

# HCBS Conference 2017

## ACL/CMS Track: HHS Investments in Cross Cutting Quality Measurement Initiatives

Jean Close, CMS  
Ralph Lollar, CMS  
Beth Connor, CMS  
Shawn Terrell, ACL  
Arun Natarajan, ONC



# What We Will Cover

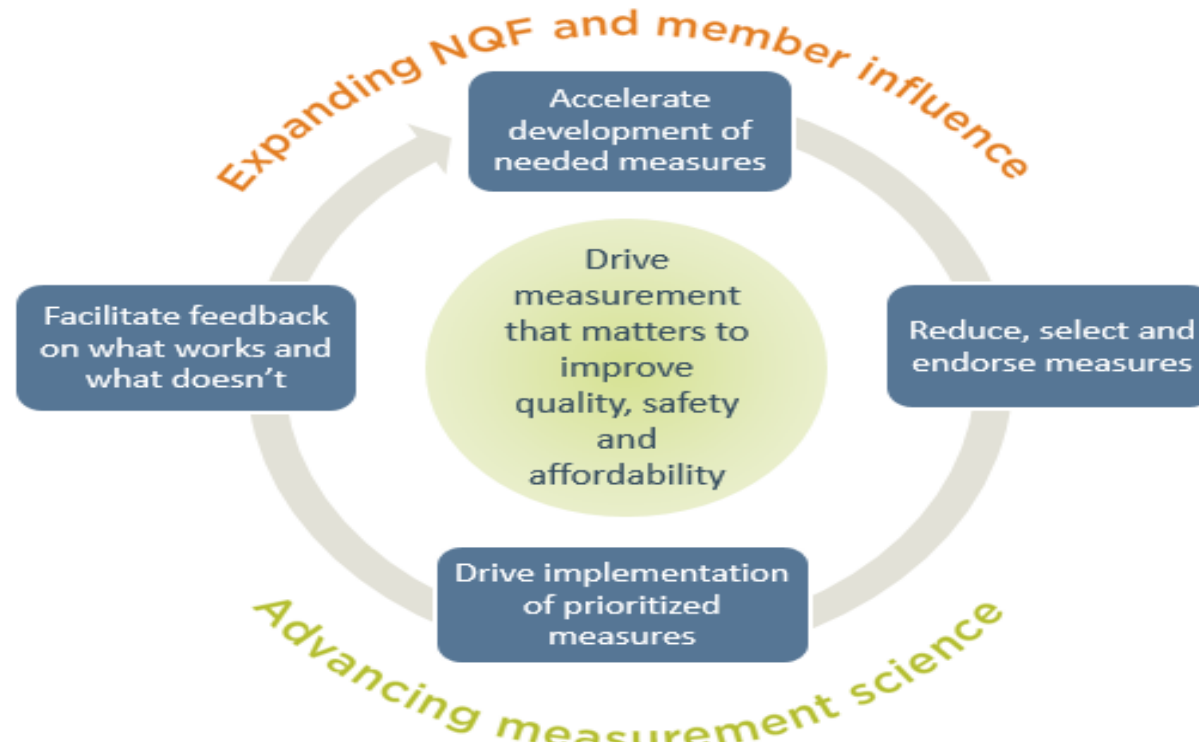
- Overview of:
  - National Quality Forum
  - Medicaid Quality Initiatives
  - HCBS Waiver Quality
  - The IMPACT Act
  - ACL Quality Initiatives
  - ONC Initiatives

# **Introduction to NQF and the HCBS Quality Project**

## **Shawn Terrell, ACL**

# What is the National Quality Forum?

*The National Quality Forum's (NQF) mission is to lead national collaboration to improve health and healthcare quality through measurement.*



NQF **leads, prioritizes** and **collaborates** to drive measurable improvements in health and healthcare.

# **A New Frontier for NQF...**

**Addressing Performance Measure Gaps  
in Home and Community-Based Services  
to Support Community Living**

# Project Purpose and Objectives

- Provide multi-stakeholder guidance on the highest priorities for measurement of home and community-based services that support high-quality community living
- Create a conceptual framework for measurement, including an HCBS definition
- Perform a synthesis of evidence and environmental scan for measures and measure concepts
- Identify gaps in HCBS measures based on the framework and environmental scan
- Make recommendations for advancing HCBS quality measurement

# Multistakeholder Committee

- Joe Caldwell (Co-Chair), National Council on Aging
- Stephen Kaye (Co-Chair), University of California San Francisco
- Robert Applebaum, Scripps Gerontology Center, Miami University
- Kimberly Austin-Oser, Anthem, Inc.
- Suzanne Crisp, Public Partnership Limited
- Jonathan Delman, University of Massachusetts Medical School
- Camille Dobson, National Association of States United for Aging and Disabilities
- Sara Galantowicz, Abt Associates Inc.
- Ari Houser, AARP Public Policy Institute
- Patti Killingsworth, Bureau of TennCare
- Charlie Lakin, National Institute on Disability and Rehabilitation Research (former)
- Clare Luz, Michigan State University
- Sandra Markwood, National Association of Area Agencies on Aging
- Barbara McCann, Interim Health Care
- Sarita Mohanty, Kaiser Permanente Northern California
- Gerry Morrissey, The MENTOR Network
- Ari Ne'eman, Autistic Self Advocacy Network
- Andrey Ostrovsky, Care at Hand (former)
- Mike Oxford, Topeka Independent Living Resource Center
- Lorraine Phillips, University of Missouri
- Mary Smith, Illinois Division of Mental Health
- Anita Yuskas, Pennsylvania State University

Quality in Home and  
Community-Based  
Services to Support  
Community Living:

Addressing Gaps in  
Performance Measurement

FINAL REPORT  
SEPTEMBER 2016



NATIONAL  
QUALITY FORUM

This report is funded by the Department of Health  
and Human Services under contract HHSM-500-  
2012-00009I, Task Order HHSM-500-T0014.

# Quality in Home and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement



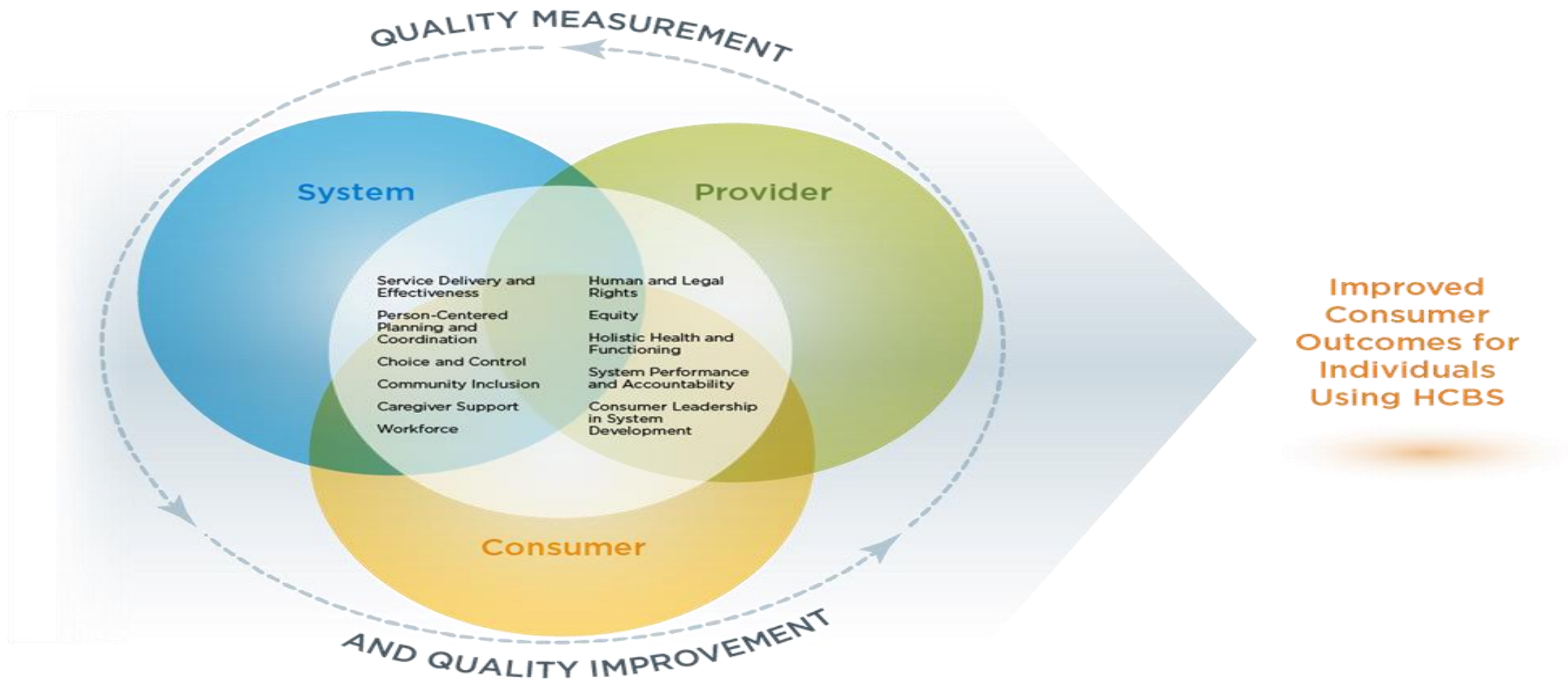
# Seeking to Align Measures Across Programs to Improve Outcomes for Individuals Using Home and Community Based Services



