

Performance Measurement for the Medicare and Medicaid Eligible (MME) Population in Connecticut

Guiding Principles

Measurement Matrix Showing Domains, Measures, Sub-Populations, and Relevant Health Neighborhood Providers

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Principles for Performance Measurement for Connecticut's MME Population

Underlying principles guide selection of performance measures for the Medicare and Medicaid Eligibles (MME) population in Connecticut. These guiding principles pertain to placing a priority on person-centered care and the systems' responsibility to educate, inform and support individuals regarding their care delivery options across the full continuum of medical, behavioral and social support services. The performance measurement is based on an extensive stakeholder process that includes stakeholders and experts in the field. Measures included in this compendium were selected based on their clinical, scientific, and programmatic significance. This compendium offers a range of the potential measures available in the field today. Stakeholders in the CMMI effort will be asked to select a more limited set of measures for both the CMMI Health Neighborhoods with shared savings and, for the purpose of monitoring, evaluating and managing the CMMI demonstration.

Based on stakeholder discussions, Performance Measurement efforts of the CMMI MME initiative are based on agreement that:

• Person- and family-centered: experience of care must reflect the needs of the whole person as defined later in this document

• A broad set of domains as defined in this document are all important to the CMMI demonstration for MMEs

• Continuity of care across the Medicare and Medicaid continuum is highly valued

• Value consists of both quality and cost-effectiveness and reflects results that offer the "right" amount of integrated care in the "right" amount of time

• Consumer must be treated with dignity and respect throughout the continuum of care with a real voice in the process

• Patients and their families/informal caregivers must be educated on care options in a manner that supports their ability to make meaningful choices about their health and well being

• Home-based care should be delivered whenever possible, including medical, behavioral, and long-term care services and supports

• Home-based performance measures are given highest priority whenever available and applicable

• Maximization of function and quality of life are highly valued

• Understanding of the contextual nature of disability requires an interactive dynamic between abilities and supports

• Community access and participation represent fundamental aspects of health

MME adult sub-populations for performance measurement purposes (for further discussion):

• Older adults (age 65 older)

• Individuals with disabilities*

• Individuals with severe and persistent mental illness (SPMI)

Americans with Disabilities Act (ADA) has a three-part definition of *disability*. Under ADA, an individual with a disability is a person who (1) has a physical or mental impairment that substantially limits one or more major life activities; OR (2) has a record of such an impairment; OR (3) is regarded as having such impairment.

Physical impairment is defined by ADA as "any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin, and endocrine."

ADA nor the regulations that implement it list all the diseases or conditions that are covered, because it would be impossible to create a comprehensive list, given the variety of possible impairments.

For the purposes of this document, the terms patient/consumer/person and clinician/physician/providers are used interchangeably to reflect various stakeholders' preferences.

Definitions, Proposed Performance Measurement Domains and Performance Measures

Definitions

One of Connecticut's ASO/Health Neighborhood initiative's key goal is to ensure that MMEs have access to coordinated, integrated, comprehensive health care inclusive of their medical, behavioral and community support needs across the Medicare and Medicaid continuum. We seek to provide quality, cost-effective health care and associated social and long-term services and supports, in partnership with the patient, his or her family, where desired by the MME, across multiple components of quality. Within this document, "domains" express the focus of the choice of, and delivery and monitoring of medical, behavioral and social support services. As such, the Department and providers have organized a Performance Measurement approach based on domains, listed below.

In the Health Neighborhood, there are multiple "core" providers participating on the team. The Health Neighborhood will collectively maintain responsibility for offering quality care; individual members of the team will take lead responsibility for specific aspects of care delivery. The providers in the Health Neighborhood include:

Primary care practitioners

Physician specialists

Hospitals and tertiary care providers

Behavioral health providers

Long Term Social Supports (LTSS) providers (including but not limited to rehabilitation therapy); and,

Residential care facilities & other institutional settings.

Home Health

Pharmacy/pharmacist

Podiatry

Individuals may be included on the team; however the provider types listed above are mandatory team members. In the measurement instrument, additional providers are listed for selected performance measures.

Have the ability to utilize any provider in the Fee-For-Service network; however, the Health Neighborhood is responsible for tracking and coordinating care regardless of where it is received.

