Ladies and gentlemen, thank you for standing by. Welcome to the Intro to Quality Measures in Managed LTSS webinar. During the presentation, all participants will be in listen and only mode. Afterwards, we will conduct a question and answer session. At that time, if you have a question, please press the one follow-up by the four on your telephone. If you would like to ask a question during the presentation, use the chat feature in the lower left-hand corner. To reach an operator at any time, please press star zero. As a reminder, this conference is being recorded, Friday, November 30, 2012. I would now like to turn the call over to Joe Caldwell with National Council on Aging.

Thank you for joining the webinar. Today the webinar is hosted by a coalition known as the Friday morning collaborative. And this is a coalition of national aging cash aging and disability organizations who have come together at the national level to promote home based community service and advanced policy. And we are supported by the Scan foundation. Currently, the coalition consists of about 30 national organizations. Actually, I think 32 now is what we are up to. It is a great mix of aging and disability organizations, with a focus that have come together around home community-based services.

On today’s webinar, you know, we started these about a year and a half ago. And it really is a way to reach state advocates that are working on home and community-based services issues. And on today’s webinar, we have over 780 individuals that have registered for the webinar across the country. And again, it is a good mix of aging and disability. And on this webinar, it also seems like we are reaching a wider audience that includes researchers, state government entities, and even some health plans that have joined today.

And I think it is because it is a really hot and relevant topic that there is a lot of interest in. So let me give you just some of the logistics of the webinar today. And then, we will sort of introduced the webinar and turn it over to our speakers. We are pleased to have two excellent speakers on this topic. First hear from
Sarah Scholle from the National Committee on Quality Assurance, NCQA, and she will be followed by Alice Lind from the Center for Healthcare Strategies, and CHCS has been a big supporter of the Friday morning collaborative and has been on other webinars. Aunt Alice, in particular, -- And Alice, in particular, is a chair of the dual eligible workgroups within NQF, so she will talk about that about that. And if the acronyms NQF or NCQA don't make a lot of sense, you are exactly on the right webinar. Because that is what we are hoping to accomplish today, to really help to educate and build capacity around some of the quality issues that are out there.

So, just some of the logistics. All lines will be muted during the call. If you would like to ask a question, you can do that any time during the call by using the chat function on the lower left-hand corner of the screen. And we will keep an I on questions coming in, and of the end of the call, we'll get to as many questions as we can. Also, on this call, we are going to try to take some live questions from the phone. And this is the first time we are doing this. So, it is a bit of fun experiment. So we will see how it goes.

At the end, an operator will be on and we'll explain how to ask a question via the phone. But, in order to do that, you will have to be dialed in on the phone to ask your question. One question that we get a lot is, will the PowerPoint the available? And the answer is, yes. And it will come to you, to everyone who registered for the webinar, in an e-mail early next week. You'll get the PowerPoint, and you also get a link to the entire archive of the webinar. And please feel free to pass that onto other people who might be interested in the webinar and listening.

And if you want it sooner than next week, what you can do is you can go to the web address on the screen, which is NCOA.org/HCVSwebinars, and on that page, you'll find all of the webinars that we have done over the past year, and will post the archive in the PowerPoint as soon as we can.

So I would like to set the stage before I turn it over to the speakers. And, you know, our collaborative at the national level of aging and disability organizations have really put doing a lot of work this past year around the tool demonstration -- duals demonstrations and move towards managed care that is occurring in the states. And you know, one of the things that we have really focused on lately has been the area of quality measures.
And this is a critically important area. I think that everybody sort of understands that it is really a tool that can be used to ensure consumer protections. It can enhance the choice of consumers about plans, and really enhance plant performance. And I think, you know, it is a tool that can be used to create incentives, to meet desired goals, like rebalancing or promoting options for self correction, or making sure there is an adequate direct care workforce.

But saying that, you know, it is a very challenging area. And I think there is a lot of different challenges within that. And I think the first is to really start, you know, with ourselves. And I think, a lot of the Medicaid home and community-based services advocates, there is a sort of a lack of capacity -- a lack of capacity or knowledge about the quality measures, some of the entities that are out there, and some of the terminology commonly used in managed care.

So, things like HEDIS and CAHPS and NQF, I think for a lot of those, that comes from the Medicaid side. We are still unfamiliar with this whole territory, and that is exactly one of the things we hope to accomplish on today's webinar. I think, you know, another thing we have struggled with in our coalition is that a lot of these entities that have done managed care sort of quality endorsement and oversight really has a sort of approached it from a medical model or acute care clinical model orientation.

Something that I think we struggle with as HCVS advocates is really the need to sort of adopt a different paradigm around quality. A different framework at looking at quality. And so, I think that is something that we have sort of struggled with. We are trying to understand the quality world, to sort of communicate that policy framework around HCVS.

Another thing we are struggling around in the area of measurement, I think there is widely acknowledged gaps around major development. And therapy questions that I think we are trying to understand, you know, who is going to develop these measures, and really where is the funding going to come from? And where is the plan to sort of develop, you know, these measures? And the issue is that
things are happening now, the dual demonstrations are rolling out, you know, states are not waiting and moving toward managed care. And so what do we do in the short term as these measures are developed?

I think within our coalition, a lot of the organizations really feel that there should be better federal guidance around a core set of home and community-based services, quality measures and performance measures. And of course, that is easier said than done. But, I think the past decade or so, there has been a much clearer vision of some of the goals of HCBS, and you see that in CMS regulations, for example, around person centered planning. Or when you look at the AARP scorecard, or even things like the national court indicators, and the framework for quality within that. You can see a lot of consistency, and I think something our coalition is, you know, I think striving for is for some more clear guidance around HCBS quality measures.

And like I said in the short term, you know, we are really concerned about things moving forward without quality measures in place. We are really just pointing to the states to figure it out. So I think in the short term, we really have to look at what the states have in place right now and some of the promising practices that are out there. And those are all things that we’re kind of hoping to do in future webinars, to try to highlight some of the things that are out there right now that advocates can learn from and states can learn from.