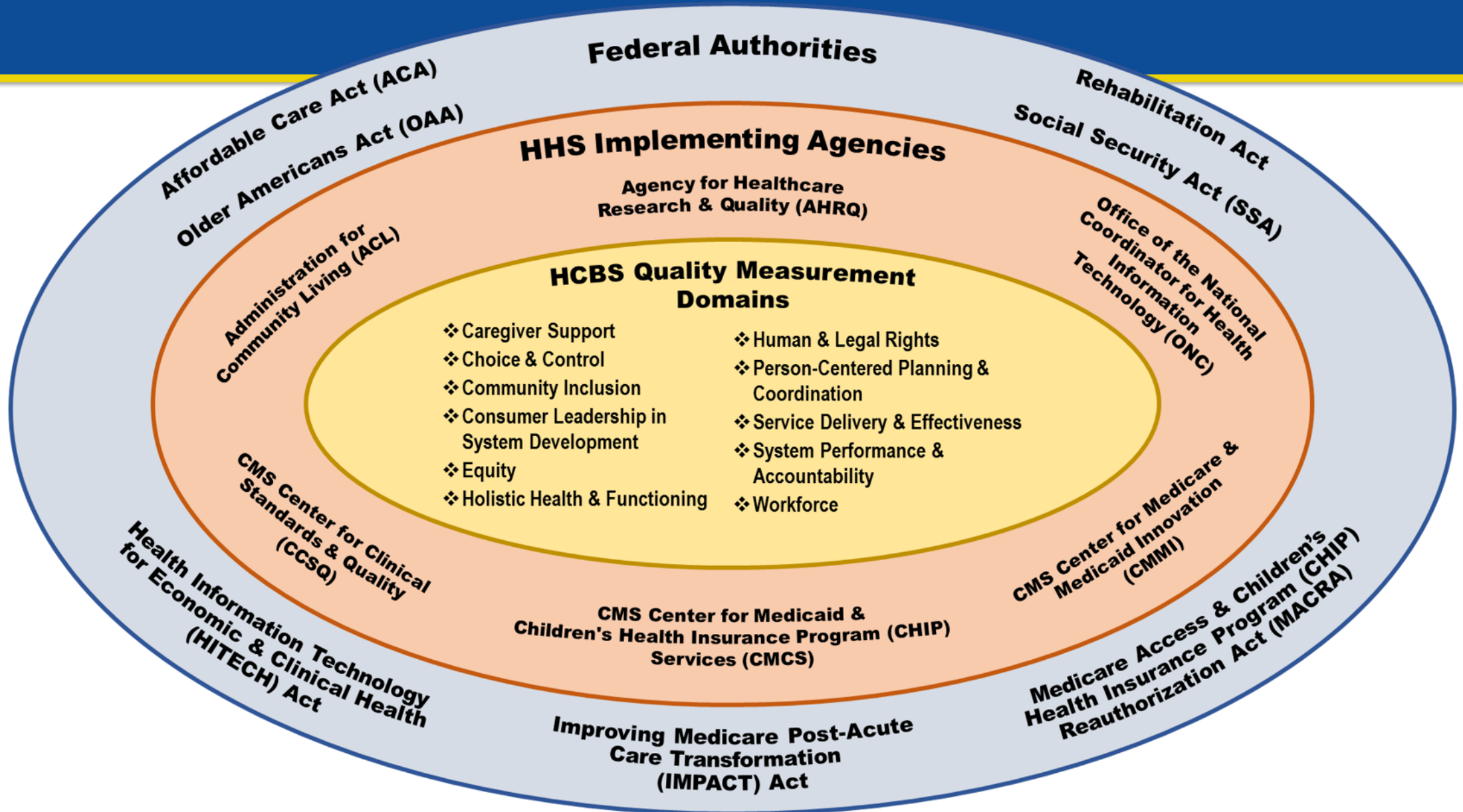
**Jean Close**

Centers for Medicaid & Medicaid Services  
Center for Medicaid and CHIP Services, Disabled &  
Elderly Health Programs Group

# NQF Conceptual Framework



# HHS Investments in Cross-cutting Quality Measurement Initiatives



## **ACRONYMS**

- ACA = Affordable Care Act
- ACL = Administration for Community Living
- AHRQ = Agency for Healthcare Research & Quality
- CCSQ = Center for Clinical Standards & Quality
- CHIP = Children's Health Insurance Program
- CMCS = Center for Medicaid & CHIP Services
- CMMI = Center for Medicare & Medicaid Innovation
- CMS = Centers for Medicare & Medicaid Services
- HCBS = Home & Community Based Services
- HHS = Department of Health & Human Services
- HITECH = Health Information Technology for Economic & Clinical Health
- IMPACT = Improving Medicare Post-Acute Care Transformation
- MACRA = Medicare Access & CHIP Reauthorization Act
- OAA = Older Americans Act
- ONC = Office of the National Coordinator for Health Information Technology
- SSA = Social Security Act

# FEDERAL GOVERNMENT AUTHORITIES

- Affordable Care Act (ACA)
- Health Information Technology for Economic & Clinical Health (HITECH) Act
- Improving Medicare Post-Acute Care Transformation (IMPACT) Act
- Medicare Access & Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA)
- Older Americans Act (OAA)
- Rehabilitation Act
- Social Security Act (SSA)

## **HHS IMPLEMENTING AGENCIES & CMS CENTERS**

- Department of Health & Human Services (HHS)
  - ❖ Administration for Community Living (ACL)
  - ❖ Agency for Healthcare Research & Quality (AHRQ)
  - ❖ Office of the National Coordinator for Health Information Technology (ONC)
  - ❖ Centers for Medicare & Medicaid Services (CMS)
    - Center for Clinical Standards & Quality (CCSQ)
    - Center for Medicaid & Children's Health Insurance Program (CHIP) Services (CMCS)
    - Center for Medicare & Medicaid Innovation (CMMI)

## HCBS QUALITY MEASUREMENT DOMAINS\*

- Caregiver Support
- Choice & Control
- Community Inclusion
- Consumer Leadership in System Development
- Equity
- Holistic Health & Functioning
- Human & Legal Rights
- Person-Centered Planning & Coordination
- Service Delivery & Effectiveness
- System Performance & Accountability
- Workforce

\*Reference: [Quality in Home and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement](#), September 2016

- Describes key components of a conceptual foundation for home and community based services (HCBS) quality measurement, specifically an operational definition of HCBS, list of characteristics describing high-quality HCBS, and measurement framework of 11 domains and 40 subdomains.

