



**Integrated Care Initiative  
Oversight, Monitoring and Continuous Improvement  
Stakeholder Workgroup Meeting #3  
August 20, 2012, 3:00-5:00 PM**

**Highlights from Workgroup Meeting #3**

**Thank you very to all who participated and provided input into this workgroup process. Your recommendations and suggestions are valued and appreciated as we continue on our path of creating an integrated care system for our Medicare/Medicaid Eligible (MME) population. The following is a recap of the final session of our Oversight, Monitoring and Continuous Improvement Stakeholder Workgroup meetings:**

**Workgroup Series Goals:**

**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.

**Small Group Activity:**

In Workgroup Meeting #2, participants identified their top 5 quality domains and some potential measures within each quality domain. The group discussed 3 of the top 5 domains providing potential measures and recommendations. In Workgroup Meeting #3, this process continued in 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.

As a reminder, the top five quality domains as selected by workgroup participants were as follows:

1. Person-Centered Care (9 votes)
2. Quality of Life (9 votes)
3. Care Management (8 votes)
4. Clinical Care (8 votes)
5. Poverty Issues (8 votes)



Based upon input from Workgroup Meeting #2, domains were reorganized into the following 6 areas:

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

The groups also identified and decided upon the following additional quality performance measures:

**Quality of Life:**

- Resume life activities post NH
- Availability and access to quality ethnic food in facility
- Personal goals – What do you want out of life? Like to do? Where do you want to reside?
- Housing Availability (continuum of housing) Independent & Assisted Living

**Clinical Care:**

- Clinical Care – Individuals with disabilities relating End of Life/Hospice Care
- Clinical Care – Emerging secondary chronic conditions
- Prevalence of pressure ulcers
- Prevalence of Hospital Acquired Infections (HAI)
- Immunizations
- Increase/prevalence of Sexually Transmitted Infections (STI) in the elder population

**Utilization:**

- ED Utilization
  - Percentage of NH transfers avoided
  - Percentage of community based physicians that send patient to ED after hours
- Use of Preventative Services
- Nursing Home Utilization
  - Admitted to NH for 1<sup>st</sup> time vs. repeat visit
- Acute Care Utilization
  - OBS (Observation) Stays (increase transparency)
  - Use of acute care in last few months of life
  - 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 to Care:**

- 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...)
- Number of appointments as well as number of missed appointments and reasons
- Geographical access
- Physical access to facility, exam rooms, and so forth....
- Geriatrician capacity in RI
- Proactive coordination of behavioral/mental and medical/physical health

### **Care Management:**

- Proactive coordination of behavioral/mental and medical/physical health
- Decision of coordinating MD and knowledge of who by care team
- Ability to access real time information on admissions and discharges across care setting
- 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

### **Additional Recommendations/Suggestions:**

- Advanced Directives: End of Life planning
  - Palliative Care Discussion (Occurrence and documentation) Palliative Care Bundle
- Focus on new and promising innovative delivery models (pilot or demonstration)
- Measure and Report FFS/PCCM and MCO
- Person-centered Care – Transportation; assisted transportation
- Age Distribution – population specific measures (elder adults, younger duals)
- Address communication strategies and measures with members who are non-verbal etc... (such as communicating with the member's advocate/guardian)
- Identify and monitor health literacy needs and provisions of cultural & linguistic services
- Social/Environmental quality measures – social isolation, employment
- Defining the standards/expectations of the culture of care
- Access to "emergency" or "walk-in" appointments at their PCP practice