Purpose of the ASO/Health Neighborhood Initiative, “person-centered” care is defined as health care and social supports that are Medicare and Medicaid continuum in a manner that:

Person-centered Care is defined as the provision of health care and social supports that:

Provides the MME with needed information, education and support required to make fully informed decisions about their care options and actively participate in self-care activities;

Supports the MME and their family or caregiver, if desired by the MME or is otherwise appropriate, in working together with their medical and behavioral health providers and care manager(s) to obtain necessary supports and services;

Includes the development of an individualized plan of care, when appropriate, that is created in full partnership with the MME consistent with his or her personal preferences and choices and is implemented in the most integrated manner and setting possible.

Purposes of this Performance Measurement Matrix, “person-centeredness” is identified as a distinct domain but it is also anticipated that measures incorporate a person-centered approach to delivery of services and supports, measurement and quality management. Domain definitions are intended to be both conceptual, but practical, in nature. Each domain is associated with detailed m

Performance Measurement Domains

Otherwise indicated, the measures in the compendium have been validated by one or more of these measurement sources at the end of this document.

| Main Name | Working Definition |
|--|---|
| <p>Person-centered Experience of Care</p> | <p>Measures of person-centered care will assess the extent to which health care and other services satisfy the definition identified above, including, but not limited to:</p> <ul style="list-style-type: none"> • providing MMEs with a positive experience of care that is characterized by respect for the autonomy of the individual • provider 1) skills and knowledge of social and environmental determinants of an MME’s health • supporting the MME in achieving self-determination, empowerment and capacity to perform self-care • partnering with MMEs and their families in a culturally and linguistically appropriate manner to design and execute a plan of care; and, • Incorporating the needs of the MME, as he or she defines them, in delivering medical, behavioral and support services. |
| <p>Care Coordination</p> | <p>The degree to which coordinated and integrated, person-centered interventions that address long-term social supports (LTSS) and medical needs across the Medicare and Medicaid continuum for all services and, in a variety of settings, are implemented. Care coordination includes all services, programs (e.g. waiver services) and program types for individuals with one or more chronic conditions. Care coordination further includes end-of-life and palliative care.</p> |
| <p>Care Transitions</p> | <p>The degree to which providers share information and coordinate medical, behavioral and social supports at a point of transition between services and locations where care is delivered. These settings may include hospitals, skilled nursing facilities, rehabilitation facilities, practitioners’ offices, assisted living facilities and private residences with the intent to integrate all services across the continuum including medication management.</p> <p>With regard to ensuring that care transitions are person-centered, MMEs receive the benefit of full communication and education for the purpose of making decisions with their family and/or caregiver, when desired and appropriate, to support their ability to participate in the decision-making and care delivery process.</p> |

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| Medication Management and Coordination | <p>The degree to which all medications and dietary supplements (prescriptions, over-the-counter medications) by MMEs are reconciled, evaluated, monitored and coordinated by providers in order to achieve evidence-based treatment goals. The medication management processes will identify and resolve problems with:</p> <ul style="list-style-type: none"> - medication discrepancies (drug names, doses, dosage forms, schedule, quantities, and discontinued medications) - medication appropriateness - medication effectiveness - medication safety - medication adherence <p>Such measurement efforts should include, but not be limited to, the degree to which MMEs are educated on appropriate medication use and self-management (in a Medication Action Plan - MAP) and medication management recommendations are shared with prescribers/other providers (in a Medication Management Recommendation - MMR).</p> |
| Prevention | <p>Preventive services include those that are provided to prevent, or screen for the presence of, communicable diseases, chronic disease or injury. For the purpose of this CMMI initiative, prevention is the extent to which care providers emphasize prevention and screening and promote the “right service, at the right place, in the right amount” by decreasing: duplicative or avoidable health care services; those that could otherwise cause harm; and/or those that are inconsistent with evidence-based guidelines for medical, behavioral and social support services including medication management.</p> |
| Mental Health | <p>Services provided to assess, treat and improve cognitive, mood, anxiety, psychotic, and/or substance use disorders and symptoms and related function.</p> |
| Palliative and End-of-life Care | <p>Services for consumers with advanced or terminal illnesses and their families that are intended to provide patient-centered comfort, dignity, options and guidance regarding palliative and end-of-life care decisions.</p> |
| Primary Care | <p>Services provided to assess, treat and improve the common acute and chronic medical conditions found in the MME population.</p> |
| Barriers to Care | <p>Factors that enhance consumer access to care to positively influence health status or health outcomes include, but not limited to, appointment, geographic, physical, cultural, linguistic and other barriers (e.g. transportation, physical barriers) to obtaining care and maintaining health.</p> |