So you know, they do not have to reinvent the wheel. And so this webinar is really the first in a series. And we hope to accomplish today is really a very basic overview. And it might be too basic for some people that have join today, but for a lot others, I can't tell you how many people, this past week, have really e-mailed me or come up to me and said, this is exactly what they need. Sort of an overview of what is HEDIS, what is CAHPS, what is NQF, this whole quality universe that is out there.

But on additional webinars, we hope to highlight some of those things that are in development. And some of the promising practices that are out there. So you know, this is the first with her, and if you have tuned in for simple answers, there really are none. This is a really complicated area, and it might produce more questions than answers, but we’re really hoping that we kick off with dialogue, with the
people that have joined the webinar from the states, and with the national advocates, about how we can really work together to advance the whole quality agenda and HCBS. And so that is really an introduction to the webinar, and I'm really pleased that Sarah and Alice are on today to help make sense of this. So I'm going to turn it over to Sarah from NCQA to lead off with her presentation about NCQA and HEDIS and some of these terms. So, I will turn it over to you.

Okay, great. Thank you so much, Joe. I am delighted to have the opportunity to talk with you all today and hope that I can provide a good overview of this quality measurement space. First, I'll just say a little bit about NCQA, the National Committee on Quality Assurance. We are not a federal agency, we are not for profit. We have been around now for over 28 years. And our mission is to improve the quality of healthcare across the country. And we do that by measuring quality, by publicly reporting information about the quality of healthcare, and providing that information so it can be used to hold healthcare providers and health plans accountable for providing good quality care to their members and to their patients.

So we, as a not for profit, what we really stand by is bringing multiple stakeholders into a room to help us weigh the options for measuring. What is good quality care? Understanding the evidence, and try to come to some consensus about what might be the best way to improve quality and improve outcome. So I will tell you a little bit about the process of development as we go on. So, my objectives for this presentation are to help you understand the landscape of quality measurement and the quality enterprise, introduce terms like HEDIS and CAHPS, help you to understand how we develop measures, and what makes a good quality measure.

And building on some of Joe's comments, I do want to say that the context of my presentation is the work that NCQA has done, focusing on outpatient care, and the acute care benefits. So, hospitals and primary care and specialty care providers. We have done. The work that is related to home and community-based services to date. We are very interested in him, and hope that we will have a chance to come back and tell you about the work that we have been doing, to think about how to measure quality for people with dual eligibility. But we wanted to let you know that today, I will be talking about what we have done.
That may not seem like it applies as well, but it should be, we think, a helpful approach and methods that could be applied to home and community-based services. I want to warn you that sometimes we have experienced is we have started talking about quality with people around the issues of people with dual eligibility. We are hearing that sometimes the words that we are using mean different things in different settings and that the quality issues are different. And so we're hoping that this will be the beginning of a conversation about how to think about quality. More broadly.

So what is quality in healthcare? And I think this statement sums it up pretty well. It is the right care and the right amount at the right time. And so we want that care to be safe and effective. We want it to be mindful of and adapted to the values and preferences and the situation of the individuals and families whose care is being evaluated. We wanted to be provided without waste and in the right amount, so that there is good access to care, and that it should be timely and address issues that can prevent bigger problems.

And we know that quality problems are widespread, and they have to do with not getting enough care, getting the wrong care, and getting to much care. So as we think about the measures that we look for, they could be addressing these different kinds of quality problems. And why would you want to measure quality? Well, if we don't measure where we are, we won't be able to tell if we are getting where we want to be in the future.

As you can tell by our mission and vision statement, we believe that having information about quality is important and critical to developing policies and encouraging healthcare providers, health plans, other organizations, patients and families and consumer -- consumers to all work together towards a goal. Quality information can be useful to facilitate choice of health plans or providers. It can incentivize improvement, it can help to manage costs.

So that is what we have been working on at NCQA for the past two decades. And we have some reason to believe that measuring leads to improvement. And this slide shows how quality has improved and
some HEDIS measures, I'll get to the definition of that over time. But what you can see here, I am not
sure if you can see me pointing to the arrow, but if you look at the top two lines in this chart, you will
see that children who need to have the chickenpox vaccination, when we first started measuring, it was
75%, and now it is right around 90%. So we believe that improvement can happen when we start
measuring.

Likewise, poor control of A1C, that is at the bottom, that is a measure that you want to be as low as
possible, and we have seen that that has gone down over 10 years worth of reporting. So we think that
measuring quality, reporting and publicly does energize people to work together to try to figure out how
to improve.

There are different kinds of quality measures. And this is I hope a very straightforward way to think
about quality. As being something about the structure of care, something about the process, of what
happens, and then the outcomes. In the end, was it better for -- are people better off because of the
work that you do? Structural measures are things that get out, to health plans have systems to support
good care? And that could be things like consumer protection and policies for credentialing their
providers.

We look to process measures to say, to patients receive recommended care. So that could be, did they
get the vaccinations that they were due? The mammograms? Or, for people with chronic illness, is there
care being monitored so that their blood pressure is at goal? Or for people with diabetes, is their blood
sugar at a goal?

And the outcomes could be outcomes that are focused on patient experiences. So looking at whether
care is accessible, whether communication with providers is good, whether there is customer service
systems that work well. It could also look at outcomes that are related to problems that are indicative of
problems like hospitalizations or readmissions. It could also the outcomes that get at trying to reduce
people's risk of heart attack. And also functioning.
I have to tell you, that outcomes box is the box we have the fewest tools, the fewest quality measures, and the most challenge. Because it is an area we have to think about where do people start off and do you expect improvement. And we want to be really careful about, as we him -- as we are using measures for incentivizing, that we are not having the effect of encouraging people to avoid the most challenging kinds of patients.

NCQA measures quality, structure and process through our accreditation process through programs and to our recognition programs for practices, like our patient centered medical home recognition program. We measure process and outcomes through HEDIS measures. These are measures of quality, and I'll talk some more about that. But also, to surveys with patients.

