

# Itoqa

LONG-TERM  
QUALITY ALLIANCE





# Mission

To improve the effectiveness and efficiency of care and the quality of life of people receiving long-term services and supports (LTSS) by fostering person- and family-centered quality measurement and advancing innovative best practices.

# Strategic Agenda (2010-2012)

**Key Strategy:** Address a national health challenge, **TRANSITIONS IN CARE**, affecting people receiving LTSS in order to produce demonstrable improvement in quality and cost reductions

**Quality  
Measurement**

Care transitions; impact on people's health and QoL; effects on potentially avoidable hospitalizations, re-hospitalizations and total health care costs.

**Quality  
Improvement**

Person- and family-centered, effective transitional care practices

**Outreach/Public  
Awareness**

Information and policies that advance high quality, person- and family-centered transitional care

# LTQA Strategic Framework

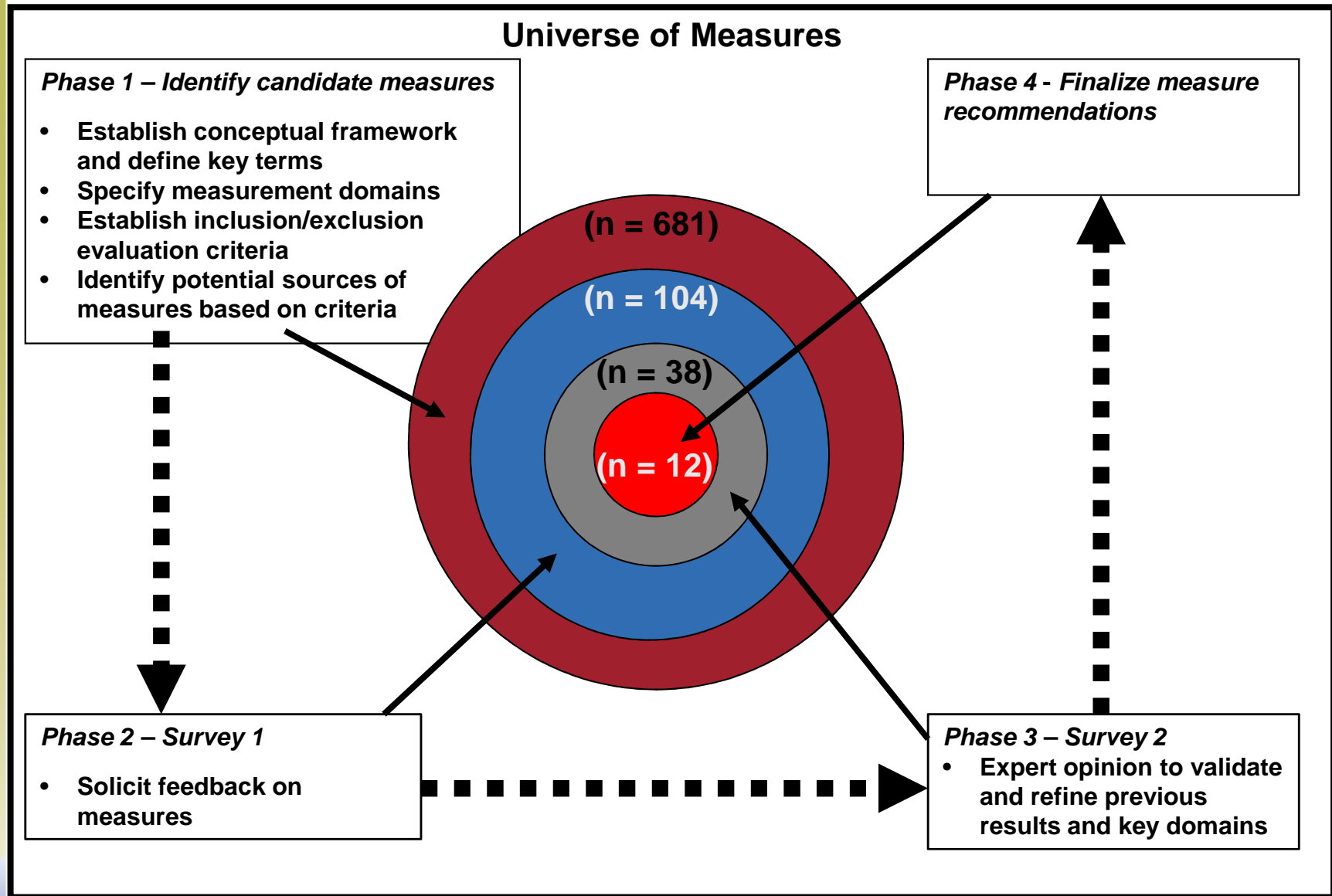




# QUALITY MEASUREMENT

- » Goal. Advance the use of key person- and family-centered quality indicators specific to adults who require long-term services and supports (LTSS) that are focused on improvement in care transitions and health related quality of life, and reductions in potentially avoidable hospitalizations, re-hospitalizations and total health care costs.

