



# **Stakeholder Workgroup Series Oversight, Monitoring, & Continuous Improvement: Final Recommendations**

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## **I. Purpose/Goal**

### **Overall Goal:**

To solicit recommendations from external stakeholders for the development of state contract procurement documents.

### **Oversight, Monitoring, & Continuous Improvement Goal:**

To provide recommendations for determining the appropriate quality performance measures for individuals enrolled in the program to monitor outcomes; and develop a process for oversight, evaluation, and continuous quality improvement.

## **II. Methodology**

- From **July 9, 2012 – August 21, 2012**, the RI Executive Office of Health and Human Services (EOHHS)/Medicaid Program organized a series of workgroup meetings.
- Each workgroup met 3 times over this 7 week period.
- Each workgroup covered topics selected as imperative to the planning, development, implementation, and monitoring of these initiatives.
- The 3 topic areas selected were as follows:
  - Outreach and Information
  - Services and Supports
  - Oversight, Evaluation, and Continuous Improvement
- An invitational announcement letter/email was developed and sent to stakeholders for participation in the workgroup series in the weeks prior to the start of the meetings.
- Stakeholders were asked to forward workgroup invitation letters/emails to any other interested parties.
- In order to have well-rounded input, state representatives as well as topic experts from the community were selected as workgroup facilitators.
- An email listserv was developed to send continuous workgroup updates and workgroup handouts.
- All workgroup presentations and handouts were posted to the RI Executive Office of Health and Human Services website at [www.ohhs.ri.gov](http://www.ohhs.ri.gov) under “Integrated Care”

- An email box was set up at [integratedcare@ohhs.ri.gov](mailto:integratedcare@ohhs.ri.gov) for any questions and comments related to the Integrated Care Initiative

### **III. Summary of Oversight, Monitoring, & Continuous Improvement Input Process**

- Workgroup Session 1 Summary
  - In this first meeting, participants were given an overview of the Integrated Care Initiative along with the workgroup's purpose and goals.
  - Participants were asked to begin to think about and identify some potential quality measures.
  - Post-meeting, workgroup members were asked to complete a survey which would be reviewed in the following session.
- Workgroup Session 2 Summary
  - A data presentation was given with information about the MME population, for background information.
  - Survey results were reviewed and a group activity was conducted to determine what the top domains were as decided by the stakeholder workgroup.
  - Once domains were identified, potential measures for each domain were discussed.
- Workgroup Session 3 Summary
  - The process continued from workgroup meeting #2 in the form of further smaller group activities.
  - Participants were split into two groups who met and discussed the domains and potential measures in order to come to a consensus as final group recommendations were formed.

### **IV. Final Group Recommendations**

Based upon input from the Workgroup meetings, domains were reorganized into the following 6 areas:

1. Utilization
2. Clinical Care (Preventative, Chronic Care, Behavioral, Substance abuse etc...)
3. Access to Care
4. Person-Centered Care
5. Quality of Life (includes Poverty Issues)
6. Care Management

## **V. Conclusion**

The group shared many pertinent ideas and recommendations for potential inclusion as part of the core set of quality measures, which can be found in Appendix B. The measures were all-inclusive with both process and health outcome measures spanning the 6 determined domains. Clinical Care, Person-Centered Care, and Care Management were the domains where most of the suggested potential measures aligned. There was also much overlap amongst the domains and many suggested potential measures covered more than one domain.

RI Medicaid will take these domains and measures into consideration as we continue to develop the monitoring, oversight, continuous improvement component of the Integrated Care Initiative. As we take these potential measures into consideration, the state may conduct further feasibility analysis to determine the capacity of future integrated care entities to implement certain measures. In addition, efforts at the national level are occurring by entities such as NCQA, CMS, and others to identify and develop a core set of quality measures. RI Medicaid is in anticipation of the distribution of the required core set of measures to be released by CMS at approximately the end of the fourth quarter of 2012. Measures related to LTSS and person-centeredness present an ongoing area of opportunity. Below are measures that were suggested surrounding these two areas as well as additional suggestions.

## **APPENDIX A:**

### **LTSS, Patient-Centered, and Other Suggested Recommendations**

#### **LTSS Related Measures:**

- Percentage of NH transfers avoided
- Percentage of community based physicians that send patient to ED after hours
- Admitted to NH for 1<sup>st</sup> time vs. repeat visit
- Rate of admissions for LTC patients (admission/readmission)
  - Ability to keep patients in same NH to reduce disruption of care and maintain quality of life
- Access & availability of appropriate care and services (DME etc...) to facilitate transitions from LTC to community.
- Number of Nursing Home refusals (NH refuses to admit patient)
- Cost vs. Level of Care
- Needs assessment in marketplace for overnight providers (Certified Nursing Assistant, Home Health Aide, etc...)
- Care for older adults - % of adults received Advanced Care Planning, Medication Review, Pain Screening, Functional Status Assessment
- Caregiver support – Frequency and % of caregivers receiving needed assistance
- Patient Activation Measure
- Resume life activities post NH
- Housing Availability (continuum of housing) Independent & Assisted Living
- PCP notified of hospital or NH admission (Safe Transition Project Best Practices)
- Team member experience and credentials: capacity and knowledge base of LTC/LTSS and need of this particular population