# HCBS Waiver Program

**Ralph Lollar**

**Director, Division of LTSS**

**Disabled and Elderly Health Programs Group**

**Center for Medicaid and CHIP Services**







# The IMPACT Act Measures CMS Data Element Library

National Home and Community Based Services Conference  
Wednesday, 8/30/17, 4:15 – 5:30pm

Beth Connor, MS, RN  
Centers for Medicare and Medicaid Services  
Center for Clinical Standards and Quality  
Division of Chronic and Post-Acute Care



# Disclaimer

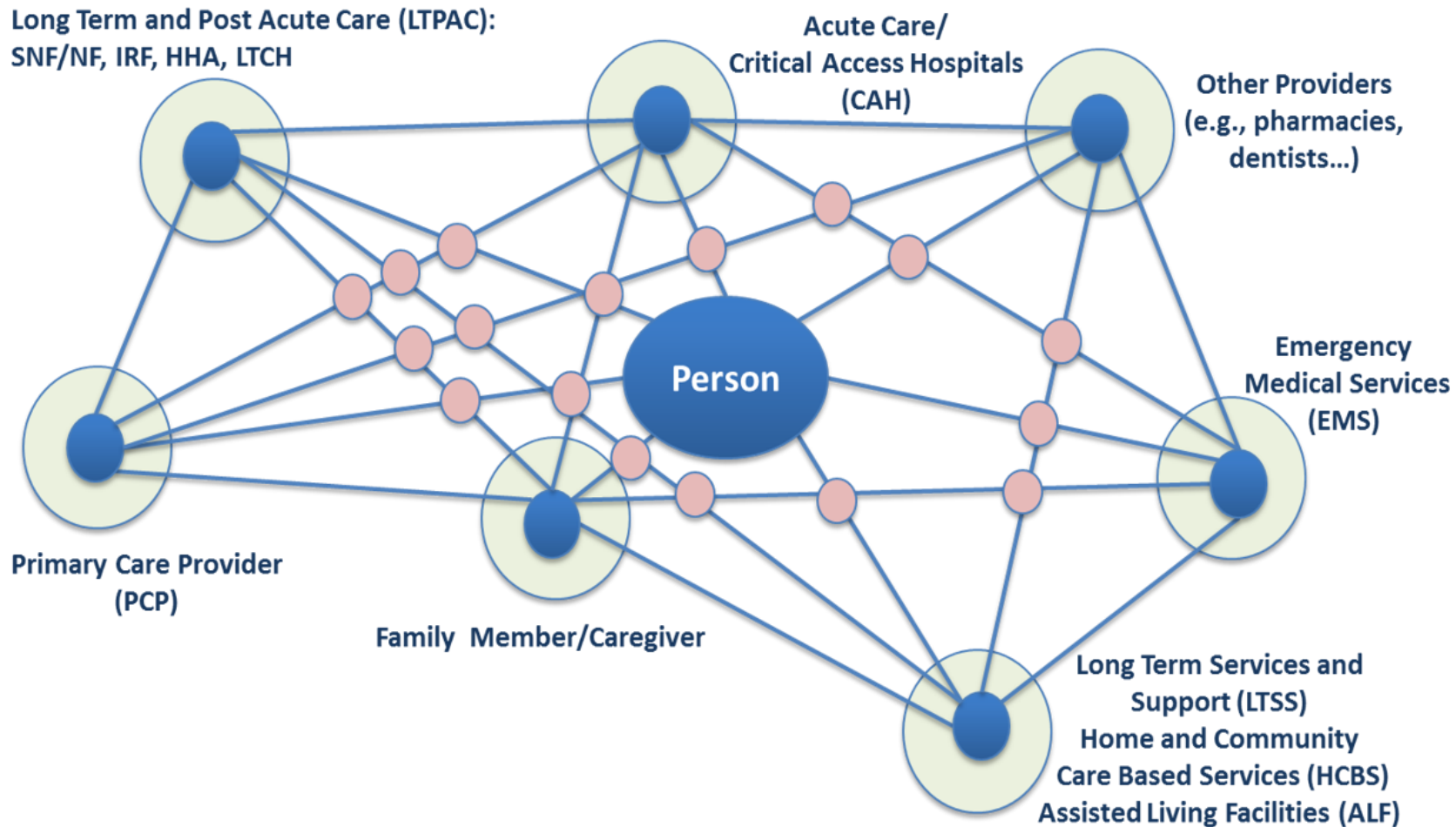
- This presentation was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.
- This presentation was prepared as a service to the public and is not intended to grant rights or impose obligations. This presentation may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

# Topics

- IMPACT Act Review
- IMPACT Measures
- CMS Data Element Library (DEL)

# Data Follows the Person

## Data Follows the Person



# IMPACT Act of 2014

- Bi-partisan bill passed on September 18, 2014, and signed into law October 6, 2014
- **The Act requires the submission of standardized assessment data by:**
  - Long-Term Care Hospitals (LTCHs): LCDS
  - Skilled Nursing Facilities (SNFs): MDS
  - Home Health Agencies (HHAs): OASIS
  - Inpatient Rehabilitation Facilities (IRFs): IRF-PAI
- **The Act requires that CMS make interoperable standardized patient assessment and quality measures data, and data on resource use and other measures** to allow for the exchange of data among PAC and other providers to facilitate coordinated care and improved outcomes

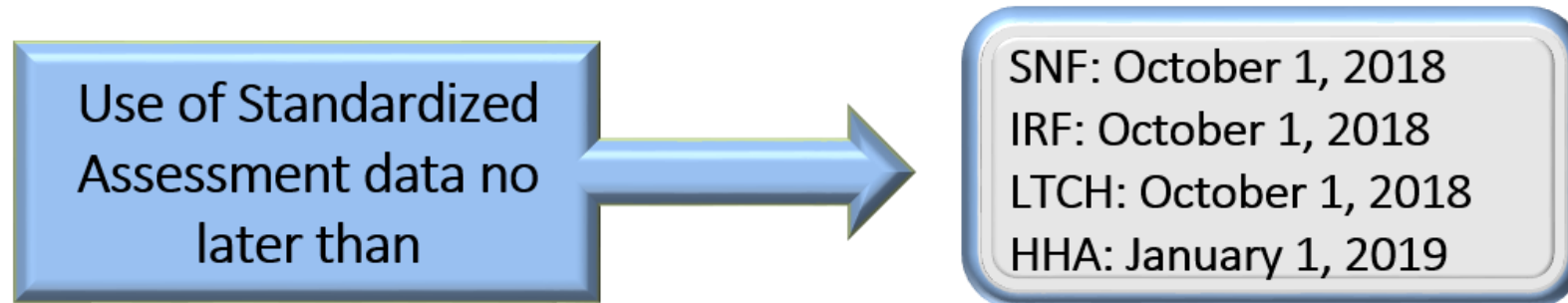
[Improving Medicare Post-Acute Care Transformation \(IMPACT\) Act of 2014](#)

# IMPACT Act Measures Domains

Measure Domain	Measure Name
<b>Functional status</b>	Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)
<b>Skin integrity</b>	Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short Stay) (NQF #0678)
<b>Medication reconciliation</b>	Drug Regimen Review Conducted with Follow-Up for Identified Issues Post Acute Care (PAC)
<b>Incidence major falls</b>	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)
<b>Transfer of Health Information</b>	Transfer of Information at Post-Acute Care Admission, Start or Resumption of Care from Other Providers/ Settings Transfer of Information at Post-Acute Care Discharge to Other Providers/Settings
<b>Medicare Spending Per Beneficiary</b>	Medicare Spending Per Beneficiary-Post Acute Care (PAC)
<b>Discharge to Community</b>	Discharge to Community-Post Acute Care (PAC)
<b>Potentially Preventable Hospital Readmissions</b>	Potentially Preventable 30-Day Post-Discharge Readmission Measure