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| Functional Status | Services provided to screen for and address limitations in function related to conducting activities of daily living (ADLs) (e.g. ambulation, dressing, and bathing) and Instrumental Activities of Daily Living (IADLs) e.g. shopping, ability to use the telephone, food preparation). Additional aspects of functions status may include, but not limited to, employment and ability to live independently with services and supports as needed. |
| Quality of Life | The extent to which the consumer is satisfied with his or her quality of life including but not limited to physical, psychological, social and environmental factors. |
| Savings | Definition to be determined |

NOTE: Performance measures listed in the following matrix that are included in the Health Homes Core Quality Measures are indicated with an asterisk (*). These measures (total of 7) are listed at the top of each relevant domain.

Measures

centered care

| Performance Measure | Source for Data (claims; electronic health record (EHR); self-report) | Relevant Health Neighborhood Provider(s) | Other Domains Relevant Performance Measure |
|--|--|---|---|
| Percentage of client receiving care, appointments, and information | Self-report (CAHPS survey items) EHR | All | Care coordination/Care tra |
| Communication with and/or other provider | Self-report (CAHPS survey items) | All | Care coordination/Care tra |
| Engagement of client and family in care and involvement in care plan to desired extent | Self-report (CT MFP quality of life survey) EHR | Care manager | Care coordination/Care tra |
| Respect for client and family with respect and dignity | Self-report (CT MFP quality of life survey) | All | Care coordination/Care tra Palliative care |
| Centered care planning questionnaire | Self-report (see Tondora and Miller reference) | All | Care coordination/Care tra |

Transitions

| Performance Measure | Source for Data (claims; EHR; self-report) | Relevant Health Neighborhood Provider(s) | Other Domains Relevant Performance Measure |
|--|---|---|---|
| Percentage of clients with Ambulatory Sensitive Condition Hospital Admission | Claims | Primary Care Medical Specialist Behavioral health Home health care Care manager | Clinical care Behavioral health Medication management |
| Percentage of Record Transmitted in care Professional Inpatient facility to Primary provider within 24 hours | Claims EHR Self-report | Hospital SNF for rehabilitation Care manager Primary Care | Clinical care |
| Percentage of Cause Readmission within 30 days | Claims | Primary Care Medical Specialist Behavioral health Home health care | Clinical care Behavioral health Primary care |

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|---|---|---|---|
| | | <i>Care manager</i> | |
| Percentage of enrollees with service coordinators to get what they need | Self-report (see Palmer et al reference, page 9) | Care manager | Access Person-centered care |
| Rating of education and guidance provided by clinical staff at time of discharge | Self-report (see Coleman reference; CTM-3 or CTM-15) | Hospital Care manager | Person-centered care |
| Rating of education and guidance provided by SNF at time of discharge | Self-report (adaptation of CTM-3 or CTM-15 to specify SNF rather than hospital) | SNF for rehabilitation SNF for long-term care Care manager | Person-centered care |
| Assess, implement care for those who become eligible for SNF | EHR | Care manager | Access |
| Use of written care plan | EHR | Care manager | Person-centered care |
| Coordination of administrative information between Medicare and Medicaid covered benefits | EHR | Care manager | Person-centered care Access |
| Use of referral and authorization process | EHR | Care manager | Person-centered care Access |
| Use of patient & user friendly complaints, grievance, and appeals process | Self-report (see Commonwealth of Massachusetts reference, page 30) | Care manager | Person-centered care |
| Use of adequate medical and behavioral health integration | EHR | Care manager Primary care Medical specialist Behavioral health Pharmacy/Pharmacist | Person-centered care Access Medication management |
| Use of adequate primary and specialty care integration | EHR | Care manager Primary care Medical specialist | Person-centered care Access Medication management |
| Use of adequate medical and long-term services and supports integration | EHR | Care manager Primary care Medical specialist Long term supports and services providers | Person-centered care Access |
| Percentage of practices or clinical neighborhoods being run as person-centered care homes, based on specific criteria | EHR | All providers | Person-centered care Access |

