achieve an Interoperable HIT Infrastructure

<http://www.healthit.gov/sites/default/files/ONC10yearInteroperabilityConceptPaper.pdf>

- Health IT in LTPAC Issue Brief

[http://www.healthit.gov/sites/default/files/pdf/HIT\\_LTPAC\\_IssueBrief031513.pdf](http://www.healthit.gov/sites/default/files/pdf/HIT_LTPAC_IssueBrief031513.pdf)

## ASPE Report:

- EHR Payment Incentives for Providers Ineligible for Payment Incentives and Other Funding Study

<http://aspe.hhs.gov/daltcp/reports/2013/ehрпи.shtml>

## Quality Measurement Workgroup Draft Recommendations on LTPAC and BH QMs (no final recommendation)

[http://www.healthit.gov/facas/sites/faca/files/HITPC\\_QMWG\\_LTPAC\\_BH\\_Rec\\_2014-05-06\\_0.pdf](http://www.healthit.gov/facas/sites/faca/files/HITPC_QMWG_LTPAC_BH_Rec_2014-05-06_0.pdf)





# HHS Community Living Council

Jamie Kendall, Director Special Projects

Center on Aging and Disability Policy

Administration for Community Living

June 17, 2014



# HHS Community Living Council

- In 2013 Secretary Sebelius formed the CLC to help HHS promote community living in the U.S., with Kathy Greenlee (ACL) and Jon Blum (CMS) as co-chairs
- Participants include staff from ACL, AHRQ, CDC, CMS, HRSA, IHS, SAMHSA, OASH, ASPE, ASFR, ASPA, OCR, & ONC
- The CLC convened five workgroups to examine community living issues: *Developing a High-Performing Long-Term Services and Supports System, Integrated Care Models and Seamless Transitions, Evidence-Based Consumer Supports, Community Integration, and HCBS Quality*
- The HCBS Quality Workgroup is led ACL, CMS, and AHRQ

# Goal 2 HCBS Quality Workgroup

Strategic Goal 2: Identify, Develop, and Implement Standardized Measures of Quality Community Living that can be used by HHS, States and other public and private entities to ensure the quality of, and access to, the services and supports being provided in the community for populations in need of, and/or who use, home and community based long- term services and supports (regardless of payer).

- Objective 1: Use the National Quality Strategy as an overarching HHS Framework for Measuring Quality Community Living
- Objective 2: Using the Framework Developed, Identify Gaps & Create a Work Plan to Develop HHS Standardized Measures of Quality Community Living
- Objective 3: Identify federal programs and their respective Authorities to Implement HHS Standardized Measures of Quality Community Living
- Objective 4: Operationalize a comprehensive approach to a quality community living across programs to ensure quality in the program design, implementation, reporting, and oversight

## Next Steps

- HHS is working to procure a Task Order through a Consensus-Based Entity Indefinite Delivery Indefinite Quantity Contract - “Priority Setting for Health Care Performance Measurement: Addressing Performance Measure Gaps in Priority Areas”
- Work underway in other areas of the contract could inform work on HCBS quality going forward

# Resources

National Quality Strategy: <http://www.ahrq.gov/workingforquality/>

HHS Community Living Initiative: <http://www.hhs.gov/od/community/index.html#activities>

NQF MAP: [http://www.qualityforum.org/setting\\_priorities/partnership/measure\\_applications\\_partnership.aspx](http://www.qualityforum.org/setting_priorities/partnership/measure_applications_partnership.aspx)

NQF Prioritizing Measures: [http://www.qualityforum.org/prioritizing\\_measures/](http://www.qualityforum.org/prioritizing_measures/)

CMS HCBS Quality: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-HCBS.html>

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# National Quality Forum

## Priority Setting for Health Care Performance Measurement: Addressing Performance Measure Gaps in Priority Areas

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**Cille Kennedy**

Office of Health Policy

Division of Health Care Quality and Outcomes/ASPE

HCBS Quality Measures Summit

June 17, 2014



**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Office of the Assistant Secretary for Planning and Evaluation

# National Quality Forum (NQF)

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- **Consensus-based entity**
  - Representatives of diverse, experienced, key health-related stakeholders
  - Endorses quality measures (is not a measure developer)
- **MIPPA §183 mandated a contract with a consensus-based entity, e.g., NQF, to:**
  - Synthesize evidence;
  - Convene key stakeholders; and
  - Make recommendations on:
    - An integrated national strategy, and;
    - Priorities for health care performance measurement in all applicable settings; and
  - Endorse standardized health care performance measurement.
- **ACA §3014 provided new duties for the consensus-base entity**
  - Including identifying gaps in endorsed quality and efficiency measures



# Purpose of Current NQF CMS Contract

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- Identify and analyze gaps in quality measures
- Recommend priorities for measure development in 5 priority areas:
  - Adult Immunizations;
  - Alzheimer’s Disease and Related Dementias;
  - Care Coordination;
  - Health Workforce; and
  - Patient-centered Care and Outcomes



# Approach

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- Convene multi-stakeholder groups with topic-related, diverse representation and substantive knowledge
- Develop conceptual framework for each subtask
- Conduct environmental scans
- Synthesize evidence and conduct gaps analysis
- Obtain input via public webinars
- Produce a Final Report for each subtask



# Opportunities to Provide Input

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- Draft reports for 4 subtasks available to public on June 23, 2014
  - Adult Immunization;
  - Care Coordination;
  - Patient-Centered Care and Outcomes; and
  - Health Workforce
- Public webinar for above 4 subtasks scheduled for June 30, 2014
- Public comment period closes July 14<sup>th</sup> at 6:00 pm
- Public Input for Alzheimer’s Disease and Related Dementias
  - Late August, exact dates TBD



# Quality Measures for the Community?

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- Not just replacing institutional/PAC setting care
- Be aware of unintended consequences
- Think of all that life in the community means
  - Some of which is provided in institutional and PAC settings, e.g., socialization, recreation, religious interaction
  - What is the person expected to do all day? Watch TV? Think *systematically* of what people do.
- What can be learned from de-institutionalization of people with IDD and MH conditions?