# Statutory Timelines: Standardized Patient Assessment Data

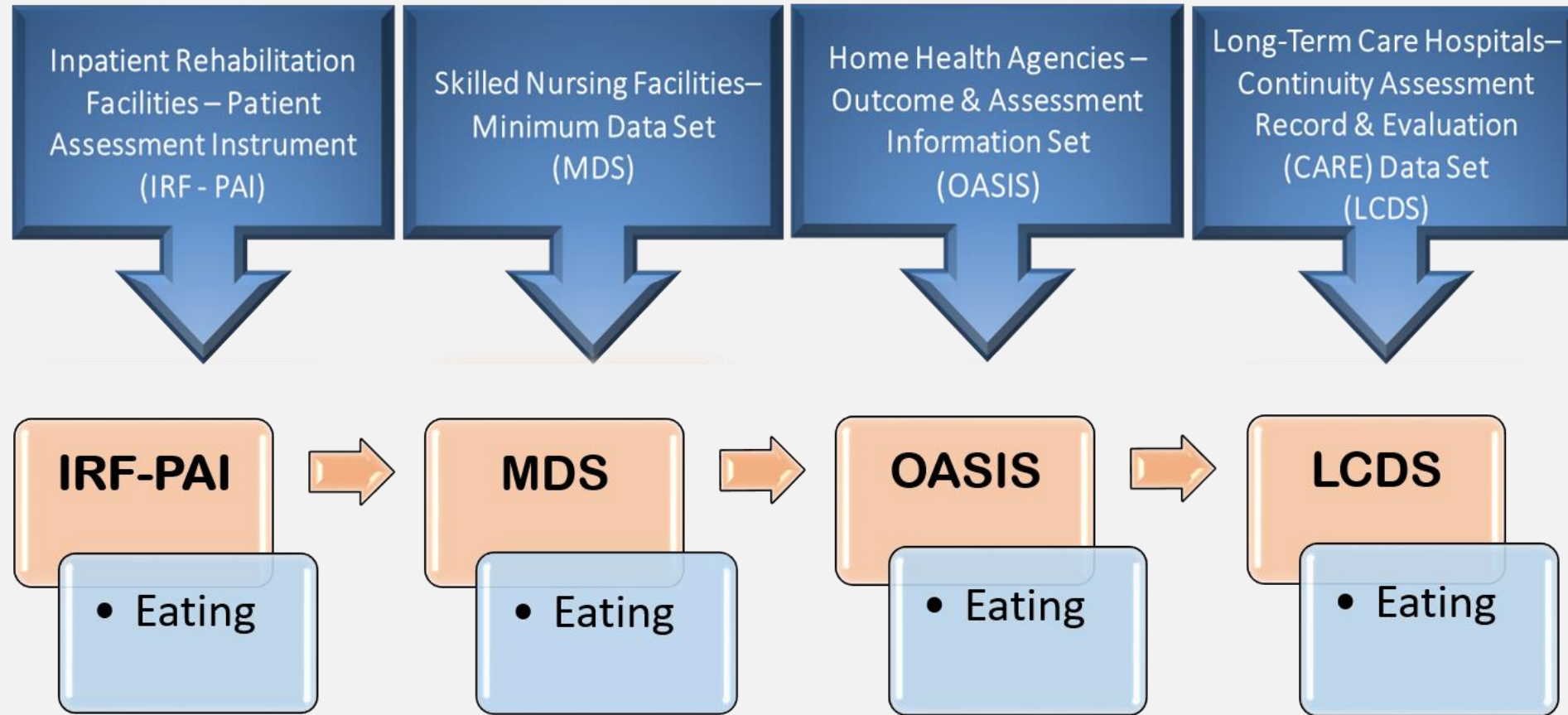
- **Requirements for reporting assessment data:**
  - Providers must submit standardized assessment data through PAC assessment instruments under applicable reporting provisions



- The data must be submitted with respect to admission and discharge for each patient, or more frequently as required
- **Data categories:**
  - Functional status
  - Cognitive function and mental status
  - Special services, treatments, and interventions
  - Medical conditions and co-morbidities
  - Impairments
  - Other categories required by the Secretary