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| Standardized, all condition 30-day hospital readmission | Claims | Primary Care Medical Specialist Behavioral health Care manager | Clinical care Behavioral health Medication management |
| Primary sensitive hospital readmissions for: Chronic heart failure Chronic obstructive pulmonary disease Hypertension Diabetes Myocardial infarction Asthma Urinary tract infections | Claims | Primary Care Medical Specialist Behavioral health Home health care Care manager | Clinical care Behavioral health Medication management |
| Readmission rates for care coordination-sensitive conditions in people with impaired mobility: Congestive heart failure Urinary tract infection; Diabetic ulcers Autonomic dysreflexia | Claims | Primary Care Medical Specialist Home health care Care manager | Functional status Clinical care |
| 30-day hospital readmissions within 30 days | Claims | Primary Care Medical Specialist Behavioral health Home health care Care manager | Clinical care Behavioral health Primary care |

Medication Management

| Performance Measure | Source for Data (claims; EHR; self-report) | Relevant Health Neighborhood Provider(s) | Other Domains Relevant Performance Measure |
|---|---|---|---|
| Percentage with evidence of medication reconciliation at the hospital discharge | EHR | Hospital Primary care Care manager | Care coordination/Care transition Behavioral health Clinical care |

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|---|--|--|--|
| Age with evidence of medication reconciliation at the time of SNF discharge | EHR | Pharmacy/Pharmacist SNF rehabilitation SNF long-term care Care manager Primary care Pharmacy/pharmacist | Care coordination/Care transition Behavioral health Clinical care |
| Age with evidence of monitoring of long-term medications | EHR | Primary care Behavioral health Medical specialist SNF long-term care Pharmacy/Pharmacist Care manager | Care coordination/Care transition Behavioral health Clinical care |
| Percentage improved in management of oral medications | EHR; OASIS; MDS (OASIS is the Outcome Assessment and Information Set used for all Medicare and Medicaid home health care recipients; MDS is the Minimum Data Set used for all nursing home residents) | Primary care Home health care Long term services and supports SNF rehabilitation SNF long-term care Care manager | Functional status Behavioral health Clinical care Care coordination/Care transition |
| Rate of care for improper medication administration, or for medication side effects | Claims EHR | Primary care Home health care Pharmacy/pharmacist Long term services and supports Care manager SNF rehabilitation SNF long term care | Behavioral health Clinical care Care coordination/Care transition |
| Rate of adherence to medication regimen in older women after fracture | EHR | Primary care Medical specialist SNF long-term care | Clinical care |
| Percentage of patients with new Rx for warfarin who have INR within 6 weeks | Claims | Primary care Medical specialist SNF long-term care | Clinical care |
| Percentage of generic drugs on formularies | EHR | Primary care Pharmacy/Pharmacist SNF rehabilitation SNF long-term care | Access |
| Percentage of counseling about medication management | EHR | Primary care Pharmacy/Pharmacist Care manager | Care coordination/Care transition Prevention Behavioral health |
| Percentage of compliance with medication management | EHR | Primary care | Behavioral health |

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|---|--|--|--|
| Medications | Self-report (no endorsed self-report measure identified) | Medical specialist Home health care Pharmacy/Pharmacist | Prevention |
| Percentage of individuals on the current Beers list | EHR | Primary care Home health care Pharmacy/pharmacist Long term services and supports Care manager SNF rehabilitation SNF long term care | Behavioral health Prevention Clinical care |

Definition

| Performance Measure | Source for Data (claims; EHR; self-report) | Relevant Health Neighborhood Provider(s) | Other Domains Relevant Performance Measure |
|--|---|---|--|
| Percentage receiving body mass index (BMI) assessment | Claims; EHR | Primary care Care manager | Clinical care |
| Percentage receiving influenza immunization | Claims EHR Self-report | Primary care Pharmacy/Pharmacist Home health care Care manager | Medication management Care coordination/Care transition |
| Percentage receiving pneumococcal vaccination | Claims EHR Self-report | Primary care Pharmacy/Pharmacist Home health care Care manager | Medication management Care coordination/Care transition |
| Percentage with blood pressure measurement in preceding 2 years | EHR | Primary care Medical specialist Care manager | Clinical care |
| Percentage of women with mammography screening per clinical practice guidelines | Claims EHR | Primary care Medical specialist Care manager | Clinical care |
| Percentage of women receiving bone density testing for osteoporosis per clinical practice guidelines | Claims EHR | Primary Care Medical specialist Care manager | Functional status Clinical care |
| Percentage with documented fall risk assessment and fall prevention intervention | EHR | Primary care | Clinical care |
| Percentage receiving glaucoma screening | EHR Claims | Primary care Medical specialist | Functional status |