I wanted to give you a good example of how in one topic area, what it would mean to have a structural measure, process measure and outcome measure. So, care coordination is an area where we have been spending a lot of time trying to think about how we measure this critical concepts. So, a measure of structure would be, does a healthcare practice have a standard way of documenting referrals to another provider? Either a specialist, or it could be a home and community-based service. And how do they track that referral and figure out whether the person actually followed up on the referral? And what information came out of that referral? And how does that affect their care?

So the structure could be, do they have that system in place? Do they have a standardized form and a tracking system? A process measure would be, what percentage of referrals had all of the information that was needed for the specialist who was at target. Or, what percentage of referrals were actually completed, and the report from the specialty physician actually got back to the provider that made the referral. So that is process. And if process measure is looking at, you know, do the right thing happen.

And outcome could be, from the patient's perspective, for my performers -- providers informed enough about the care I had in other places? It could also be coming to the information actually turn into a plan that allowed the person to be able to return to work and social activities? From a systems point of view,
where a healthcare delivery system point of view, readmissions is a really important outcome, because that shows where you have poor care coordination.

As discussed, quality measures can be used for accountability, they can use for public reporting, they can use for quality improvement. Ideally, we want quality measures that could be used for all of these activities. But not all measures work well for all of these functions. When we are using measures for accountability or public reporting, because they have so much influence, it can have so much influence on what providers do or how health plans spend their money, we want to be really careful that we are promoting a measure that is useful, and that won't have unintended consequences.

I think I mentioned this push about structure and process measures. This slide just gives you some more examples of what structure and process standards, like our accreditation standards for health plans, or standards for primary care practices. What those kinds of standards would look for. And all of these would require that the practices or the organizations provide documentation that they are actually implemented these kinds of activities.

So, what is HEDIS? HEDIS is the healthcare effectiveness data and information set. It is the group of quality measures that NCQA developed and maintained. And right now, I think there are more than 70 measures. All of these measures are used, and health plans that report those measures to NCQA, they report them using very detailed specifications. And the measures have to be audited. And that is the way that we know that the information we are getting allows us to make apples to apples comparisons across health plans.

These measures are developed with an eye towards the evidence base about what will lead to better outcomes. And, we update these measures on a regular basis to try to raise the bar and to reflect where there are changes in scientific knowledge about different conditions.
HEDIS measures address a number of different dimensions. I have talked about some of them already today. Some are about effectiveness of care. To hypertension patients have blood pressure under control? Some are about access. The patient able to get an appointment with their primary care physician when they needed it? Some are about utilization and relative resource use. And these get out average length of stay, they get at the intersection of quality and cost. We have a measure of readmissions as well. I think about 40 measures are actually in that effectiveness of care and access domain. And those are used to evaluate health plans. And you can find information about health plans on NCQA’s website.

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Now, NCQA, actually, it has been over 15 years now, I think, that we have included patient ratings of their healthcare providers and systems and how we report on performance for health plans. And how we actually score people's accreditation. So this survey, which is developed and maintained by the agency for healthcare research and quality is an integral part of HEDIS reporting. And so, it includes questions about communication with physicians, about access to care, about the customer service areas of the health plan, and more recently, we have included questions that get out of wellness and care coordination.

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So, one of the questions that we talked about with Joe in advance of this webinar was, well, where do these quality measures come from? And who decides which measures get implemented? It is actually a long process, and it involves a number of different constituencies. And we wanted you to understand a little bit about what we have to look at to begin to think about developing a quality measure. First of all, we always try to start with the evidence base. About what is effective treatment. Because if we are going to be measuring something and holding it and asking everybody to do it, we want to be clear that that evidence base exists. To rearrange our resources to focus on a specific activity.

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Sometimes that evidence-based comes from the research literature. And then not evidence base gets summarized through guideline development. And we like to look to organizations like the US preventative services task force, and other groups that carefully weigh the evidence. And then we use that information to help decide and develop performance measures that look to see, okay, we’ve got evidence that a treatment works. We have a guideline that makes recommendations about when that treatment should be provided for what population. And then we can develop a measure that looks to see, are those guidelines being implemented. And NCQA is one of a number of organizations that develop measures.
A question is, who gets to decide which of these measures actually get implemented? And endorsed for these factional -- national programs? So, the National Quality Forum is another not-for-profit organization that works to endorse measures and make sure that they are methodologically sound and appropriate for use in different kinds of programs. You’re going to hear a little bit from Alice about the work that NQF has done around thinking about care for people with dual eligibility.

That national endorsement process is important, because to try to mediate among different kinds of measures that might exist that get at this same topic, and to make sure that the measures are really addressing the concerns of different stakeholders. Measure in the mentors, or the organizations that actually collect data, report on data about quality and publish that information, while CMS, the Center for Medicare and Medicaid services, is probably the guest measure implemented in the US, but NCQA does it for health plan reporting. Also, there are a number of active state coalitions, such as in California and Massachusetts, Wisconsin, where they have worked to develop and report on providers health plans or other organizations within their community.

So what I just talked about was kind of the bigger picture of moving from evidence to implementing a measure. But this slide actually looks at the details of what we do when we start off to develop a measure. And one thing that I did want to make clear is that all along the process, we are looking for input from multiple stakeholders. And we convene advisory panels that represent consumers, providers, health plans, employers, federal and state government, others, to help guide us. And one of the reasons we bring all of these different stakeholders into the room to help guide us is that they bring different kinds of expertise, and we are trying to make sure that as we are developing a measure, we are really considering the perspective of the different players.

So as we are setting priorities, we are often leaning heavily to look at what consumers and employers and purchasers really want to see. In quality measurement. We reviewed the evidence, and there, we need expertise in thinking about what is the evidence base that comes from the research. There are sometimes when there isn't research evidence to help us guide a process, and then it becomes important to understand what is the motivation for the measure, and how do we know that it is a good
place to put our efforts. We draft specifications, we field test measures, we always have to revise the specifications, based on what we learn from the feasibility and reliability and validity of measures. You know, how good are these measures? To come up with a final measure that gets selected.

And one thing that we know from 20 years of experience is that we may start off with a number of ideas, and as we go through this process, some of us are going to drop out. And they might drop out because the evidence is weak, or it is hard to create a measure that is going to represent the evidence well. You might find that in field testing, it is not feasible, or would be an undue burden to produce. But we know that through this process, this careful process, it is really important to have a measure that comes out at the end that people will believe in.

