What Matters Most: Quality Measurement from the Person’s Perspective
Session Goals

1. Introduction to the “Essential Attributes of a High-Quality System of Care for Adults with Complex Care Needs.”

1. Presentation of current quality measurement work that aims to advance the Essential Attributes.

1. Discussion of how the Essential Attributes are being used at the state-level to support delivery system reform.

1. Understand how Foundations can be involved in quality measurement work and how the Essential Attributes can be used in grant-making.
Speakers

• Sarah Barth, JD
  Principal
  Health Management Associates

• Erin Giovannetti PhD
  Senior Research Scientist
  National Committee for Quality Assurance

• Alice Lind, RN, BSN, MPH
  Section Manager, Grants and Program Development
  Health Care Authority
Group Activity – Steps 1 and 2

- On each table there are post-it notes.

- **Step 1:** Write down your personal “essential attributes” of a quality system of care. (2-minutes)

- **Step 2:** Share your “essential attributes” with the person to your right. (2-minutes)
Group Activity – Steps 3 and 4

• Each table needs to pick a “reporter.”

• **Step 3:** Share your “essential attributes” with your table. Determine the table’s top 4 “Essential Attributes.” (10-minutes)

• **Step 4:** Table report-out and reflections from Sarah Barth.
What Matters Most:

Essential Attributes of a High-Quality System of Care for Adults with Complex Care Needs

Sarah Barth, JD
October 19, 2017
Our firm

We are a leading independent, national healthcare research and consulting firm providing technical and analytical services.

We specialize in publicly-funded health programs, system reform and public policy.

We work with purchasers, providers, policy-makers, program evaluators, investors and others.

Our strength is in our people, and the experience they bring to the most complex issues, problems, or opportunities.
ESSENTIAL ATTRIBUTES
WORKING GROUP

+ The SCAN Foundation convened diverse experts representing the interests of adults with complex care needs
+ Federal officials working on relevant programs and representatives of other foundations with related interests participated as ex-officio members
WORKING GROUP GOAL

Develop consensus on the Essential Attributes of a high-quality system of care that supports system transformation and evaluation, and is from the vantage point of adults with complex care needs.
WORKING GROUP PROCESS

Included:

✚ A comprehensive literature review
✚ Individual interviews with each working group member and select ex-officio members
✚ Three meetings of the working group and ex-officio members to develop consensus around the Essential Attributes

✚ Identified the importance of formalizing approaches to considering the needs of family/caregivers as essential
## WORKING GROUP MEMBERS

<table>
<thead>
<tr>
<th>Name</th>
<th>Role, Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>G. Lawrence Atkins</td>
<td>Executive Director, Long Term Quality Alliance</td>
</tr>
<tr>
<td>Melanie Bella</td>
<td>Independent Consultant</td>
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<tr>
<td>Rich Bringewatt</td>
<td>Co-Founder &amp; CEO, National Health Policy Group</td>
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<tr>
<td></td>
<td>Co-Founder &amp; Chair, SNP Alliance</td>
</tr>
<tr>
<td>Helen Burstin</td>
<td>Chief Scientific Officer, National Quality Forum</td>
</tr>
<tr>
<td>Jennifer Dexter</td>
<td>Assistant Vice President, Government Relations, Easter Seals</td>
</tr>
<tr>
<td>Lynn Friss Feinberg</td>
<td>Senior Strategic Policy Advisor, AARP Public Policy Institute</td>
</tr>
<tr>
<td>Allison Hamblin</td>
<td>Vice President for Strategic Planning, Center for Health Care Strategies, Inc.</td>
</tr>
<tr>
<td>Jennifer Goldberg</td>
<td>Directing Attorney, Justice in Aging</td>
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<tr>
<td>Alice Lind</td>
<td>Manager, Grants and Program Development, Washington State Health Care Authority</td>
</tr>
<tr>
<td>Debra Lipson</td>
<td>Senior Fellow, Mathematica Policy Research</td>
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<tr>
<td>Deidre Gifford</td>
<td>Director of State Policy and Programs, National Association of Medicaid Directors</td>
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<tr>
<td>Margaret E. O’Kane</td>
<td>President, National Committee for Quality Assurance</td>
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<tr>
<td>Pam Parker</td>
<td>Medicare-Medicaid Integration Consultant, Minnesota Department of Human Services</td>
</tr>
<tr>
<td>Carol Regan</td>
<td>Senior Advisor, Community Catalyst, Center for Consumer Engagement in Health Innovation</td>
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</tbody>
</table>
## EX-OFFICIO MEMBERS & ADDITIONAL PARTICIPANTS