# What is Standardization?

## Standardizing Function at the Item Level



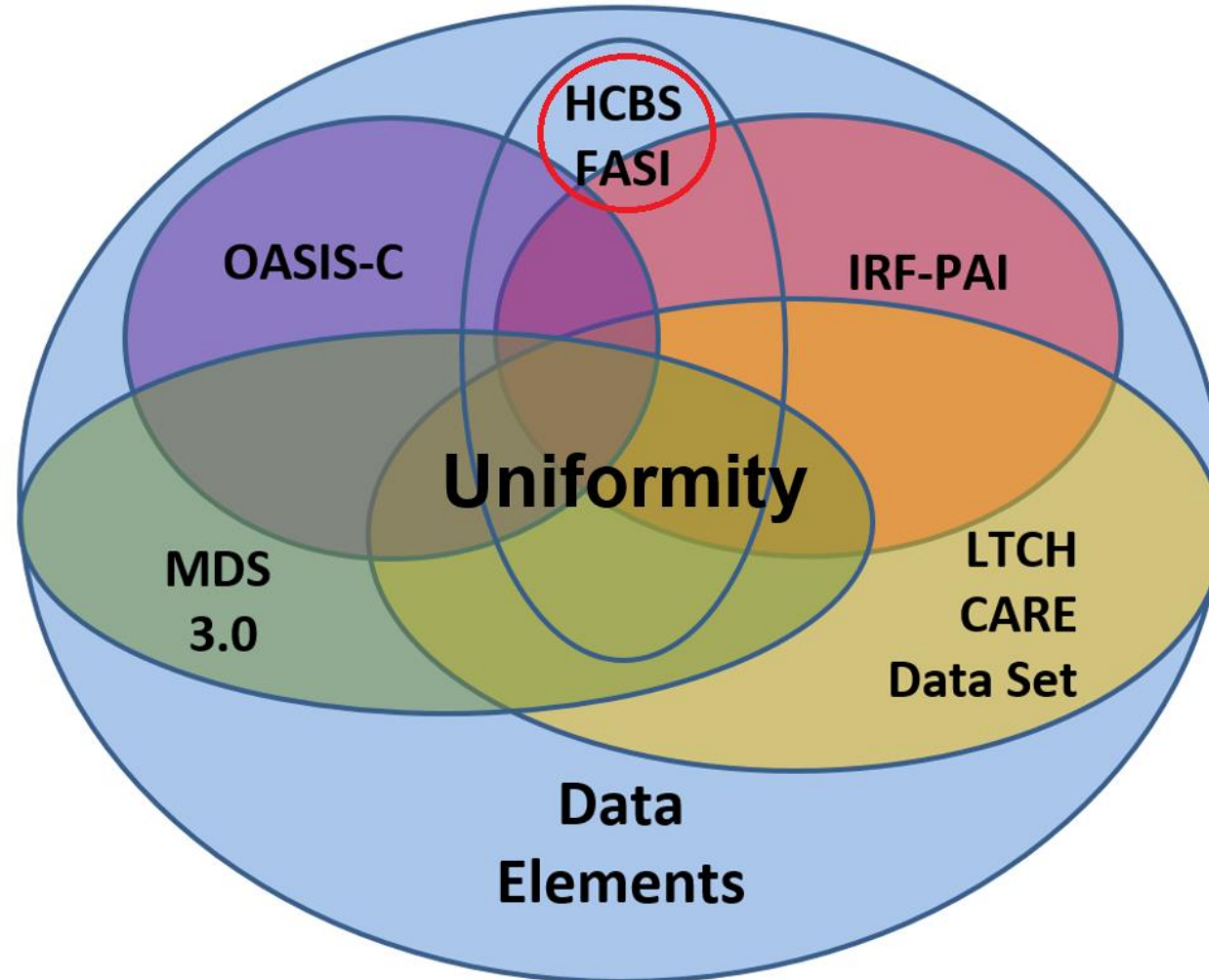


# Data Elements: Standardization

## One Question: Much to Say → One Response: Many Uses

GG0160. Functional Mobility (Complete during the 3-day assessment period.)										
Code the patient's usual performance using the 6-point scale below.										
<p><b>CODING:</b></p> <p><b>Safety and Quality of Performance</b> - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.</p> <p><i>Activities may be completed with or without assistive devices.</i></p> <p>06. <b>Independent</b> - Patient completes the activity by him/herself with no assistance from a helper.</p> <p>05. <b>Setup or clean-up assistance</b> - Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.</p> <p>04. <b>Supervision or touching assistance</b> - Helper provides VERBAL CUES or TOUCHING/ STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.</p> <p>03. <b>Partial/moderate assistance</b> - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.</p> <p>02. <b>Substantial/maximal assistance</b> - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.</p> <p>01. <b>Dependent</b> - Helper does ALL of the effort. Patient does none of the effort to complete the task.</p> <p>07. <b>Patient refused</b></p> <p>09. <b>Not applicable</b></p> <p><b>If activity was not attempted, code:</b></p> <p>88. Not attempted due to <b>medical condition or safety concerns</b></p>	<p>Enter Codes in Boxes</p> <table border="1"> <tr> <td><input type="text"/></td> <td><input type="text"/></td> <td>A. <b>Roll left and right:</b> The ability to roll from lying on back to left and right side, and roll back to back.</td> </tr> <tr> <td><input type="text"/></td> <td><input type="text"/></td> <td>B. <b>Sit to lying:</b> The ability to move from sitting on side of bed to lying flat on the bed.</td> </tr> <tr> <td><input type="text"/></td> <td><input type="text"/></td> <td>C. <b>Lying to Sitting on Side of Bed:</b> The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, no back support.</td> </tr> </table>	<input type="text"/>	<input type="text"/>	A. <b>Roll left and right:</b> The ability to roll from lying on back to left and right side, and roll back to back.	<input type="text"/>	<input type="text"/>	B. <b>Sit to lying:</b> The ability to move from sitting on side of bed to lying flat on the bed.	<input type="text"/>	<input type="text"/>	C. <b>Lying to Sitting on Side of Bed:</b> The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, no back support.
	<input type="text"/>	<input type="text"/>	A. <b>Roll left and right:</b> The ability to roll from lying on back to left and right side, and roll back to back.							
	<input type="text"/>	<input type="text"/>	B. <b>Sit to lying:</b> The ability to move from sitting on side of bed to lying flat on the bed.							
	<input type="text"/>	<input type="text"/>	C. <b>Lying to Sitting on Side of Bed:</b> The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, no back support.							
<pre> graph TD     A[Data Element &amp; Response Code] --&gt; B[Care Planning/Decision Support]     A --&gt; C{QI}     A --&gt; D[Payment]     A --&gt; E[Quality Reporting]     A --&gt; F[Care Transitions]             </pre>										

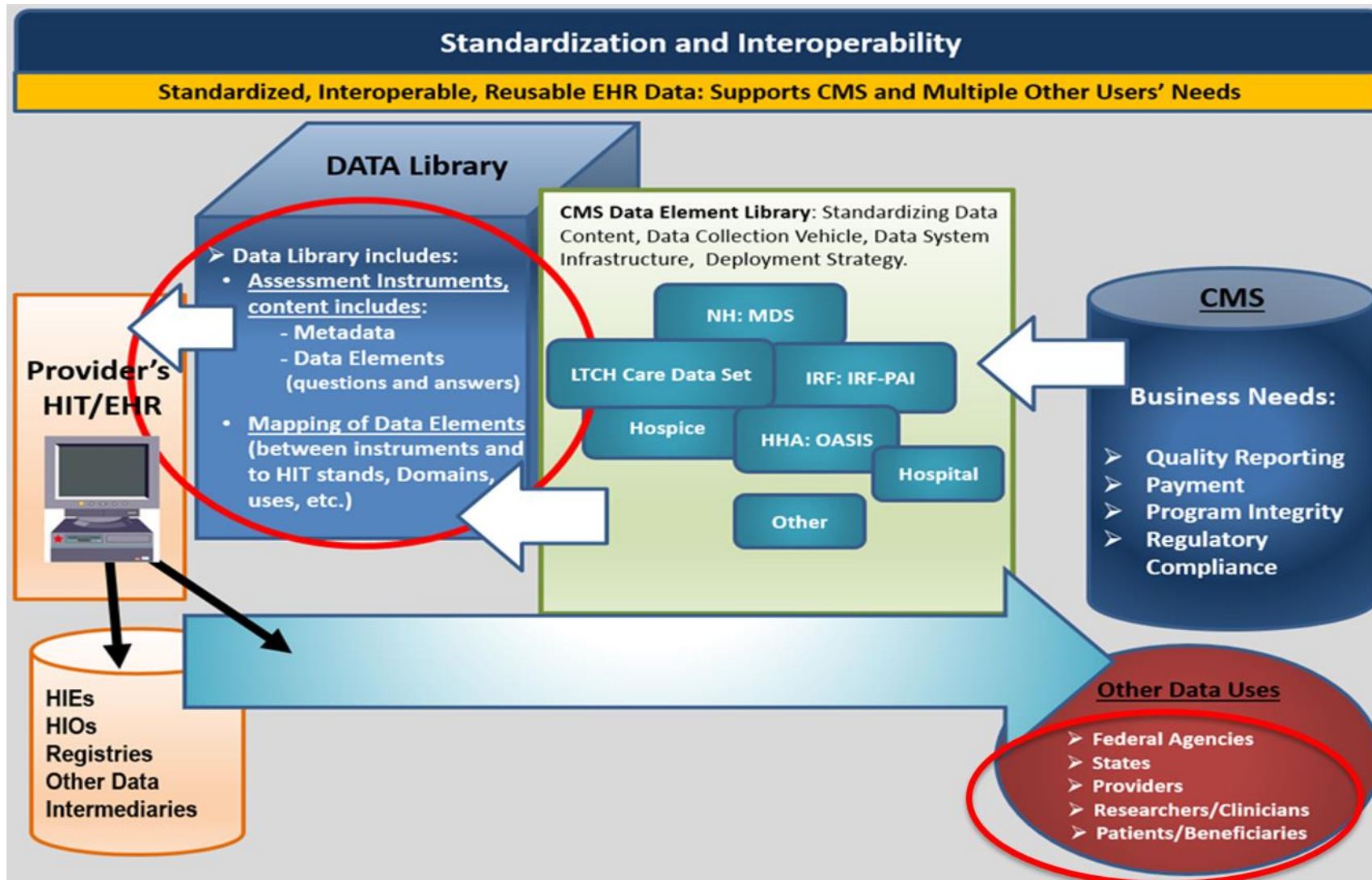
# Data Elements: Standardization



# Data Element Interoperability

- **The IMPACT Act requires that CMS make post-acute care assessment data elements interoperable to:**
  - “**allow for the exchange of data** among PAC providers and other providers **and the use** by such providers **of such data** that has been exchanged, including by using common standards and definitions, in order **to provide access to longitudinal information** for such providers **to facilitate coordinated care and improved** Medicare beneficiary **outcomes.**”
- Interoperable data elements facilitate improvements to reduce overall provider burden by allowing the use and reuse of healthcare data
- Supports provider exchange of electronic health information to facilitate care coordination and person-centered care
- Supports real-time, data driven, clinical decision making