# Approach to Measure Selection



# Measurement Framework: Key Domains

Measures of Structure,  
Process, and Outcome

Key Domains for Measuring Transitions in LTSS		IOM Aims
<i>Domain 1</i>	Person- and Family-Centeredness	Safe Effective Patient-Centered Timely Efficient Equitable
<i>Domain 2</i>	Transitional Care Processes	
<i>Domain 3</i>	Performance Outcomes	

# Select Sources of Measures

Category	Potential Source	Examples of Candidate Measures/Measure Sets
Government Agencies	Agency for Health Care Research and Quality (AHRQ)	AHRQ Prevention, Inpatient, Patient Safety Indicators CAHPS Surveys National Quality Measures Clearinghouse™
	Centers for Medicare & Medicaid Services (CMS)	Minimum Data Set 2.0 OASIS
Accreditors	NCQA	Healthcare Effectiveness Data and Information Set (HEDIS)
	The Joint Commission	National Quality Core Measure Sets
Associations, Professional Organizations/ Societies	American Nurses Association (ANA)	National Database of Nursing Quality Indicators (NDNQI) for the American Nurses Association (ANA)
Private Organizations	RAND Corporation	Assessing Care of Vulnerable Elders (ACOVE)
Other	National Quality Forum (NQF)	All performance measures endorsed as national voluntary consensus standards



# Consensus Development

## Survey #1

- » Included 104 measures that “fully/largely” met inclusion criteria
- » Solicited ratings of importance—e.g., “definitely include,” “may be useful”
- » Threshold established, > 85% “definitely include” + “may be useful”
- » 38 measures met threshold

## Survey #2

- » Included 38 measures from Survey #1
- » Within each domain, solicited rank order priorities
- » Threshold established,  $\geq 60\%$  “definitely include” or “may be useful” OR  $\geq 2$  “definitely include” with  $\geq 3$  voters.
- » 12 measures met threshold

# Recommended Measures

<b>1. Patient &amp; Family Centered Care</b>	Hospital Consumer Assessment of Healthcare Providers and Systems (AHRQ-HCHAPS®, NQF 166)
	Client Perceptions of Coordination Questionnaire (Australian Coordinated Care Trials)
<b>2. Transitional Care</b>	
» <i>Patient Understanding</i>	3-Item Care Transition Measure (CTM-3, NQF 228)
» <i>Falls</i>	% of pt >65y/history of falls (2 or more/fall with injury) had a plan of care within 12 month (AGS/NCQA/PCPI®)
	% of pt >65y who receive at least two different high-risk medication (NCQA HEDIS®)
» <i>Medication</i>	% of discharges from Jan 1st to Dec 1st of the measurement year for members >65y for whom med were reconciled on or within 30 days of discharge (NCQA HEDIS®)

# Recommended Measures

<b>2. Transitional Care</b>	(cont'd)
» <i>Status</i>	mean change score in basic mobility of pt in a post-acute-care setting assessed (AM-PAC [CREcare], NQF 429)
	mean change score in daily activity of pt in a post-acute-care setting assessed (AM-PAC [CREcare], NQF 430)
	% of pt who need urgent, unplanned medical care (OASIS, CMS)
» <i>Plan Record</i>	% of patients (regardless age), discharged from an inpatient facility to home/any other site of care from whom a TR was transmitted to the facility/PP/other health care professional for follow-up-care within 24hours of discharge (PCPI, NQF 648)
	Advanced Care Plan (NCQA HEDIS®, NQF 326)
<b>3. Cost Effective</b>	all-cause-readmission (risk adjusted) (United Health Group, NQF 329; NCQA HEDIS®)



# Measurement Gaps

- » Social support and role of family caregivers
- » Person/family experience of care/readiness/engagement
- » Functional status
- » Quality of life
- » Health disparities
- » Preventive care
- » Discharge and transitional care processes
- » Special populations (e.g., dementia, MRDD)
- » Palliative care/end of life
- » Cost and cost-effectiveness
- » Access to care
- » Facility level measures of transitional care performance



# Areas for Further Research

- » Discharge and transitional care processes across each episode of care (e.g., assessment of risk, needs and preferences compared to delivered service and support; scope of LTSS)
- » Social support (e.g., engagement, roles and responsibilities; experience with care; access to community services)
- » Personal experience (e.g., transition process to person with deficits in ADLs; becoming a family caregiver)
- » Candidate measures that failed to meet inclusion criteria — e.g., possess strong evidence and alignment with the conceptual domains but lack widespread use/generalizability