And in particular, because as we are developing measures, we are thinking about the endorsement process. And how an independent group like the National Quality Forum will review both the process of our measure, and the support and evidence that we can provide for all of the steps along the way. So we need to document. What makes this an important measure? Why should we have clinicians and organizations or patients complete surveys about this topic? Why is it important? Is it about the impact on health? Is it about the opportunity to address disparities or gaps in care? What is the scientific evidence base that supports doing something?

So if we are going to measure care coordination, how do we know that this specific to be that we are recommending is going to lead to improvement? From the measure itself, we want to know, is it valid? Are we really capturing what we think we want to capture? Is it reliable and repeatable? And how much variation do we see across organizations or practices or whatever the unit it is that we are comparing, are we seeing meaningful differences?

If a measure is always done, if something is always done, then that is not a very good measure, because it does not help us distinguish between high-performing organizations or low performing ones. We want to know about feasibility. We want to know, to what extent could a measure be influenced unfairly? How much gaming is possible in a measure? We want to look for measures that are not susceptible to errors or unintended consequences, or gaming. And that can be audited.
We are also interested in the cost of data collection, and how information is going to be used. And our target users could be consumers. Right now, we are thinking heavily about how people coming into the exchanges will be able to use quality measures to help select health plans. It could be providers who are looking at how they could use this information to prove -- to improve quality. Or for health plans, as a way for employers and states and the federal government to choose which health plans they're going to contract with.

This next slide gets into the nitty-gritty of quality measures. And I would just talk briefly about this, because the devil is in the details. In measuring quality. What we have found is that to be very clear that we are making their comparisons, we need to have a lot of specificity about the eligible population for measure, for whom an activity is specifically recommended. We want to know about that denominator's actually get into the number that we are going to measure. We want to be able to exclude people for which something is not relevant.

In fact, in some work that we are hoping to do, we are looking at some more of our existing HEDIS measures, and looking to see whether we need to develop new exclusions, so that the measures aren't applied to people for whom they are not really relevant. So for example, for blood sugar can troll. -- Blood sugar control. So, for somebody who is frail or has multiple chronic conditions, or is in hospice care, maybe getting their blood sugar down is not the best way to improve their overall outcomes. So those are the kinds of things that we want to think about.

And all of these pieces of a quality measure our pieces that we spend hours, days, I can't tell you how much time, trying to get it right so that what comes out is actually useful information. Now many of you are, I'm sure, aware of the Medicare star ratings, and NCQA also reports information about the quality of different health plans. It is on our website. And so if you're interested in seeing how some of these quality measures get summarized, and how you can use it to compare health plans, you can look on our website, or in Consumer Reports at the ranking of health plans that we conduct for them.
So in summary, quality of care is getting the right care and the right amount at the right time. And we believe that it is important to measure quality, because measuring quality helps us know where we are, where we want to go, when we have gotten there. And the HEDIS and CAHPS measures are tools that are in our toolbox for measuring quality. They are widely used for health plans. Many of these have been adapted for reporting at the provider level. You can see, I think, that we use a rigorous development process, and that is because we want these measures to be useful and implemented on a wide basis.

While the measures that exist in HEDIS and CAHPS were designed for more of a general health plan population, Medicare, Medicaid commercial, we think that the methodology that we use to develop pressures could be applied for home and community-based services. And we are actively working to think about how we take the knowledge and the experience that we have, and use it to measure quality for people with dual eligibility. So I will stop there, and if you have any more questions, in the slide deck, you will see my contact information. I will be happy to answer questions, hopefully at the end of this call, but off-line if you want to reach me, here is my information. So now, I will turn it over to Alice.

Thank you so much, Sarah. I have a feeling that anyone who is in this audience is probably thinking they wish that you had done the intro for every talk I have ever given. It is such a good baseline knowledge to have before you start leaping down the rabbit hole of details which is very tempting to do when you work in this area. So again, I just wanted to introduce you to our organization, the Center for Healthcare Strategies. I want to point out that we have improvement of healthcare quality as part of our core mission statement, and also is through all of our priorities through the organization. Today, I am good to talk a little bit about long-term supports and services, quality measurement, and especially as it relates to managed care.

Again, as Sarah said, talk a little bit more about the National Quality Forum specific to its work in partnership. And then we will end with some action that you can take in terms of turning to resources that are available for you nationally and locally. We will talk a little bit about where you can provide input to the financial alignment demonstrations going on now for those enrolled in both Medicare and Medicaid. And just around the bend for you to the other two. -- For you to be alert to.
About a year ago, the Center for Healthcare Strategies conducted a number of interviews with states, health plans and key advocates in several states about what was going on in their state right now with quality measurement for complex populations. What we found was that there is a lot of fragmentation across measurement approaches, across the populations, that the different state agencies who are involved in this work tend to not work together on these issues, and so, what resulted, and this is a paper that is published out on the United Hospital fund website, what has resulted is that there are actually few crosscutting measures that if you wanted to see how is healthcare and long-term supports and services being provided for the complex population in your local area, that you could not just take one or two or three measures, even, and put a complete picture together.

There is a lot of measures that are utilization based, for example, the rate of admissions to hospitals, or the rate of readmissions to hospitals. But in terms of the quality measures that Sarah was just talking about, really still in the beginning stages of knowing what are the best ways to do that. So knowing that, a lot of the folks that we will talk to work in silos. We started having conversations with folks about how to make sure that if you are moving down a pathway of improving care for a complex population, or if you are moving folks who use long-term supports and services into the managed care settings, you have all of these conversations with critical stakeholders at the table.

We found some innovation in looking across the population. A lot of where the action is is within health plans themselves. So as states begin to enroll these more complex populations with the managed care plans that are either new to them or, you know, have been traditionally providing care to a less critical population, that the health plans themselves have found that they really need to focus in on the high risk subgroups within their plans. They work very diligently on identifying folks, triaging them to the best outreach methods, and then get them into a comprehensive assessment in order to develop a person centered care plan.