# The CMS Data Element Library (DEL)

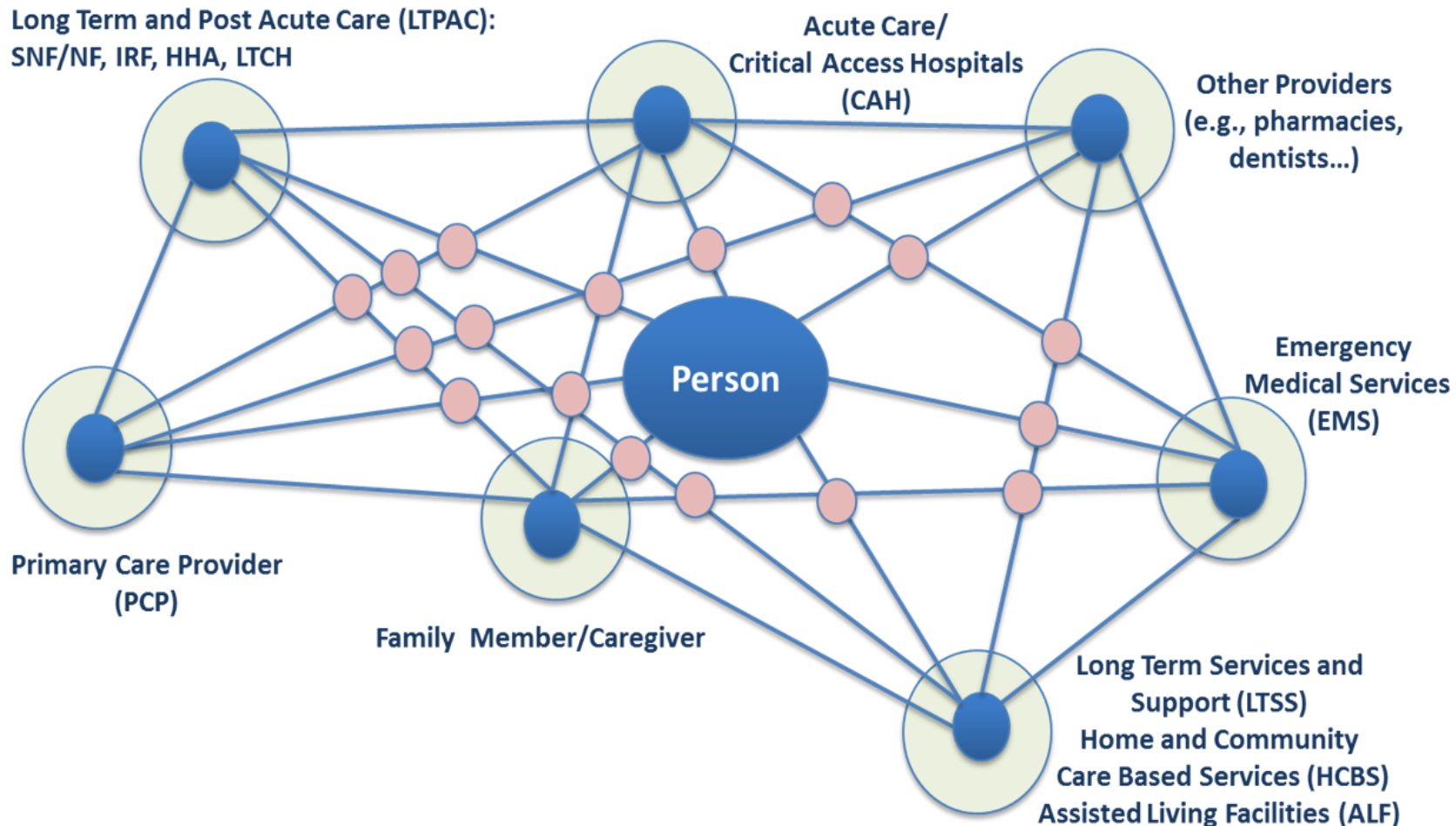


# Opportunities to Re-Use Standardized and Interoperable PAC Assessment Data Elements

- **Leveraging and mapping LTPAC assessment data elements to nationally accepted Health IT standards supports:**
  - Information exchange and re-use with and by:
    - Acute care hospitals and primary care providers
    - Long-term and post-acute care providers
    - Home and community based providers (HCBS)
    - Other providers
    - Health Information Exchange Organizations
  - Use and re-use of assessment data in a variety of document types including:
    - Transfer documents
    - Referral documents
    - Care plans
    - LTPAC Assessment Summary Documents

# Data Follows the Person

## Data Follows the Person



# Questions?

- For more information on the IMPACT Act, please visit the IMPACT Act home page [here](#).
- For more information on Post-acute Care Quality Initiatives, please visit:
  - [Inpatient Rehab Facilities](#)
  - [Skilled Nursing Facilities](#)
  - [Long-term Care Hospitals](#)
  - [Home Health Agencies](#)
- For more information on Post Acute care, sign up for the [Post-Acute Care Listserv](#)
- DEL website and listserv- coming soon!
- If you have any questions, please feel free to contact:
  - Beth Connor [Beth.connor@cms.hhs.gov](mailto:Beth.connor@cms.hhs.gov)

# ACL Quality Initiatives

**Shawn Terrell**

**Office of Policy Analysis and Development**

**Center for Policy and Evaluation**





# Developing HCBS Quality Measures from National Core Indicators for Intellectual and Development Disabilities, and Aging and Physical Disabilities (NCI-IDD/AD)

- **ACL Contract with Human Services Research Institute**
- The NCI-IDD/AD:
  - Two distinct but related sets of survey instruments
  - Designed to assess state systems performance along a number of key indicators related to community living for various populations.

# National Core Indicators

Focus population:

**Adults with I/DD** who receive at least one service in addition to case management from state IDD systems

- NCI began development in 1997
- Survey Suite: Adult Consumer, Family, Staff Stability
- 46 states and DC
- Funded in by state membership fees with ACL support for specific expansion activity
- Most participants are receiving services under an HCBS Waiver
- A small % are either state only, or ICF/ID

# National Core Indicators - AD

Focus population:

**Older adults and adults with physical disabilities** accessing publicly funded services in:

- Skilled Nursing Facilities
  - Medicaid Waivers
  - Medicaid State Plan
  - State Funded Programs
  - Older Americans Act Programs
  - PACE
  - MLTSS
- 
- NCI-AD began development in 2012
  - Adult in-person survey only
  - Pilot report on initial 3 states published 2014
  - Survey was revised in 2015 based on pilot results
  - 20 states are participating in 2017-2018 survey year.

# ACL Contract with Human Services Research Institute

- NASDDDS and NASUAD are collaborators
- Refine and expand use of NCI and NCI-AD surveys:
  - Publish results in peer reviewed journals:
    - Psychometric testing (reliability, validity)
    - Sampling procedures
    - Interview protocols
    - Implementation consistency & validity across states
  - Revise existing measures for person-centered planning questions/survey to adapt to current expectations
- Submit at least 20 measures for NQF endorsement from NCI and NCI-AD surveys
- Technical Assistance to States

# Research and Training Center (RRTC) on Outcomes Measurement for Home and Community Based Services

- ACL's (NIDILRR) announced a new grant on September 30, 2015
  - the Research and Training Center on Outcomes Measurement for Home and Community Based Services
    - Grantee: University of Minnesota
    - The grant is for \$875,000 per year for 5 years.

# RRTC/OM Research Studies

- Study 1: Soliciting broad stakeholder input on NQF HCBS Measurement Framework
- Study 2: Gap analysis – NQF HCBS Measurement Framework & Current Instruments
- Study 3: Identification of high quality/fidelity implementation practices
- Study 4: Refinement and development of measures
- Study 5: Ascertain Reliability, Validity & Sensitivity to Change of Measures
- Study 6: Identification & testing of risk adjusters