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|--|---------------|--|--|
| | | Care manager SNF long-term care | |
| Age receiving hearing assessment | EHR | Primary care Medical specialist Care manager SNF long-term care | Functional status |
| Age receiving colorectal cancer screening | EHR Claims | Primary care Medical specialist Care manager | Clinical care |
| Age receiving fall risk assessment | EHR Claims | Primary care Medical specialist Care manager Hospital SNF rehabilitation SNF long-term care | Functional status |
| Age receiving cognitive status assessment | EHR | Primary care Medical specialist Behavioral health Care manager Hospital SNF rehabilitation SNF long-term care Palliative care | Functional status Behavioral health Medication management Palliative care |
| Age receiving mental health assessment | EHR | Primary care Medical specialist Behavioral health Care manager Hospital SNF rehabilitation SNF long-term care Palliative care | Functional status Behavioral health Medication management Palliative care |
| Age receiving pain screening | EHR | Primary care Medical specialist Care manager Hospital SNF rehabilitation SNF long-term care Palliative care | Functional status Behavioral health Medication management Palliative care |
| Age screened for alcohol use (AUDIT-C or CAGE) | EHR | Primary Care Behavioral health Care manager | Functional status Behavioral health Medication management |

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|---|--|--|---|
| Not screened for other substance use | EHR | Primary Care Behavioral health Care manager | Functional status Behavioral health Medication management |
| Not screened for urinary incontinence | EHR | Primary Care Home health care Medical specialist SNF rehabilitation SNF long-term care | Functional status Medication management |
| Not screened for elder abuse or neglect | EHR | Primary care Care manager | Person-centered care Behavioral health |
| Not many days at home | Claims (JEN Associates refining measure; needs validation) | Primary care Medical specialist Care manager Behavioral health | Functional status Behavioral health Medication management Care coordination/Care transition Clinical care Access to care |

Behavioral health

| Performance Measure | Source for Data (claims; EHR; self-report) | Relevant Health Neighborhood Provider(s) | Other Domains Related Performance Measure |
|--|---|--|---|
| <i>Up After Hospitalization for Illness within 7 days of discharge</i> | <i>Claims</i> | <i>Behavioral health Care manager</i> | <i>Care coordination Transitions</i> |
| <i>for Clinical Depression and Follow-up Plan</i> | <i>EHR</i> | <i>Behavioral health Care manager Primary Care</i> | <i>Prevention</i> |
| <i>and Engagement of Alcohol other Drug Dependence Treatment</i> | <i>Claims EHR</i> | <i>Behavioral health Care manager</i> | <i>Care coordination transitions</i> |
| access behavioral services quickly | Self-report; EHR | Care manager Primary care Behavioral health Home health care Hospital Long term services and supports SNF rehabilitation SNF long-term care | Care coordination transitions Functional status Access to care |
| age improved in behavior | EHR; OASIS | Care manager | Care coordination |

| | | | |
|--|-----------------|---|---|
| problem frequency | | Primary care Behavioral health Pharmacy/Pharmacist Home health care Hospital Long term services and supports SNF rehabilitation SNF long-term care | transitions Medication manag Functional stat |
| ...e improved in anxiety level | EHR; OASIS | Care manager Primary care Behavioral health Pharmacy/Pharmacist Home health care Hospital Long term services and supports SNF rehabilitation SNF long-term care | Care coordination transitions Medication manag Functional stat |
| ...age stabilized in cognitive function | EHR; OASIS; MDS | Care manager Primary care Behavioral health Pharmacy/Pharmacist Home health care Hospital Long term services and supports SNF rehabilitation SNF long-term care | Care coordination transitions Medication manag Functional stat |
| ...age with newly diagnosed prescribed antidepressant F/U appt in 30 days | Claims | Care manager Primary Care Behavioral Health Pharmacy/Pharmacist Long term services and supports SNF long-term care | Care coordination transitions Medication manag |
| ...readmission to psychiatric within 30 days and 180 days | Claims | Care manager Primary care Behavioral health Pharmacy/Pharmacist Long term services and supports | Care coordination transitions Medication manag |
| ...of outpatient follow-up after tion for mental health and/or stance use disorder | Claims | Care manager Primary care Behavioral health Pharmacy/Pharmacist Long term services and supports | Care coordination transitions Medication manag |