We know some of that action is happening at the health plans, and the rest of us are learning a lot from what they are doing. Sarah already addressed some of what the drawbacks are to using HEDIS measures for this complex population for Medicaid and Medicare are. And use, as an example, you know, the
attempt to lower the blood sugar for people in frail populations, or what the folks in Minnesota called the old, old population. They have a disproportionate group of beneficiaries over the age of 85 who, you know, as a nurse or a social worker or a family member, you would be much more worried about, are they getting adequate nutrition, then worried about should their blood pressure -- blood sugar be managed down to a lower level. Those are the kinds of exceptions the HEDIS is starting to take a look at and improved.

Medicaid poses special challenges to measurement. Now that Medicare and Medicaid are looking at how enrollment will happen in jointly managed plans, even more so, because Medicare really wants to preserve the choice of beneficiaries to move in and out of plans as regular a basis as warranted. Usually that means monthly disenrollment, but folks can either choose to go back to fee for service Medicare or switch their health plans. Every time that happens, that person jumps out of the denominator of that measure and might jump into somebody else's denominator, but overall, might not have a long enough experience to hold a single health plan accountable for that care that is delivered.

That being said, a lot of states have to fall back on the use of HEDIS measures, because as Sarah said, they are the ones most widely in use. There is really good evidence on the preventive care measures, the utilization measures are defined in such a way that you could compare apples to apples on things like the readmissions to hospitals, which has been a struggle until HEDIS got a standard definition for that. But then again, health plans are really looking beyond some of those standard approaches, and states and their stakeholders too are looking beyond the standardized approaches for quality of care measures.

In our paper on the IQ knighted Hospital fund -- on the United Hospital fund site, we look at various areas of critical interest for the complex populations. Today, I'm going to focus specifically on the long-term focuses and support measures. So, using Sarah's basic construct of structure measures, process, outcome measures, I will just walk through what is available and where we see some of the gaps. The structural measures that states tend to use to manage the quality measurement system for the folks who use long-term services and support are built off of assurances that were developed for their waivers with the federal government. Most of these are the 1915 (c) waivers. There is a series of assurances built into those between the state and federal governments on a number of items. And what this means is that the state is saying to CMS, this is how we will guarantee that as we move folks out of
the fee for service system, or out of the general population of tracking their care, and into the specialized waiver group of services.

We guarantee to you that we will talk their quality of care along these different concepts. And so, for example, the level of care is evaluated and reassessed on a regular basis, that there is a service plan developed for each beneficiary that includes their personal goals, the risk factors related to their health and safety, and that the service plan is also of dated on a regular basis. That qualified providers deliver the care to these folks so that there is some licensing standard or a criminal background check, or some other way that the state monitors who it is that they’re working with to provide a set of services.

And then health and welfare, bottom line, the state issuers to CMS that they will try to protect folks from abuse, neglect and exploitation. From a structural standpoint, financial accountability and administrative accountability, the state looks at the overall population enrolled in these waiver programs and assures to CMS that they will not be spending money overall than if these folks were institutionalized. For example, in nursing home care.

Were some of the gaps exist, the trucks roll side, is that once you move this set of services into -- the structural side, is that once you move this set of services, you need to ensure that the health information system shares this kind of information. How does the health plan use information that has been collected over the years for folks in these waiver programs? So that they do not need to re-credential folk who are already qualified providers from the states, or how the health plan credentialing process could then turn around and share back with the state what they have learned about the qualifications of providers.

That is just as an example. Next, the process measures that are in place for long-term support and services. A lot of these, again, build off of some standardize measures in HEDIS. The medication review, depression screening, flu and pneumonia vaccines are all very important for folks in the long-term supports and services group. On the other hand, there are weaknesses here, just because some of these measures could be setting specific. In other words, some of them only works for folks in institutions. Others only work for folks in home care. And some are specific to the over 65-year-old population. And
so all of the younger folks using home and community based services move out when the statements
the measure itself into the managed care setting. There is gaps in the process measure group, which
include a standard way to assess mental health, a standard functional assessment, standard ways across
states to do level of care determination. Most states have standardized these kinds of things within their
own state. Again, if you wanted to look across on a national spectrum, there is a purple storage is out
there in terms of health plans monitor the quality of care of quality along these lines.

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The outcome measures, when we started to look at what is available and what states are starting to
think about using, there are some that have been built into the Oasis system that home health agencies
use. There are some really good measures of the outcomes of home health in relationship to improving
or stabilizing some of the activities of daily living or symptoms such as pain or difficulty breathing. There
are some standardize measures for the rate of hospitalization and beneficiaries being able to live in their
own home. New York has done a lot of work in this area, which is one of the reasons that we were out
there researching the topic.

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A really good place to turn in terms of looking how states are starting to think about using outcomes
measures. However, the gaps here again are huge. The CAHPS surveys are just now beginning to be
tailored to the needs of people in the home and community-based services. And I think both Joe will talk
little bit about plans for getting you up to speed about that through this venue, and Center for
Healthcare Strategies will be offering an opportunity about that as well.

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Some of the other ones are looking at the transitions from institutional care back to home, and how
beneficiaries proceed through that. Do they receive adequate information about the transition? Do they
know what medications they are supposed to take, etc., in a way that prevents their readmission back
into the hospital. And quality is life. Those kinds of measures are really not standardized from state to
state. We have noticed that states are beginning to build their overall quality strategy off of the health
and human services national quality strategy. And the triple aim that CMS and HHS have put out is to
have better care, healthier people in communities, and more affordable care. And those priorities that
tie to the national quality strategy really resonate for folks thinking about how to support people living
in the community. And especially that last bullet point of the priority list. To work with communities to
promote the wide use of best practices to enable healthy living.
We really want to make sure that the national quality strategy is focused on the overall population and does not leave folks off because they are higher users of services that might have been neglected from some of these national approaches in the past.