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Gretchen Alkema</td>
<td>Vice President of Policy &amp; Communications, The SCAN Foundation</td>
</tr>
<tr>
<td>Eliza Navarro Bangit</td>
<td>Director, Office of Policy Analysis and Development, Administration for Community Living, Department of Health and Human Services (HHS)</td>
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<tr>
<td>Stephen Cha</td>
<td>Director, State Innovations Group, Centers for Medicare &amp; Medicaid Services (CMS)</td>
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<tr>
<td>Bruce Chernof</td>
<td>President &amp; CEO, The SCAN Foundation</td>
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<tr>
<td>Tim Englehardt</td>
<td>Director, State Innovations Group, CMS</td>
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<tr>
<td>Marcus Escobedo</td>
<td>Senior Program Officer, The John A. Hartford Foundation</td>
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<tr>
<td>Susan Mende</td>
<td>Senior Program Officer, Robert Wood Johnson Foundation</td>
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<tr>
<td>MaryBeth Musumeci</td>
<td>Associate Director, Kaiser Commission on Medicaid and the Uninsured</td>
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<tr>
<td>Lisa Patton</td>
<td>Division Director, Center for Behavioral Health Statistics &amp; Quality, Substance Abuse and Mental Health Services Administration (SAMHSA)</td>
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<tr>
<td>Nidhi Singh Shah</td>
<td>Health Policy Analyst, CMS/Center for Clinical Standards and Quality</td>
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<tr>
<td>Stephanie Gibbs</td>
<td>Senior Program Officer, Center for Health Care Strategies, Inc.</td>
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<tr>
<td>Erin Giovanetti</td>
<td>Research Scientist, Performance Management, National Committee for Quality Assurance</td>
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<tr>
<td>Ann Hwang</td>
<td>Director, Community Catalyst, Center for Consumer Engagement in Health Innovation</td>
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<tr>
<td>Wally Patawaran</td>
<td>Program Officer, The John A. Hartford Foundation</td>
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<tr>
<td>Kali Peterson</td>
<td>Program Officer, The SCAN Foundation</td>
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<tr>
<td>Diane Rowland</td>
<td>Executive Vice President, Kaiser Family Foundation&lt;br&gt;Executive Director, Kaiser Commission on Medicaid and the Uninsured</td>
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<tr>
<td>René Seidel</td>
<td>Vice President of Programs and Operations, The SCAN Foundation</td>
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<tr>
<td>Emily Zyborowicz</td>
<td>Manager, Research &amp; Identification, Peterson Center of Healthcare</td>
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</tbody>
</table>
Affirm their support and commit to advancing the Essential Attributes produced through the consensus process
Individuals are able to live their lives with services and supports reflecting their values and preferences in the least restrictive, most independent setting possible with access to a delivery system that respects and supports their choices and decisions.
HIGH-QUALITY SYSTEM FOR ADULTS WITH COMPLEX CARE NEEDS

Attribute 1:
Each individual’s range of needs and goals, both medical and non-medical, as well as for family/caregivers, are identified and re-evaluated on an ongoing basis to drive care plans.

Attribute 2:
Each individual’s needs are addressed in a compassionate, meaningful, and person-focused way and incorporated into a care plan that is tailored, safe, and timely.

Attribute 3:
Individuals have a cohesive, easily navigable delivery system so that they can get the services and information they want by themselves or with support when needed, and avoid the services they do not need or want.

Attribute 4:
Individuals and their family/caregivers continually inform the way the delivery system is structured to ensure that it is addressing their needs and providing resources tailored to them.
What Matters Most: Essential Attribute 1

Each individual’s range of needs and goals, both medical and non-medical, as well as for family/caregivers, are identified and re-evaluated on an ongoing basis to drive care plans.

#HealthCareQuality
Each individual’s needs are addressed in a compassionate, meaningful, and person-focused way and incorporated into a care plan that is tailored, safe, and timely.

#HealthCareQuality
What Matters Most: Essential Attribute 3

Individuals have a cohesive, easily navigable delivery system so that they can get the services and information they want by themselves or with support when needed, and avoid the services they do not need or want.

#HealthCareQuality
What Matters Most: Essential Attribute 4

Individuals and their family/caregivers continually inform the way the delivery system is structured to ensure that it is addressing their needs and providing resources tailored to them.

#HealthCareQuality
The Essential Attributes aim to:

- Support system transformation and evaluation, as well as core elements in the functioning of such a system
- Help guide future efforts to develop quality measures that capture the goals, preferences, and desired life outcomes of adults with complex care needs
Developing Person-Driven Outcomes

Erin Giovannetti, Ph.D.
Senior Research Scientist
What Matters Most?