#### **Person-Centered Related Measures:**

- Patient's self-determination
- Patient's inclusion in care plan development
- Care for older adults - % of adults received Advanced Care Planning, Medication Review, Pain Screening, Functional Status Assessment
- Caregiver support – Frequency and % of caregivers receiving needed assistance
- Patient Activation Measure
- Member satisfaction – (CAHPS) including family/caregiver satisfaction
- Personal goals – care plan
- Clinical Care – Individuals with disabilities relating End of Life/Hospice Care
- Patient Safety - Timeliness of care provided
- Better comprehensive assessment – Geriatric, alcohol and substance abuse
- Physical access to facility, exam rooms, and so forth....
- Care Planning - Advanced Directives/ End of Life planning
- Availability and access to both high quality foods and ethnic foods in facility
- Assessments - Health-related Quality of Life; physical and mental health

- Personal goals – What do you want out of life? Like to do? Where do you want to reside?
- Assessments - Functional Status Assessment; ability to live independently, employment
- Person-centered Care – Transportation; assisted transportation

**Other Suggestions/Recommendations:**

- Using Best Practice Models
- Monitoring - Measure and Report FFS/PCCM and MCO
- Populations - Different populations of MMEs such as elder adults and younger duals
- Address communication strategies and measures with members who are non-verbal etc...(such as communicating with the member's advocate/guardian)
- Cultural Competency - Identify and monitor health literacy needs and provisions of cultural & linguistic services
- Social/Environmental– quality measures related to social isolation, employment

## APPENDIX B:

### Crosswalk of Suggested Domains and Measures

	Potential Measures/Areas of Concern	Utilization	Clinical Care (Preventative, Chronic Care, Behavioral, & Substance Abuse)	Access to Care	Person Centered Care	Quality of Life (includes Poverty Issues)	Care Management
1	Resume life activities post NH				X	X	X
2	Availability and access to quality ethnic food in facility				X	X	
3	Personal goals – What do you want out of life? Like to do? Where do you want to reside?				X	X	X
4	Housing Availability (continuum of housing) Independent & Assisted Living				X	X	X
5	Team member experience and credentials: capacity and knowledge base of LTC/LTSS and need of this particular population		X	X			X
6	PCP notified of hospital or NH admission (Safe Transition Project Best Practices)						X
7	Ability to access real time information on admissions and discharges across care setting	X					X
8	Decision of coordinating provider and awareness of who that person is by care team				X		X

	<b>Potential Measures/Areas of Concern</b>	<b>Utilization</b>	<b>Clinical Care (Preventative, Chronic Care, Behavioral, &amp; Substance Abuse)</b>	<b>Access to Care</b>	<b>Person Centered Care</b>	<b>Quality of Life (includes Poverty Issues)</b>	<b>Care Management</b>
9	Proactive coordination of behavioral/mental and medical/physical health			X	X		X
10	Geriatrician capacity in RI	X		X			X
11	Physical access to facility, exam rooms, and so forth....			X	X	X	
12	Number of appointments as well as number of missed appointments and reasons	X		X			X
13	Needs assessment in marketplace for overnight providers (Certified Nursing Assistant, Home Health Aide, etc...)	X		X	X	X	X
14	Cost vs. Level of Care	X		X			
15	Number of Nursing Home refusals (NH refuses to admit patient)	X		X		X	X
16	Access & availability of appropriate care and services (DME etc...) to facilitate transitions from LTC to community.	X		X		X	X

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17	Individuals with disabilities relating End of Life/Hospice Care		X			X	X
18	Emerging secondary chronic conditions		X			X	X
19	Prevalence of Hospital Acquired Infections (HAI)		X			X	
20	Prevalence of Pressure Ulcers		X			X	
21	Immunizations		X	X		X	X
22	Increase/prevalence of Sexually Transmitted Infections (STI) in the elder population		X			X	
23	ED Utilization	X					
24	Percentage of NH transfers avoided	X					
25	Percentage of community based physicians that send patient to ED after hours	X		X			
26	Use of Preventative Services	X		X			
27	Nursing Home Utilization: admitted to NH for 1 <sup>st</sup> time vs. repeat visit	X					
28	Acute Care Utilization: (Observation) Stays (increase transparency)	X					
29	Use of acute care in last few months of life	X				X	

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30	Rate of admissions for LTC patients (admission/readmission)	X					X
31	Ability to keep patients in same NH to reduce disruption of care and maintain quality of life			X	X	X	X
32	Advanced Directives (End of Life planning): Palliative Care Discussion (Occurrence and documentation) Palliative Care Bundle				X	X	X
33	Person-centered Care – Transportation; assisted transportation			X	X	X	X
34	Age Distribution – population specific measures (elder adults, younger duals)	X	X		X		
35	Address communication strategies and measures with members who are non-verbal etc... (such as communicating with the member’s advocate/guardian)				X		X

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36	Access to "emergency" or "walk-in" appointments at their PCP practice	X		X			
37	Defining the standards/expectations of the culture of care				X		X
38	Social/Environmental quality measures – social isolation, employment				X	X	X
39	Identify and monitor health literacy needs and provisions of cultural & linguistic services			X	X		X