## HHS Investments in Cross-Cutting Quality Measurement Initiatives

---

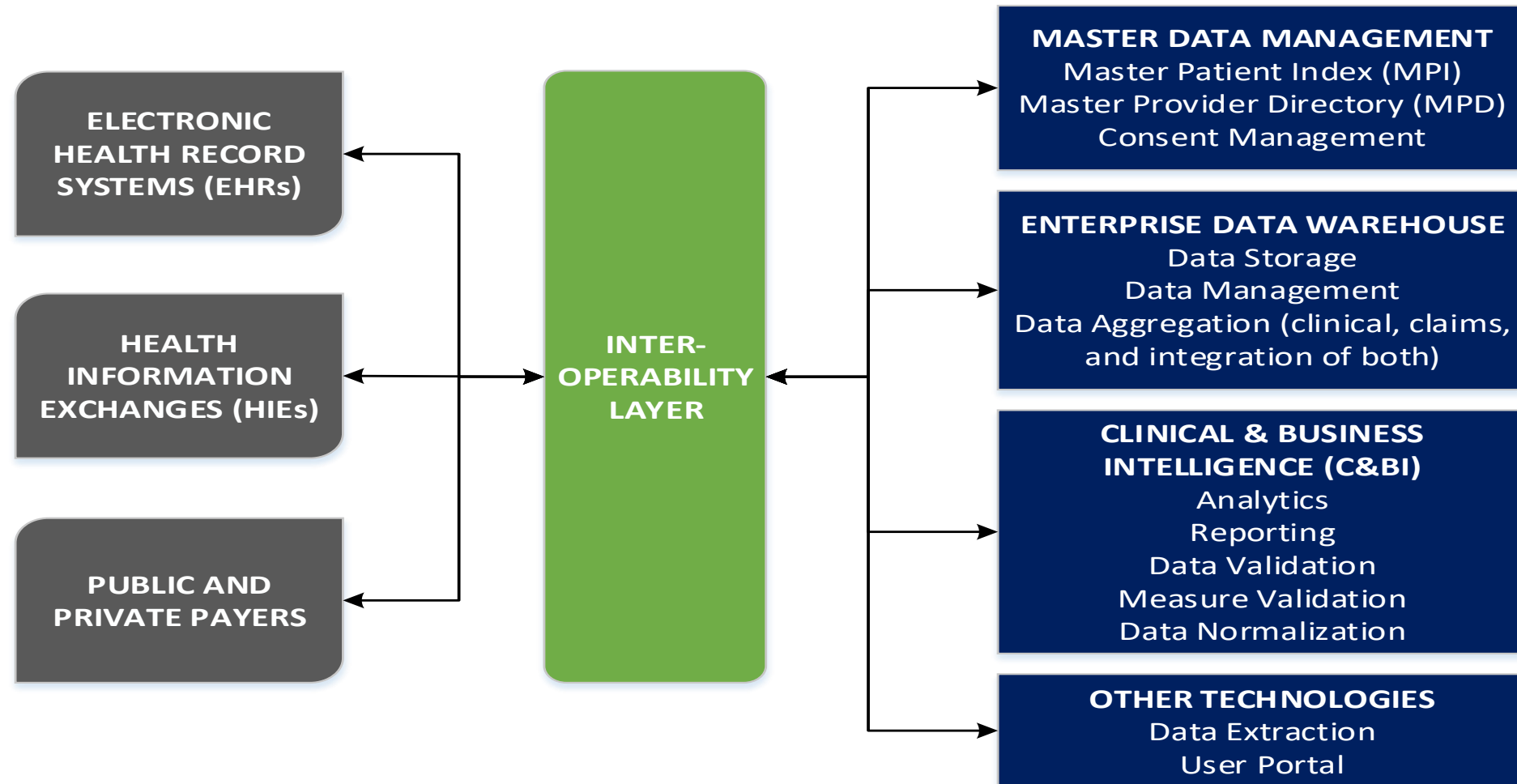
Arun Natarajan, ONC Senior Policy Analyst

[Arun.natarajan@hhs.gov](mailto:Arun.natarajan@hhs.gov)

202-550-9877



# Interoperability is critical in quality measurement!





## MISSION AND PRIORITIES

### FEDERAL HEALTH IT MISSION

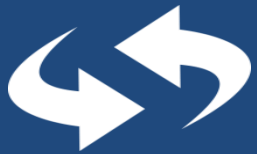
Improve the health and well-being of individuals and communities through the use of technology and health information that is accessible when and where it matters most.

### 2017-2018 ONC PRIORITIES

ONC will work to make health information more accessible, decrease the documentation burden, and support EHR usability under 21<sup>st</sup> Century Cures and MACRA.

## ONC 2017-2018 PRIORITIES

### Interoperability



### Usability



#### PATIENT

Movable health records to  
shop for and coordinate  
care

Lower cost of care through  
greater provider efficiency

More eye contact with  
providers

#### PROVIDER

Ability to efficiently send,  
receive, and analyze data

Burden reduction:

