

# QUALITY OVERVIEW

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# QUALITY DEFINED

- ▣ 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 ISSUES

- ▣ 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

# STARTLING FACTS

- ▣ 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.

# QUALITY MEASUREMENT TOOLS

- ▣ The Health Plan Employer Data and Information Set (**HEDIS®**)
- ▣ The Consumer Assessment of Healthcare Providers and Systems (**CAHPS®**)
- ▣ **ORYX™**: 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

# QUALITY - VALUE ADDED

- ▣ 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

QUALITY

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

Indicator and why selected	Measured by	Frequency or percentage	Target
<p><b>Check for Excluded Providers</b></p> <p>Regulatory: CMS requirement</p> <p><a href="http://exclusions.oig.hhs.gov/">http://exclusions.oig.hhs.gov/</a></p>	<p>Evidence of procedure for checking OIG's Excluded Providers list</p>	<p>Numerator: # of times checked annually</p> <p>Denominator: calendar quarters (4)</p>	<p>Target = 100%</p> <p>4/4</p>
<p><b>Turnover Rate</b></p> <p>Non-regulatory</p>	<p>Number of total staff compared to staff departures, excluding involuntary terminations, furloughs, and layoffs.</p>	<p>Numerator: Number of paid staff who leave in 12 months.</p> <p>Denominator: Number of staff positions during same period.</p> <p>Example: <math>2/8 = .25 \times 100 = 25\%</math> turnover</p>	<p>Target = 20% (?)</p>

# Indicator Example: Standard Tool

Indicator and why selected	Measured by	Frequency or percentage	Target
<p><b>Care plan developed with involvement by participant and/or caregiver.</b></p> <p><i>Regulatory:</i> 1115 Waiver STC 96(c)</p> <p>SOP F WIC 14529(d)(2) T-22</p> <p>CCR Section 54211(b)(2)</p>	<p>Care plans are reflective of the participant or caregiver stated values and desires as documented in the assessment process.</p> <p>Best practice will include methods for asking about preferences and values beginning at intake. (“getting to know me or 20 questions”)</p> <p>“Tell me more” approach.</p> <p>For non-verbal people, there are best practices for eliciting responses.</p>	<p><b>Numerator:</b> Number of care plans that document the inclusion of the participant (or caregivers) and their values and desires.</p> <p><b>Denominator:</b> Total number of care plans.</p>	<p>Target = 100%</p>

# Participant Scorecard

RADS

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

Benchmarking  
Example  
Using  
Standard  
Measures

From TOPS™

# Key Community Based Health Home System Outcome Results

For a 12-month cohort<sup>1</sup> 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%<sup>2</sup>.

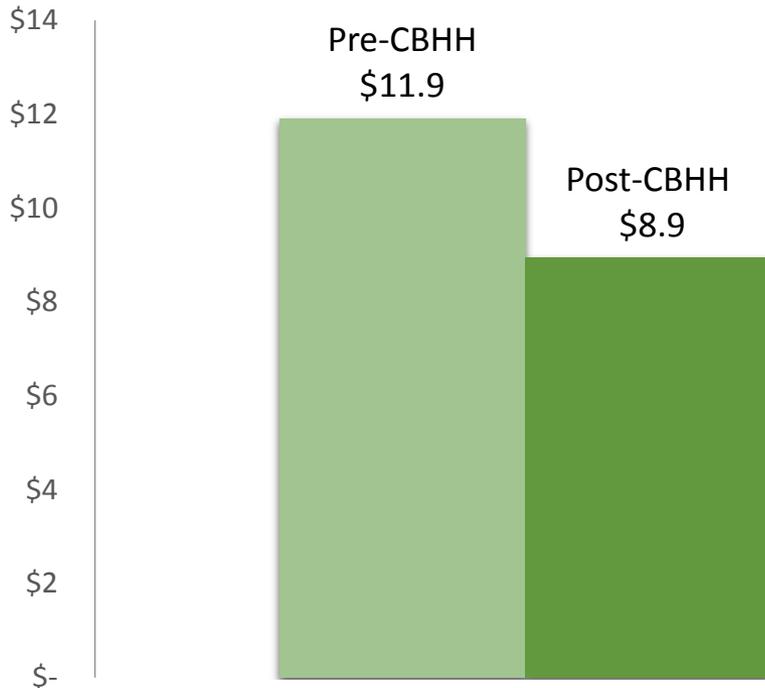
<sup>1</sup> Cohort included persons with 12 consecutive months of CBHH service during the years 2012-2014  
Each person served as their own control, ie, pre and post CBHH intervention data were compared

<sup>2</sup> (<http://www.academyhealth.org/files/2012/sunday/brennan.pdf>)



# 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<sup>†</sup> in costs)
- Hospital Admissions in the year subsequent to CBHH admission were **0.22** pmpy (approximately \$8.9M<sup>‡</sup> in costs)

<sup>†</sup>Hospital Admissions pmpy (.29) x Membership (4,888) x Hospital Admit Cost (\$8,378) ≈ \$11.9M

<sup>‡</sup>Hospital Admissions pmpy (.22) x Membership (4,888) x Hospital Admit Cost (\$8,378) ≈ \$8.9M



# Importance of Outcomes

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