So, the National Quality Forum, Sarah gave a brief introduction to their role. They have a three-part mission. Number one is to build consensus on national priorities and goals for performance improvement, working in partnership with folks to achieve those goals. The endorsement role Sarah talked about a little bit, and then promoting the attainment of national goals through education and outreach programs is one of the reasons that they are more than happy that you all are getting a little bit more exposure to the work of NQF. Their work also is guided by the National Quality Strategy. The measure applications partnership work informs the selection of performance measures to achieve the goal of improvement, transparency and value.

And the reason that we wanted to make sure that folks were alerted to the work of the National Quality Forum's map workgroups, is that two of them really touched the populations you might be most interested in. There is one workgroup working on post acute long-term care, and a second working on dual eligibility issues. Both hold public needing. Each of the meetings that are public have the opportunity for stakeholder input. The PowerPoint slides that are used to guide those in the agendas that are used are all out there on the NQF website. It is really easy as a stakeholder in this process to follow their work.

As Joe said, I am the chair of the dual eligible beneficiary group, and just wanted to make sure that you were aware at a high level of the work that has been done so far. We have published one initial report, and about to follow up with an interim report. But basically, the work of this group of folks, which includes a wide variety of stakeholders, individuals who represent different sets of providers, subject matter experts, organizational members, etc., come together to the table to look at what exists now.
So we kind of set aside all of the measurement work that is in place already, and turned our attention to what is missing for measures for dual eligibility beneficiaries. And taking that as a starting place, then we report up to CMS on where we see the needs for measures. And so our initial recommendation last year was to come up with a core measure set, and then within that, the starter set of measures that seems to us to be ready to put into place right now, and an expansion set that really needs a little bit more modification because of the issues that I talked about for the right setting of care, or the right populations included, etc.

As Joe said, these slides will be available to you, so I won't walk you through each of the measures. But the thing to know is that we tried, to the extent possible, to use endorsed measures. So the numbering behind each one of these measures is the NQF and doors to measure number. And again, a very user-friendly place on the NQF website. You can just type into your little Google search engine, NQF measure 0208 and it will take you to the place on the NQF website where you can see what this measure is all about, and which population it has an effect on, etc.

But our high leverage opportunity areas, the places where we thought we really needed to P5 quality measurement right now include quality of life, care coordination, screening and assessment, mental health and substance use, and again, looking back at those structural measures of care. What do we hope to have in place in order to make sure that care is delivered to the right people at the right time?

We discovered a number of gaps. And he's probably won't be unfamiliar -- and these probably won't be unfamiliar to those of you working out in the field. Some of the most important things that you would hope that you would know at the end of the day after you have put a program into place is, did it improve the functioning of the person, did it improve their sense of control and autonomy and determination in their environment. Are they living independently to the extent possible? Are they in the most appropriate care setting? A lot of these things are still yet to be hammered out in that kind of standardized measure way that Sarah talked about.

Similarly, the post acute care, long-term care subgroup, looked at a number of these areas. Their priorities are very similar to ours in terms of wanting to look at function, goal attainment, patient
engagement, or we would say beneficiary or persons engagement in their experience of care. A lot of these areas that they consider the high leverage areas. But they too found a lot of gaps in terms of having standardized ways to measure these areas.

But I did not want to leave with you thinking that all is lost. There is a lot of work being done because of the attention right now to this area. And here are some resources that you can keep track of, either locally or on a national level. There is the AARP long-term supports and services scorecard. That program that many of you may be aware of has published the first set of measures. Right now, going back to the set to plan for the next report that will come out in a couple of years, to talk about how to strengthen the measures, are there any to be added or to be dropped, etc. So that is a place to just check back into on a periodic basis.

You can check your own states results on that scorecard set of measures. And so, very useful to know about. The AHRQ similarly does state snapshot so that you can look at the quality of your state health care against national rates. And then a couple of other places that really eight -- relate specifically to those financial alignment demonstrations going on right now for Medicare and Medicaid enrollees, a set of standards are being set. Each state will have an avenue to weigh in on those measures and to follow them and encourage the state to be transparent in its publishing of them. And I can talk a little bit more about that if there are questions about it.

Examples of those that you might be interested in knowing is that CMS is working with states to have to find ways of measuring what proportion of the staff is trained in consumer direction, for example. And how do you involve advocates and stakeholders in the guidance of your program and in health plan program guidance itself?

A couple of quick places for you to keep track of, again. CMS is keeping their quality of care updates out on their website. That is a very useful place to look. We will be, again, having a webinar on the updated version of CAHPS that is being developed for testing right now. And also theNational CoreIndicators set, which is another useful thing for folks to be alerted to. And then the ongoing work of the NQF measures partnership application is right here in this link. I wanted to make sure that was handy for you.
And I also and Sarah does have our website there, but feel free to contact us and we will be happy to help answer questions off-line as well. So, thanks. Jo, I will turn it back to you.

Great. And thanks, Sarah and Alice. Those were great presentations. And I think at this point, I will let the operator, on and tell people how to get into Q4 questions, and then we’ll take some questions that came in during the chat. So, Kathy, are you there?

Certainly. Ladies and gentlemen, if you would like to register for a question, these press the one followed by the four on your telephone. You’ll hear a prompt to acknowledge the request. If your question has been answered and you would like to withdraw the question, please press one followed by the three.

Okay, great. Will take a few questions that came in during the chat. One question that came in and there is probably no easy answer, but I will see if anybody has any response to this. What stays do you think are using some of the most innovative or tested measures around home and community based services or LTSS? Alice, I know that you have done the roadmap, and I don’t know if anything comes to mind as like sort of states to look at, or maybe states that we might want to invite on future webinars.

What I would say is that different states have different best practices. I would say there is probably no single state that I would say is doing everything perfectly. But in terms of where to look for best practices in individual buckets, several states have built their comprehensive assessment tool to be able to link to outcomes, and then measure whether the services delivered resulted in improved or stabilized outcomes over time.
And in turn, some states with big cross agency databases are starting to be able to use the medical, long-term supports and services, behavioral health data and community health data all in a single data system to be able to identify folks at high risk and share that information with the folks who are providing care and services out in the community. So, Washington does a really good job of that. Oregon has a good standardized assessment tool that is applied to the long-term supports and services population. There are several states who do a good job in that kind of structural way of making sure that the information systems kind of support the work that goes on in the community.

