HCBS Quality Measures Summit

June 17, 2014
Data Element Uniformity and Cross Setting Quality Measures

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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
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
- 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: Multiple Incompatible Data Sources

Nursing Homes
- MDS
- LTCHS
- LTCH CARE Data Set

Inpatient Rehab Facilities
- IRF-PAI

Home Health Agencies
- OASIS

Hospitals
- No Standard Data Set

Physicians
- No Standard Data Set

LTCHS (LTCH CARE Data Set)

Outpatient Settings
- No Standard Data Set

GOAL:
Transition

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

<table>
<thead>
<tr>
<th>Hospital Quality Reporting</th>
<th>Physician Quality Reporting</th>
<th>Post Acute Care</th>
<th>Payment Model Reporting</th>
<th>“Population” Quality Reporting</th>
</tr>
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<tbody>
<tr>
<td>- Medicare and Medicaid EHR Incentive Program</td>
<td>- Medicare and Medicaid EHR Incentive Program</td>
<td>- Inpatient Rehabilitation Facility</td>
<td>- Medicare Shared Savings Program</td>
<td>- Medicaid Adult Quality Reporting*</td>
</tr>
<tr>
<td>- PPS-Exempt Cancer Hospitals</td>
<td>- Physician Quality Reporting System (PQRS)</td>
<td>- Nursing Home Compare Measures</td>
<td>- Hospital Value-based Purchasing</td>
<td>- CHIPRA Quality Reporting*</td>
</tr>
<tr>
<td>- Inpatient Psychiatric Facilities</td>
<td>- eRx quality reporting</td>
<td>- LTCH Quality Reporting</td>
<td>- Physician Feedback/Value-based Modifier*</td>
<td>- Health Insurance Exchange Quality Reporting*</td>
</tr>
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<td>- Inpatient Quality Reporting</td>
<td></td>
<td>- Hospice Quality Reporting</td>
<td>- ESRD QIP</td>
<td>- Medicare Part C*</td>
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<tr>
<td>- HAC payment reduction program</td>
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<td>- Home Health Quality Reporting</td>
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<td>- Medicare Part D*</td>
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<td>- Readmission reduction program</td>
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<tr>
<td>- Outpatient Quality Reporting</td>
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<tr>
<td>- Ambulatory Surgical Centers</td>
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</tbody>
</table>

**PAC Assessment Data**
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

- Measures should be patient-centered and outcome-oriented whenever possible
- Measure concepts in each of the six domains that are common across providers and settings can form a core set of measures

**Clinical Quality of Care**
- Care type (preventive, acute, post-acute, chronic)
- Conditions
- Subpopulations

**Person- and Caregiver-Centered Experience and Outcomes**
- Patient experience
- Caregiver experience
- Preference- and goal-oriented care

**Safety**
- All-cause harm
- HACs
- HAIs
- Unnecessary care
- Medication safety

**Efficiency and Cost Reduction**
- Cost
- Efficiency
- Appropriateness

**Care Coordination**
- Patient and family activation
- Infrastructure and processes for care coordination
- Impact of care coordination

**Population/Community Health**
- Health Behaviors
- Access
- Physical and Social environment
- Health Status

**Function**
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

Data Elements/Items

Quality Measure
### 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**

<table>
<thead>
<tr>
<th>A. Self-performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. Independent - no help provided</td>
</tr>
<tr>
<td>1. Supervision - oversight help only</td>
</tr>
<tr>
<td>2. Physical help limited to transfer only</td>
</tr>
<tr>
<td>3. Physical help in part of bathing activity</td>
</tr>
<tr>
<td>4. Total dependence</td>
</tr>
<tr>
<td>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</td>
</tr>
</tbody>
</table>

**Enter Code**

<table>
<thead>
<tr>
<th>B. Support provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Bathing support codes are as defined in item G0110 column 2, ADL Support Provided, above)</td>
</tr>
</tbody>
</table>

**G0300. Balance During Transitions and Walking**

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

<table>
<thead>
<tr>
<th>Coding:</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. Steady at all times</td>
</tr>
<tr>
<td>1. Not steady, but able to stabilize without staff assistance</td>
</tr>
<tr>
<td>2. Not steady, only able to stabilize with staff assistance</td>
</tr>
<tr>
<td>8. Activity did not occur</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>Coding:</th>
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<tbody>
<tr>
<td>0. No impairment</td>
</tr>
<tr>
<td>1. Impairment on one side</td>
</tr>
<tr>
<td>2. Impairment on both sides</td>
</tr>
</tbody>
</table>

**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

IRF-PAI → MDS → OASIS

Eating → Eating → Eating
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

CMS Assessment Data Element Library

- CMS Library Concept & CARE
- OASIS-C
- MDS 3.0
- HCBS CARE
- IRF-PAI
- LTCH CARE Data Set
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**
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CMS Vision for MU

The E-Health Connected Medicaid Health System

Hospital Care Coordination
Diagnostics
EHR/HIE
Order Entry Lab Result Reporting
E-Prescribing
Remote Patient Self Monitoring
MCO Medical Management
Specialist Referral
Primary Care Medical Home Provider
Research
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
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
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


- 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
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 a 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

NCI for Aging and Physical Disabilities:


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Phone: (202) 357 – 3421  Cell: (703) 328 – 3972  Email: jamie.kendall@acl.hhs.gov
MLTSS Measures
Debbie Dombrowski, Technical Director
CMCS/DEHPG
• 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

<table>
<thead>
<tr>
<th>NCQA Measures</th>
<th>PQRS Measures</th>
</tr>
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<tbody>
<tr>
<td>Functional Status Assessment</td>
<td>Screening for Clinical Depression and Follow up Plan</td>
</tr>
<tr>
<td>Pain Assessment</td>
<td>Reducing Falls Risk: Screening, Assessment, and Plan of Care</td>
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<tr>
<td>Medication Review</td>
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<tr>
<td>Medication Reconciliation Post-Discharge</td>
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<tr>
<td>Cervical Cancer Screening</td>
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<tr>
<td>Chlamydia Screening in Women</td>
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</tbody>
</table>
# Creation of New Measures

<table>
<thead>
<tr>
<th>Assessment &amp; Care Planning</th>
<th>Institution Utilization and Transition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment Composite</td>
<td>Admission to an Institution from the Community</td>
</tr>
<tr>
<td>Care Plan Composite</td>
<td>Successful Discharge to the Community after Short-Term Institution Stay</td>
</tr>
<tr>
<td>Share Care Plan</td>
<td>Successful Discharge to the Community after Long-Term Institution Stay</td>
</tr>
<tr>
<td>Assessment Update</td>
<td></td>
</tr>
<tr>
<td>Care Plan Update</td>
<td></td>
</tr>
<tr>
<td>Re-assessment &amp; Care Plan Update after Discharge</td>
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</table>
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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  • Debbie.Dombrowski@cms.hhs.gov

• Amy Gentile
  • 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
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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• 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

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

• 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

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


- 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)


- 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).

Additional Measure Resources

- AHRQ’s Prevention Quality Indicators (PQI’s), http://www.qualityindicators.ahrq.gov/Modules/pqi_resources.aspx
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
Agenda

- 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.
What is a Standard?

- 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.

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:

- **Vocabulary & Code Sets**: How should well-defined values be coded so that they are universally understood?
- **Content Structure**: How should the message be formatted so that it is computable?
- **Transport**: How does the message move from A to B?
- **Security**: How do we ensure that messages are secure and private?
- **Services**: How do health information exchange participants find each other?

Semantic Interoperability (meaning)

Syntactic Interoperability
# S&I Initiatives’ Standards

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

<table>
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<tr>
<th>Phase</th>
<th>Planned Activities</th>
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| Pre-Discovery | • Development of Initiative Synopsis  
• Development of Initiative Charter  
• Definition of Goals & Initiative Outcomes |
| Discovery | • Creation/Validation of Use Cases, User Stories & Functional Requirements  
• Identification of interoperability gaps, barriers, obstacles and costs  
• Review of Vocabulary |
| Implementation | • Creation of aligned specification  
• Documentation of relevant specifications and reference implementations such as guides, design documents, etc.  
• Validation of Vocabulary  
• Development of testing tools and reference implementation tools |
| Pilot     | • Validation of aligned specifications, testing tools, and reference implementation tools  
• Revision of documentation and tools |
| Evaluation | • Measurement of initiative success against goals and outcomes  
• Identification of best practices and lessons learned from pilots for wider scale deployment  
• Identification of hard and soft policy tools that could be considered for wider scale deployments |
• 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
Next Steps for eLTSS Initiative

- 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)
Join the LCC Initiative

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

• 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.
eLTSS Initiative: Contact Information

- **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](http://wiki.siframework.org/Longitudinal+Coordination+of+Care)
Examining Voluntary Certification: Long-Term and Post-Acute Care and Behavioral Health

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Office of the National Coordinator for HIT
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June 17th, 2014
Challenge: The Spectrum of Care is Vast... as are the Barriers to Care Coordination

- Physician Office
- Outpt. Behav. Health
- CBS
- Outpt. Rehab
- Adult Day Care
- Home Health
- PACE
- Psych Hospital
- Emergency Department
- SNF
- IRF
- LTACH
- Hospice Facility
- Home Hospice

Acuity of Illness

Intensity of Care

Low

Acuity of Illness

High

Adapted from Derr and Wolf, 2012
Opportunities for Voluntary Certification

- **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.
**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.
Resources

ONC Reports:

– Strategy and Principles to Accelerate HIE

– A 10 Year Vision to Achieve an Interoperable HIT Infrastructure

– Health IT in LTPAC Issue Brief

ASPE Report:

– EHR Payment Incentives for Providers Ineligible for Payment Incentives and Other Funding Study
  http://aspe.hhs.gov/daltcp/reports/2013/ehrpi.shtml

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

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

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
NQF 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

Jamie Kendall U.S. Department of Health and Human Services, Administration for Community Living, Washington DC 20201
Phone: (202) 357 – 3421  Cell : (703) 328 – 3972  Email: jamie.kendall@acl.hhs.gov
National Quality Forum

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

Cille Kennedy
Office of Health Policy
Division of Health Care Quality and Outcomes/ASPE

HCBS Quality Measures Summit
June 17, 2014
National Quality Forum (NQF)

- **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

• 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

• 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

- 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?

• 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
Difficulty in Functioning Associated with Different Health Conditions

Source: World Health Organization, 2009