Findings from Focus Groups with Disabled Older Adults

**Health and Quality of Life Goals**
- Manage symptoms
- Stop falling as much
- Stay sharp
- Take fewer medications
- Avoid dialysis
- Get my doctors to talk to each other
- Be heard by my doctors
- Stay out of the hospital
- Choose who helps me dress and bathe
- Help my caregiver be less stressed

**Care Preferences**
- Lose weight
- Increase mobility and stamina
- Play with my grandchildren
- Have privacy
- Choose who cares for me in my home
- Not be a burden to my family
- Stay in my home

**Caregiver Goals**
- Get my doctors to talk to each other
- Be heard by my doctors
- Stay out of the hospital
- Choose who helps me dress and bathe
- Help my caregiver be less stressed
Attribute #1
Each individual’s range of need and goals, both medical and non-medical, as well as for family/caregivers are identified and re-evaluated on an ongoing basis to drive care plans.

Attribute #2
Each individual’s needs are addressed in a compassionate, meaningful, and person-focused way and incorporated into a care plan that is tailored, safe and timely.

Person-Driven Outcomes
Individualized outcomes identified by the patient (or caregiver) as important that can be used for care planning and quality measurement.
Step 1: Eliciting what is important

What is important TO somebody instead of what is important FOR somebody

- The more significant the disability the more likely that control is vested in others
- People tend to express different goals depending on who they’re talking to
- Developed goal inventory to help start the discussion

<table>
<thead>
<tr>
<th>Health Care</th>
<th>Not important at all</th>
<th>Somewhat Important</th>
<th>Very Important</th>
<th>Extremely Important</th>
<th>Does Not Apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Don’t get burdensome medical care</td>
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<td>2. Stay out of the hospital</td>
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<td>3. Get the care I need</td>
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<td>4. Get medical equipment (e.g., wheelchair, oxygen)</td>
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<thead>
<tr>
<th>Physical Activity</th>
<th>Not important at all</th>
<th>Somewhat Important</th>
<th>Very Important</th>
<th>Extremely Important</th>
<th>Does Not Apply</th>
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<tbody>
<tr>
<td>5. Am physically active</td>
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<td>6. Care for myself (e.g., toileting, dressing, bathing)</td>
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<td>7. Do household and daily activities (e.g., cooking, shopping, finances)</td>
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<tr>
<td>8. Do recreational activities (e.g., hobbies, reading, playing games)</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Choice and Control</th>
<th>Not important at all</th>
<th>Somewhat Important</th>
<th>Very Important</th>
<th>Extremely Important</th>
<th>Does Not Apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Make choices about how I live (e.g., what I eat, what I wear, when I get up)</td>
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<td>10. Choose when to have privacy, when to be alone, or have time without family or caregivers around</td>
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<tr>
<td>11. Choose who helps me (e.g., choosing someone who speaks my language)</td>
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<tr>
<th>Community</th>
<th>Not important at all</th>
<th>Somewhat Important</th>
<th>Very Important</th>
<th>Extremely Important</th>
<th>Does Not Apply</th>
</tr>
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<tbody>
<tr>
<td>12. Drive or use other means of transportation (e.g., bus, rail, getting a ride)</td>
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</tbody>
</table>
**Option 1: Goal Attainment Scaling**

<table>
<thead>
<tr>
<th></th>
<th>-2 Much less than expected</th>
<th>-1 Current State (Less than expected)</th>
<th>0 Expected level</th>
<th>+1 Somewhat better than expected</th>
<th>+2 Much better than expected</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GOAL:</strong></td>
<td>To be strong and healthy enough to fly to California to visit family (daughter and her fiancé and son’s family) by winter 2016</td>
<td>To not be able to resume driving and not be able to fly to California</td>
<td>To have complications from surgery and not drive for at least 3 months and not make it to California for the holidays</td>
<td>To resume driving in 6 weeks and fly to California to visit family for the holidays</td>
<td>To resume driving in 4 weeks and return with daughter to California in October</td>
</tr>
</tbody>
</table>
Option 2: Prioritized Person Reported Outcome Measures

Bank of Person-Reported Outcome Tools

- Health Care Task Difficulty
- Choice and Control
- Community Inclusion
- Ability to participate in social roles and activities
- Companionship
- Depression
- Anxiety
- Sleep
- Pain
- Cognition
- Access to Services and Supports
- Caregiver Burden

Individual Measurement

Health Care Task Difficulty

Population Performance Measure

% of population “achieving” prioritized outcome

Access to services and supports
Sample of Goals Elicited

To eat without worry
To get off oxygen and breath with room air only
Go to the pool one time with daughter.
Avoid hospitalizations or ED visits over the next 6 months
Identify a home provider (agency) who can stay at home with pt when caregiver needs to attend to his own medical appts within the next 2 months.
To attend 1 lunch + 1 activity at her new senior living residence within 1 month.
Walk 5 blocks 3x/wk in 6 months
I want to get out of the house more for things other than medical appointments
Feel good about herself in spite of her pain
Practice her faith
What types of person-driven outcomes are identified?