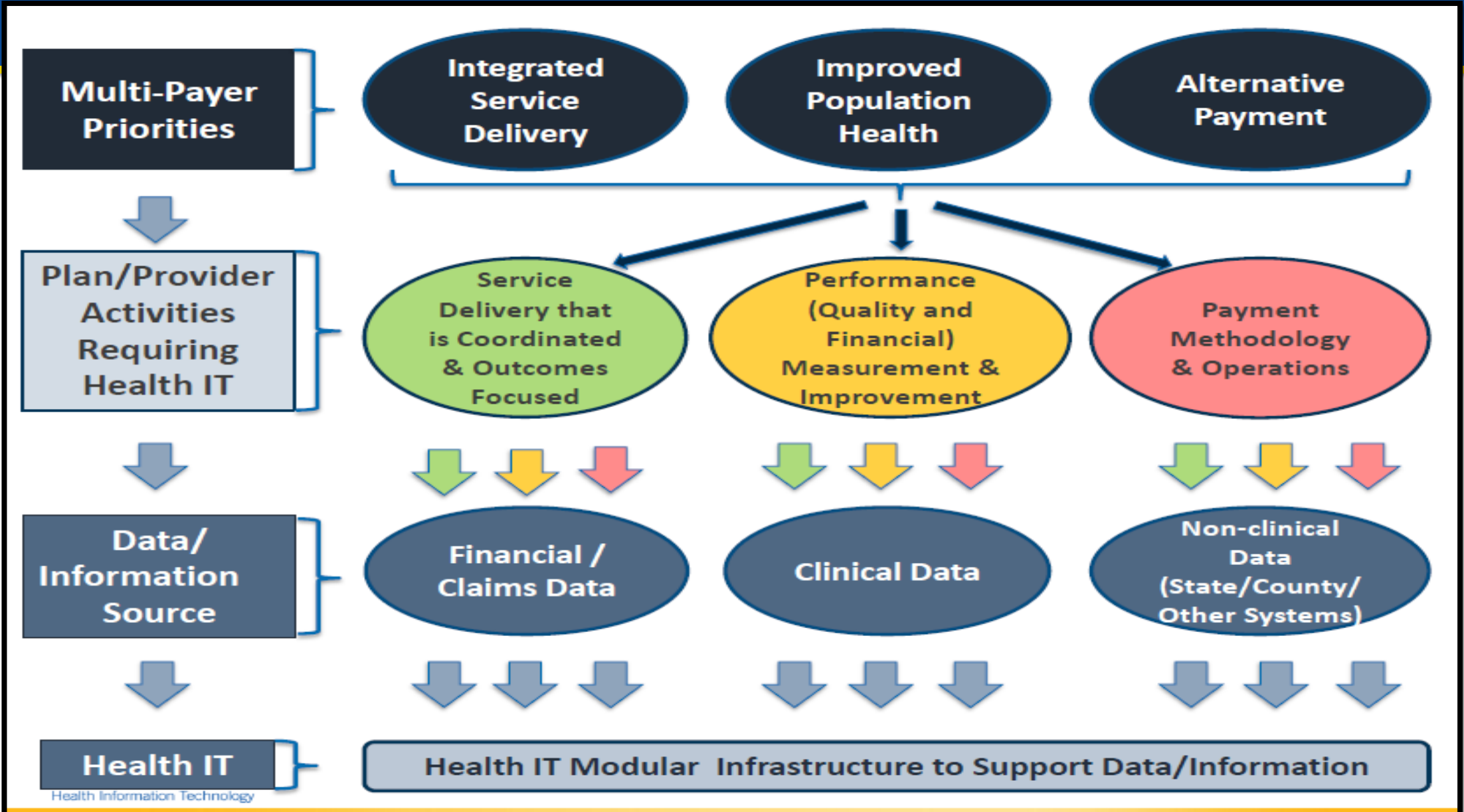
- Less wasted time
- Less hassle

#### COMPETITIVE MARKETPLACE

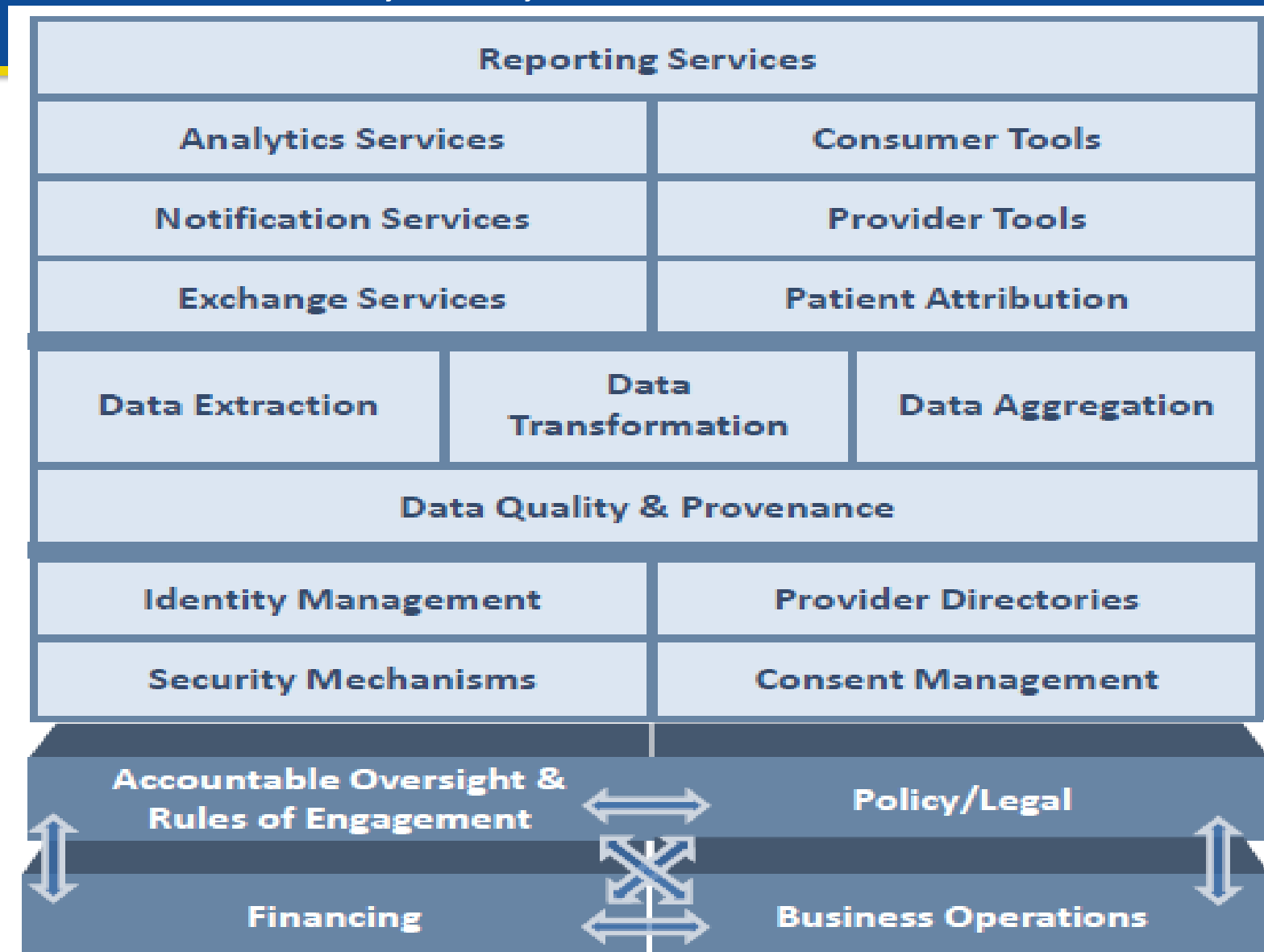
Improved data flow standards  
Accessible API's

Ability to support new  
business models and  
software applications

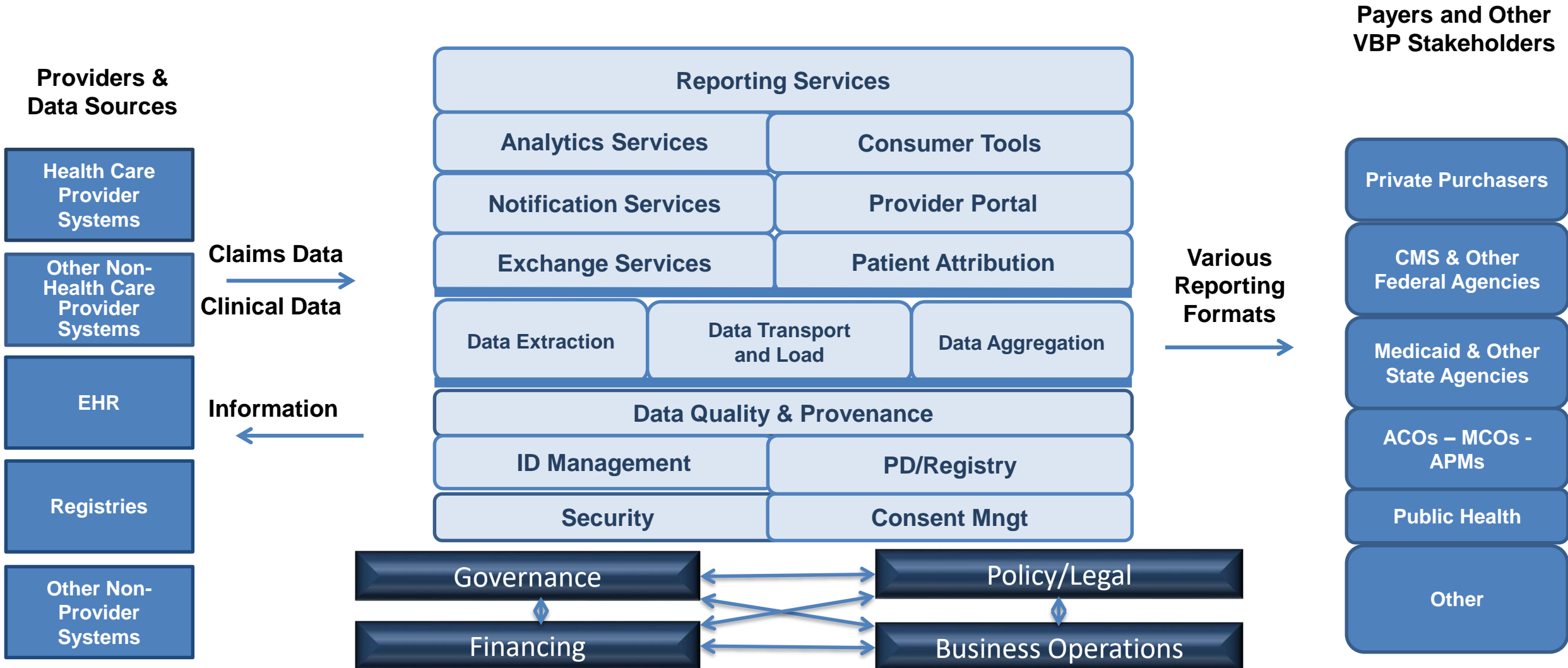
# Common Approach to Medicaid Specific and SIM Multi-Payer



- **Health IT Modular Infrastructure to Support Data/Information State, Plans, ACOs and Providers**



# HIT Modular Functions– In the context of data sources/providers and payers/other stakeholders



# Alignment for Execution

## Defining Alignment

**Conceptual Alignment** - Agreement on the ideas and concepts – the priorities and activities drivers, strategies and use cases.

**Operational Alignment** – Agreement regarding the information needs, data specifications, data sources and data flow, information transfer and use, and processes, approach, and execution of the policies, business operations, governance and financing

**Technology Alignment** - Agreement on the health IT functionality, governance, business operations, financing and executing strategies to support the data/information needs (existing, leveraged, shared, etc., including which vendor to use for any common tool)

The lines between these three levels are not exact and in any element you can be in a variation of levels.

## ***Alignment Illustration***

*Conceptual Alignment*

*Performance Reporting on 1 topic*

*Operational Alignment*

*Specifications of Metrics*

*Technology Alignment*

*Shared service, vendor specific*



## Questions and Comments

---

Arun Natarajan, ONC Senior Policy Analyst

[arun.natarajan@hhs.gov](mailto:arun.natarajan@hhs.gov)