There are other states who have really innovative ways of collecting the information on kind of health and safety sides. So, Tennessee for example has a way that when the provider is out in the home, they have an automated check-in system, so the state knows when people are in and out of the house. And, you know, it is all collected electronically, so that they have a really good pathway there.

The state of Vermont, being a nice little state, is able to work really closely with its stakeholders and get input from them and have a community-based approach to sharing information about quality of care. And most of the states who have done more managed long-term supports and services for longer periods of time like Arizona, Texas, Minnesota, those states have years of experience in refining their approach. And so, they have more transparent processes, and more available data to look at then a lot of the other states do.

Great, thanks. And I will put a plug that on future webinars, we hope to bring on some people from some of those states. So if there are people out there that are listening and maybe you are the quality person in the state, or if you know of a good presenter for future webinars that might want to tackle and share what they are doing, let us know and we are planning those webinars.

You know, another question that came in that I wanted to see if you guys had any thoughts about this and that I have kind of thought about, too. This came in from Al Norman from Mass Home Care. This gets at the issue of when you’re looking at outcomes that are person centered, how do you ensure that the outcomes are based on really the person and their goals? Like the person centered planning goals, versus the goals of the care team or what others might have. And so I think that gets at the question of really,
you know, like in HCBS, we have really moved towards person centered planning, and there is different sort of goals for different people. How can we use those in terms of trying to get some quality outcomes that are going to be different for each person, but based on a person centered plan? Do you have any thoughts on that?

Well, I will say a word or two, and maybe Sarah can talk about the challenges and trying to do the actual measurement of it. But you know, from an auditing standpoint, as a former state employee where you would go out and actually review care plans that have been developed for people or individual service plans that have been developed, you know, the thing that I would look at is, you know, on the negative side, I would like if a -- I would flag if a healthcare plan had a cookie-cutter approach where the goal was something like reducing hemoglobin A1C by X amount of points. That is not a goal that many of us have. I mean, most of us. There are probably some people with high achieving diabetics who want their blood sugar at an exact number.

But most people, the goal that they have is like, I want to be healthy enough to walk back and forth to the store, which is five blocks away. Or I want to be healthy enough that I can get to my daughter's graduation and not feel like I am struggling for breath with every move that takes me from the bed to that graduation. You know, so when I look, as an auditor, for a person centered goal, that is the kind of thing. Avoiding the cookie-cutter, and looking for the personal goal. And obviously, from a structural standpoint, systems can be set up in a way that directs towards the cookie-cutter, or directs towards that, how do you get that person to work with you on what their goals are using kind of motivational interviewing techniques or other ways that you can really, as a person supporting someone, figure out what it is that you should be helping them reach towards. But Sarah, I don't know if you want to talk about why that makes it such a hard thing to measure.

That is a very hard thing to measure. But actually, [ Pause ] --

I think we may have lost Sarah.
Sarah, your line is still connected. Are you online, or could you press your mute button?

I will try to call back out to her. Just one moment.

Okay, we will come back to Sarah. Another question that came in that I am curious about is just the timeline on developing the measures, and particularly, like this question came in about the quality of life measures and the experience sort of measures that need to be tested. You know, knowing that things are going forward right now and plans are rolling out, I don't know, Alice, if you have any sense of how long it might take to develop some of those measures and test them before they can reach the level of an NQF approval or endorsement.

Well I guess the good news is that there are a few measures that are out there on the NQF endorsement that fit in subpopulations. So, there is a quality of life measure that fits people with kidney disease, for example. And so going back, and part of NQF’s role is to go back to the measure developer &, would you work with us on extending the denominator of this population so that it is not just limited to kidney disease and we can apply it to a broader population? Or similarly, take the nursing home measures or the home health measures that look just out of folks using that set of services and how they are assessed and assisted with pain and functional status. And then expand the denominator and then test that.

But the testing part, I just want to say on the optimistic side, there is so much interest from the states right now that I think the states will be avid consumers of the opportunity to test some of these measures. And that means that they will learn a lot from that process. They might not all be publicly reportable by a year out from now, but within a couple of years or three years, I feel like we will be in a much better place than we are today.
Okay.

And this is Sarah.

Oh, hey, Sarah.

Can you hear me now?

Yes.

We must have had some kind of hiccup in the system. I want to reply to the question about how to look at goals and person specific goals, as opposed to an outcome that applies to everybody. Like a blood sugar control of a certain level, or blood pressure control of a certain level. For a measurement, it is easier to be able to say that everybody in the denominator, everybody you are looking at, ought to get the same place. That is why we have plugged pressure control of you know, bless them 140 over 90. That is recommended for most everybody. That is easier than saying, for this population, it might be this level, or it might be at this level for this population.

It gets even harder when you're trying to look at these goals that are based on people's situations and what kind of functioning or activity they want to do as individuals. Actually, at NCQA, we are seeking funding to develop such a measure that would look at whether the care plan is responsive to people's goals. And we think that it is going to require that we work alongside organizations that are caring for people with dual eligibility, and try to look to see, was a documented first with the preferences are.
And then, whether there is a way that we could actually structure a measure that would say, the goals were documented, and the care plan was developed in such a way that the person's goals were there. We are a little bit worried that there are so many ways to do it that it will be hard for us to find a way that we could make fair decisions that would allow us to make apples to apples comparisons across different organizations or providers.

But we have heard loud and clear that this is where we should be headed. We think that that kind of measure is likely to be more fruitful than a measure that would just say, did someone's functional status improve over time? Because that kind of measure is brought with all kinds of problems. We know for some people, a decline may be inevitable. And being able to maintain functioning over time would be the right thing for an organization to do and the providers are going to have to work really hard to help people maintain their level of functioning or their level of living at home or whatever their goal is.

So we are skeptical about those outcome measures that are just measuring functioning and looking for a certain level of high functioning or a certain level of improvement without taking into consideration the diversity and the expected trajectory. And we don't want any kind of measure that is going to encourage people, encourage organizations, to avoid patients who might be hard to take care of. That is certainly what we have heard on the blood sugar control and diabetics, and why we have some ways that we try to handle the situation. We know that it is not appropriate for everybody. To manage to a low level of blood sugar control. So we want to make sure that there are not any unintended consequences of measuring outcomes.