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|--|-----|---|--|
| in remission 6 months after diagnosed depression | EHR | Care manager Primary care Behavioral health Pharmacy/Pharmacist Home health care Hospital Long term services and supports SNF rehabilitation SNF long-term care | Care coordination transitions Medication manag |
|--|-----|---|--|

Palliative and End-of-Life Care

| Performance Measure | Source for Data (claims; EHR; self-report) | Relevant Health Neighborhood Provider(s) | Other Domains Relevant Performance Measure |
|---|---|--|--|
| Percentage with evidence of advance care planning | EHR | Care manager Palliative care SNF long term care | Person-centered care Care coordination/Care tra |
| Percentage who have discussed trajectory of disease and treatment options with providers | EHR | Care manager Primary care Palliative care SNF long term care | Person-centered care Care coordination/care tra |
| Percentage for whom palliative care was provided in a setting of their choice | EHR Self-report | Care manager Palliative care Home health care SNF long term care | Person-centered care Care coordination/Care tra |
| Percentage for whom a palliative care plan was created, including pain management | EHR | Care manager Palliative care Pharmacy/Pharmacist SNF long term care | Person-centered care Care coordination/Care tra |
| Percentage of individuals who died in the year (for end of life care) who were enrolled in advance care (within 7 days, 1 to 6 months of death) | Claims | Care manager Palliative care SNF long term care | Person-centered care Care coordination/Care tra |
| Percentage of deaths that occurred in settings other than a nursing facility (i.e. at home) | Claims | Care manager Palliative care Home health care SNF long term care | Person-centered care Care coordination/Care tra |
| Percentage of individuals who died | EHR | Care manager | Medication managemen |

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|--|--------------------|--|--|
| <p>one of the following is documented in the record:</p> <p>in a n</p> | | <p>Palliative care SNF long term care</p> | <p>Clinical care</p> |
| <p>of family caregiver stating that the family was treated according to wishes and/or that their needs were adequately managed</p> | <p>Self-report</p> | <p>Care manager Palliative care Pharmacy/Pharmacist SNF long term care</p> | <p>Person-centered care Medication management Care coordination/Care transitions</p> |

Additional Care Measures

| Performance Measure | Source for Data (claims; EHR; self-report) | Relevant Health Neighborhood Provider(s) | Other Domains Relevant Performance Measures |
|---|---|--|--|
| <p>Percentage of patients with blood pressure in normal range</p> | <p>EHR</p> | <p>Primary care Medical specialist Pharmacy/Pharmacist Home health care SNF long-term care</p> | <p>Prevention Medication management</p> |
| <p>Percentage of patients: percentage with HbA1c poor control (≥9 percent)</p> | <p>EHR</p> | <p>Primary care Medical specialist Pharmacy/Pharmacist Home health care SNF long-term care</p> | <p>Prevention</p> |
| <p>Percentage of patients composite: blood pressure <140/90</p> | <p>EHR</p> | <p>Primary care Medical specialist Pharmacy/Pharmacist Home health care SNF long-term care</p> | <p>Medication management</p> |
| <p>Percentage of patients with diabetes who have the following: - HbA1c test - Eye exam - Foot exam - Neuropathy screening - Retinopathy exam</p> | <p>Claims/EHR</p> | <p>Primary care Medical specialist Care manager SNF long-term care</p> | <p>Care coordination/Care transitions</p> |
| <p>Percentage of diabetics with</p> | <p>EHR</p> | <p>Primary care</p> | <p>Prevention</p> |

| | | | |
|--|---------------|---|--|
| BMI with counseling diet / exercise | | Medical specialist Care manager Behavioral health | Behavioral health Care coordination/Care tra |
| Coronary Vascular Disease Complete lipid profile and LDL control | EHR | Primary care Medical specialist Pharmacy/Pharmacist Home health care SNF long-term care | Medication managemen |
| Use of aspirin or other antithrombotic | EHR | Primary care Medical specialist Pharmacy/Pharmacist Home health care SNF long-term care | Medication managemen |
| Medication: Beta blocker for left ventricular dysfunction (LVSD) | EHR Claims | Primary care Medical specialist Pharmacy/Pharmacist Home health care SNF long-term care | Medication managemen |
| Coronary artery disease (CAD): Therapy for lowering LDL- cholesterol | EHR Claims | Primary care Medical specialist Pharmacy/Pharmacist Home health care SNF long-term care | Medication managemen |
| Medication: ACE inhibitor or ARB therapy | EHR Claims | Primary care Medical specialist Pharmacy/Pharmacist Home health care SNF long-term care | Medication managemen |
| Medication: NSAID with osteoarthritis and/or knee with pain assessments | EHR | Primary care Medical specialist | Prevention Functional status |
| Medication: Beta-blocker prescribed following AMI hospitalization | Claims | Primary care Medical specialist Care manager | Medication managemen Care coordination/Care tra |