# Strategic Issues/Next Steps

- » LTQA board and members' review and action on recommendations
- » Test measures through innovative communities initiative
- » Advocate for investments in research to address the major gaps in quality measures
- » Identify workforce implications of adoption of these quality measures including strategies that address potential training, dissemination, and practice integration



# QUALITY IMPROVEMENT/BEST PRACTICES

- » Goal. Achieve wider dissemination and adoption of person and family-centered, effective transitional care practices that are focused on improvement in care transitions and health related quality of life, and reductions in potentially avoidable hospitalizations, re-hospitalizations and total health care costs among people receiving LTSS



# Quality Improvement/Best Practices: Progress to Date

- » Proposed and received LTQA board endorsement of a set of principles and specific recommendations to guide the development, implementation, and evaluation of programs and policies aimed at improving care for people receiving LTSS.



# Principles

- » Include individuals who are recipients of LTSS in multiple settings
- » Adopt a community-based, culturally sensitive, approach
- » Incorporate measures of person- and family-centered experience
- » Encourage implementation of evidence-based transitional care practices.
- » Support payment mechanisms that promote better integration of clinical care and LTSS by aligning incentives



# Specific Recommendations

- » **Integrate** individuals, caregivers, and direct care workers as essential members of the care team;
- » **Focus** efforts on eliciting individual and caregiver preferences and goals and address these goals in care delivery;
- » **Adopt** a longitudinal, cross-setting perspective of health care and LTSS needs for individuals and families;



# Specific Recommendations

- » **Invest** in a workforce capable of integrating health care and LTSS that enables teams to work together to deliver optimal care.
- » **Create** an infrastructure, using technology where appropriate, that accelerates quality improvement by systematizing practices and protocols based on empirical evidence, and improves coordination and timely and effective communication among and between care providers, patients, and families.



# Quality Improvement/Best Practices: On-Going

- » National scan of community-based innovations designed to improve care across settings and over time for individuals requiring LTSS (2011-2012)
  - Understand not only who is developing innovative models but also facilitators and barriers to success and sustainability



# Quality Improvement/Best Practices: Next Steps

## » Disseminate and Apply Lessons Learned

- Craft results of scan into user-friendly resource
- Disseminate through LTQA membership, and communities identified in national scan
- Use as foundation for LTQA Innovative Communities



# OUTREACH/PUBLIC AWARENESS

Goal. Achieve engagement and “buy in” for policies and mechanisms that advance effective person- and family-centered transitional care and contribute to improved health related quality of life, and reductions in potentially avoidable hospitalizations, re-hospitalizations and total health care costs.



# Outreach/Public Awareness: Progress to Date

- » Implementing blueprint for internal and external messaging developed by Burness Communications in collaboration with suggestions from the workgroup
- » Promoting members engagement in major decision making groups
- » Maximizing on opportunities to spread the word (e.g., “Innovative Communities” reports, LTQA website)



# Outreach/Public Awareness: Deliverables

- » LTQA will be recognized as independent forum for generating dialogue, problem solving and innovative ideas among major stakeholders involved in solving challenges re: transitions of this vulnerable population
- » LTQA will inform delivery system innovation and implementation



# INNOVATIVE COMMUNITIES

A Collaborative Effort between the  
Quality Measurement, Quality  
Improvement and Outreach/Public  
Awareness Workgroups

# Goals

- » Convene innovative communities, representatives of national programs, funders, and others who share a common interest in supporting locally-led health care delivery system improvement;
- » Raise awareness among innovative communities and major national programs of the resources each have to offer the other in pursuing common aims of improving care transitions for those receiving LTSS, improve health and QoL outcomes and reduce costs
- » Advance a common desire to create, sustain, and support a national learning network of innovative communities.

# Background

- » Two summits sponsored by The SCAN Foundation and The Commonwealth Fund
- » Case studies of best transitional care practices stimulated dialogue and action steps
- » Representatives from >20 communities at each Summit joined leaders of public and private health organizations and federal and state policy leaders




# Desired Features

- » Holistic approach
- » Consumer engagement
- » Team orientation
- » Equal partnerships
- » Independent and invested leadership
- » Free flowing information
- » Aligned incentives and flexible funds
- » Cutting edge technology
- » Robust work-force
- » Strong volunteer network
- » Public education



# Role of LTQA

- » Provide information (e.g., Summit reports)
- » Promote testing of measures/best practices
- » Facilitate connections with funders/other stakeholders
- » Educate policy-makers
- » Advocate for policy change that support consumers



Please visit our website for more information, and  
a listing of our Board Members and Member  
Organizations.

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