- Health Care Utilization
  - Avoiding hospitalization
  - Follow up with provider

- Cognitive Function

- Travel/Vacation

- Physical
  - Pain management
  - Walking/Standing
  - Weight
  - Health condition management
  - Exercise
  - Sleep
  - Avoid falling

- Psychosocial
  - Self
  - Family
  - Friends
  - Religion
  - Mental health
  - Learning/Skills
  - Driving

- Independence
  - Living in the community/at home
  - Leaving the house for outings
  - Taking care of pet
  - Working/volunteering
  - Caregiver Support
Calculating quality from person-driven outcomes

Results from seven pilot sites testing person-driven outcomes (N=186 patients)

<table>
<thead>
<tr>
<th>Goal Attainment Scaling</th>
<th>PROM</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow-up on goal</td>
<td>90%</td>
<td>74%</td>
</tr>
<tr>
<td>Goal Met</td>
<td>62%</td>
<td>55%</td>
</tr>
</tbody>
</table>

“You know, you can tell somebody what to do, but I think you convey better things when you give people options to do, find out what they like.” – 69 year old female patient
All of a sudden, they were totally engaged in their healthcare. And that was new for a lot of them. So I thought that was really cool.

– NURSE CASE MANAGER
I have found that in doing some of the things that we put down, there’s strength in me.

– 64 YEAR OLD MALE
This work is supported by a grant from The SCAN Foundation and The John A. Hartford Foundation
Washington State’s Delivery System Reform and Person Centered Complex Care Management

Alice Lind, Manager
Grants and Program Development, HCA
October, 2017
**Attribute 1:** Each individual’s range of needs and goals, both medical and non-medical, as well as for family/caregivers, are identified and re-evaluated on an ongoing basis to drive care plans.

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Healthier Washington: The Vision

The Health Care Authority has a vision of achieving the triple aim for the citizens of Washington:

- Improve health
- Lower health care costs
- Improve the experience of care
Healthier Washington: Goals

HCA launched a Medicaid Transformation Demonstration in 2017, with these objectives:

• Build Health Systems and Community Capacity
• Ensure Financial Sustainability through Participation in Value-based Payment
• Deliver bi-directional Integration of physical and behavioral health
• Achieve Community-based Whole-person Care
• Improve Health Equity and Reduce Health Disparities
Community Based Whole Person Care Projects

• Use or enhance services in the community to meet the needs of a region’s identified high-risk, high-needs target populations.

• Promote care coordination across the continuum of health for beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their health.

• Develop linkages between providers of care coordination by utilizing a common platform.
Building on Solid Ground: Health Homes

- Target population: high risk, high cost clients with complex physical and behavioral health conditions
- Started under Medicare-Medicaid Alignment Demonstration
- Now statewide, due to measurable cost-savings under the terms of the demonstration
- Every engaged client has a person-centered health action plan
Health Homes’ Person-Centered Quality

Focus group results:

• “We set goals”; “She’s a resource person and helps me set goals.”

• “I have everything anybody could possibly want.”

• “I go outside; I go to church; I interact with my neighbors. My cholesterol was dangerously high for many years and now it’s normal.”
Health Homes’ Survey Results

Measures from CAHPS surveys, all 80-90%:

• Shared decision making
  – Did a doctor talk to you about pros and cons of treatment
  – Did a doctor ask you about which choice was best for you

• Care transition
  – Hospital staff and I agreed about clear health goals
  – I had all the information I needed to take care of myself
  – I was confident I could actually do the things I needed to take care of myself
Health Homes’ Survey Results

Measures from CAHPS surveys, all 80-90%:
• Satisfaction with coordination of care
• Care plan development
• Care plan comprehensiveness
Thank you!

Alice Lind
Alice.lind@hca.wa.gov
Q & A
**Our Vision:**
A society where older adults can access health and supportive services of their choosing to meet their needs.

**Our Mission:**
To advance a coordinated and easily navigated system of high-quality services for older adults that preserve dignity and independence.

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