Access to Care

| Performance Measure | Source for Data (claims; EHR; self-report) | Relevant Health Neighborhood Provider(s) | Other Domains Relevant Performance Measure |
|----------------------------|---|---|---|
| Time of assessment of | EHR | Care manager | Functional status |

| | | | |
|--|---|---|---|
| Environment for barriers to full mobility | Self-report (no endorsed self-report measure identified) | Long term services and supports | |
| Need for transportation or mobility assessment | Self-report (no endorsed self-report measure identified) | Care manager Long term services and supports | Care coordination/Care transition Functional status |
| Presence of financial barrier to determine any needed health and social care | Self-report (no endorsed self-report measure identified) | Care manager Long term services and supports | Care coordination/Care transition Medication management Palliative care |
| Services that required coordination for any services are medication and/or regulatory care use | Self-report (no endorsed self-report measure identified) EHR for missed appointments | Care manager Primary care Medical specialist Pharmacy/Pharmacist | Medication management Prevention Care management/Care transition |

Functional Status Measures

| Performance Measure | Source for Data (claims; EHR; self-report) | Relevant Health Neighborhood Provider(s) | Other Domains Relevant Performance Measure |
|--|--|---|---|
| Change with evidence of status assessment | EHR; OASIS; MDS | Primary care Medical specialist Home health care Care manager Long term services and supports SNF rehabilitation SNF long-term care | Care coordination/Care transition |
| Percentage improved in ambulation | EHR; OASIS | Care manager Home health care SNF rehabilitation | Care coordination/Care transition |
| Percentage stabilized in ambulation | EHR; OASIS; MDS | Care manager Long term services and supports SNF rehabilitation SNF long-term care | Care coordination/Care transition |
| Completion of assistive device needs and unmet needs | EHR; OASIS; MDS | Care manager Home health care Long term care services and supports SNF rehabilitation SNF long-term care | Access to care Care coordination/Care transition |
| Minimal decline in 3 or more of daily living (bathing, dressing, eating, transferring, | EHR; OASIS; MDS | Care manager Home health care Long term care services and | Care coordination/Care transition |

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|---|-----------------|--|--|
| toileting) | | supports | |
| stage improved in bathing | EHR; OASIS | Care manager Home health care Long term care services and supports SNF rehabilitation | Care coordination/Care transition |
| stage stabilized in bathing | EHR; OASIS; MDS | Care manager Long term services and supports SNF rehabilitation SNF long-term care | Care coordination/Care transition |
| stage improved in getting in and out of bed | EHR; OASIS | Care manager Home health care Long term care services and supports SNF rehabilitation | Care coordination/Care transition |
| stage stabilized in getting in and out of bed | EHR; OASIS; MDS | Care manager Long term services and supports SNF rehabilitation SNF long-term care | Care coordination/Care transition |
| stage who develop pressure ulcer | EHR; OASIS; MDS | Primary Care Home health care Long-term care services and supports SNF for rehabilitation SNF for long-term care | Clinical care Care coordination/Care transition |
| stage improved in dyspnea (shortness of breath) | EHR; OASIS | Care manager Long term services and supports SNF rehabilitation SNF long-term care | Clinical care Care coordination/Care transition |

Quality of life

| | | | |
|----------------------|---|---------------|-----|
| Physical health | Self-report (using the WHO Quality of Life questionnaire; see reference list) | All providers | All |
| Psychological health | Self-report (using the WHO Quality of Life questionnaire; see reference list) | All providers | All |
| Social relationships | Self-report (using the WHO Quality of Life questionnaire; see reference list) | All providers | All |
| Environment | Self-report (using the WHO Quality of Life questionnaire; see reference list) | All providers | All |

| | | | |
|---------------------|---------------------------|---------------|-----|
| ent-related measure | Self-report (measure TBD) | All providers | All |
|---------------------|---------------------------|---------------|-----|

Savings

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| asures TBD | | | |
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= Health Home Core Measure

es Examined for Connecticut Performance Measurement Compendium and Matrix

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