# Resource for Consideration: Functioning in the Community



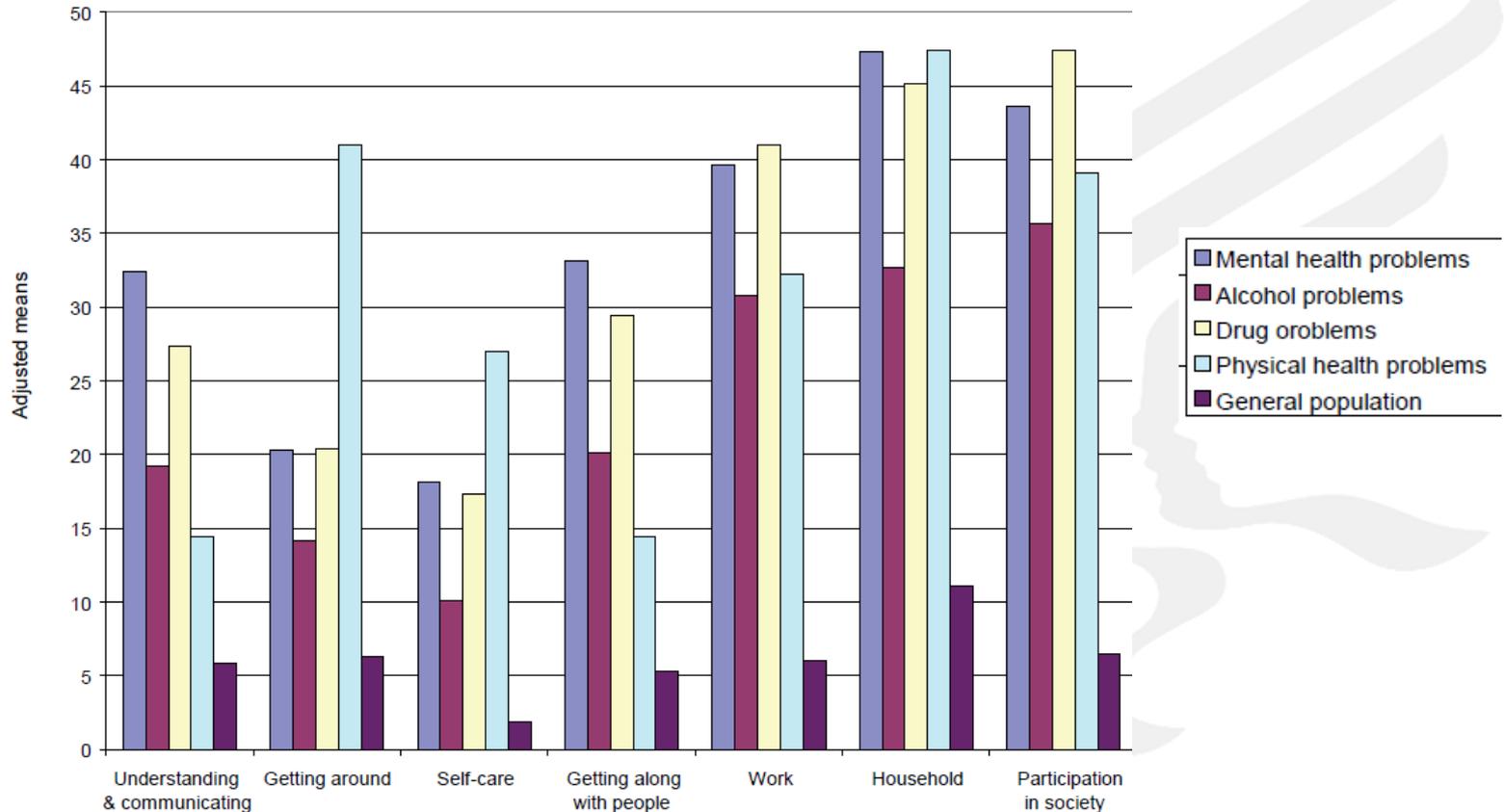
## Activities & Participation

- Learning and applying knowledge
- General tasks and demands:
- Communication
- Mobility
- Self-care
- Domestic life
- Interpersonal interactions and relationships
- Major life areas:
  - education, work & economic life
- Community, social and civic life



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# Difficulty in Functioning Associated with Different Health Conditions



Source: World Health Organization, 2009



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[www.qualityforum.org/prioritizing\\_measures](http://www.qualityforum.org/prioritizing_measures)

<http://www.who.int/classifications/icf/en/>

[http://www.cdc.gov/nchs/data/icd/ICFOverview\\_FINALforWHO10  
Sept.pdf](http://www.cdc.gov/nchs/data/icd/ICFOverview_FINALforWHO10_Sept.pdf)

<http://www.who.int/bulletin/volumes/88/11/09-067231.pdf?ua=1>

(see Fig. 3 for updated Levels of Functioning)

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