You know, that sounds really exciting. That, you know, you're thinking about that. When we were looking at all of the dual demo proposals, one of the reactions that our coalition had is a lot of times when they mentioned a care team or used the word person centered planning, they are not even talking about the person being involved in happening at all. So it is coming from a very different paradigm than, you know, home and community based services. So that sounds really exciting.
I want to check in with Kathy and maybe go to the phones if we have people on the line to ask questions.

Thank you. At this moment, I don't have any questions over the phone.

We wanted to try the phone lines. So, don't be shy. If people have questions, could you tell them again how to get in?

Certainly. To register for a question, please press the one followed by the four.

Okay, great. So let me see. Another question I thought was interesting that came in, and maybe this is a NCQA kind of question. When you are doing sort of the, I guess, the scorecards or tools for consumers, have you developed anyways about how you communicate that information to people with intellectual disabilities or people with dementia or, you know, that might have a hard time processing all of that information? It is more like, how do you feed that back out? I don't know if you have any thoughts, Sarah or Alice, on that.

I think that we have not. And it's another reminder that we have a long way to go to be able to present information, and a way that is useful to consumers. Actually, the work that we have been doing with Consumer Reports has been very helpful, because they keep asking us about it. To think more clearly about how to present information, what is the kind of information that consumers want to see.
We know that. And so we are looking actively for ways to present data in a simpler fashion and to answer the questions that people want to know. So I think this is a great suggestion. As we are embarking on the work that we are doing to try to think about measures for people with dual eligibility, and for other persons using long-term services and support, this seems like a good time for us to incorporate that as one of the steps that we do in testing our measures. Thank you for that suggestion.

And this is another good question that came in about family caregivers. Are you looking at any, you know, measures that would target family caregivers? Because that is so important in the HCBS world. And I think even the national core indicators to a family survey. So it is in other way to get past it is another way to get information about quality. I don't know if you guys are looking at anything out there, or potential measures for caregivers.

So, at NCQA, as we have been thinking about how to get at the care planning process and preferences and goals, we have been struggling with the issue of who is the target for some of those questions. Especially when a person is dependent on the family caregiver. And you know, some will allow for, they call it, proxy respondents, when it's the caregiver responding. I realize this question is actually very different. I think it is looking at the caregiver and props the burden of care for that person and the resources.

And I don't know that that has come up as one of the priorities for measurement. So I will take that back as a question to our team. Alice, what about in the work that the [Indiscernible] has done?

In the most recent dual eligibility workgroup, we did talk a lot about that. Again, casting for measures that might be available, not really finding any standardized approach to it, but, you know, it is certainly possible to do from a structural standpoint. Where the state would say to the health plan, and your comprehensive assessment of the individual, do you take into account what are the strengths and capacities of the family member to assist with care, as opposed to just assuming, oh, there is a daughter in the house, therefore, she will be able to pick up some of the burden of the direct care needs.
It is certainly on our radar, but we have not arrived at any kind of solution for it.

Okay, let me check with Kathy one more time. Is there anyone on the phone that would like to ask a question?

I do. Our first question comes from the line of Suzanne Torrey.

Hello, I was in Hampton, Connecticut. And Connecticut is supposed to be doing pretty well with patient centered work. But my personal concern relates to the feasibility of standardizing Medicaid nationally. As Medicare, I believe it is. Because I am a person who is living in Connecticut, but thinking I would like to move south. And it seems as if I have a real hill to climb in order to check out each state and see how they are handling Medicare and Medicaid. And find out which are good and which are not, and what areas they are good in and what they are not. And find out which would allow me to make a best possible choice for a place to move. Is there any feasibility? Does it seem feasible that that might move in that direction?

I know that one of the speakers said something about some states focusing on modeling themselves on the health and human services measure.

This is Alice. I will jump in on that if it is okay. I really think that the AARP long-term supports and services website is a good place to look for states to state comparisons. You can get as detailed in the weeds as you want to, or you could just think to your self, am I more or likely to need nursing home care? The mummy look at the nursing home measures. Am I more likely to be living in the home independently? And then look at the measures. But in terms of which package of services are offered
from a comparison standpoint, they do some of the best. The collected all into one place for you better than a lot.

The Kaiser family foundation also has state to state comparisons that is Peter go out there on the website. But you know, I am trying to think if there is -- it seems like there are at least a couple of sources like that, and it just depends on how much you want to get into the weeds. But in terms of who provides comparable parked buses of services, I think AARP is your best bet.

Okay, thanks.

And I think we are kind of running it out of time. But what I will do is we had a lot of great questions coming in, and I'll make sure that the presenters get your questions. At least for informational. Because I think there is a lot of good information in the questions themselves. And in a minute, I'm going to tell you about an online community that we have been trying to promote. And I do think on this topic, it would be great to continue the conversation. We had like 800 people registered for this webinar. There is a lot of expertise out there.

If you are interested on joining this online community, you can go to this address. There is already about 300 or 400 people in the community. But we are trying to get people to realize how you can use it. And you can use it to post a question, share things from your state, and particularly on this quality issue, I think it would be great to continue the discussion.

And then, just lastly, we are in the process of lining up the next webinar. And it looks like tentatively, it will be on December 18. And for that one, we are lining up presenters to talk about the HCBS experience survey, which is a survey that is about to be sort of pilot tested and launched. And the goal is that that would essentially maybe become a CAHPS measure. And so, there is excitement about it, and we want to learn more about it, and I am sure that you'll be excited to learn more about it too.
And again, if you have people in mind that might be good presenters from states, to share them with us, but us know. We want to line up some more webinars around this quality measure area.

So with that, I again thank the presenters for their excellent presentations, and thank all of you for participating. And we will talk on the next webinar. And everyone have a great weekend. Thanks.

Ladies and gentlemen, that does conclude the conference call for today. We thank you for your participation and ask that you disconnect your lines. Have a great day, everybody.

[ Event Concluded ]