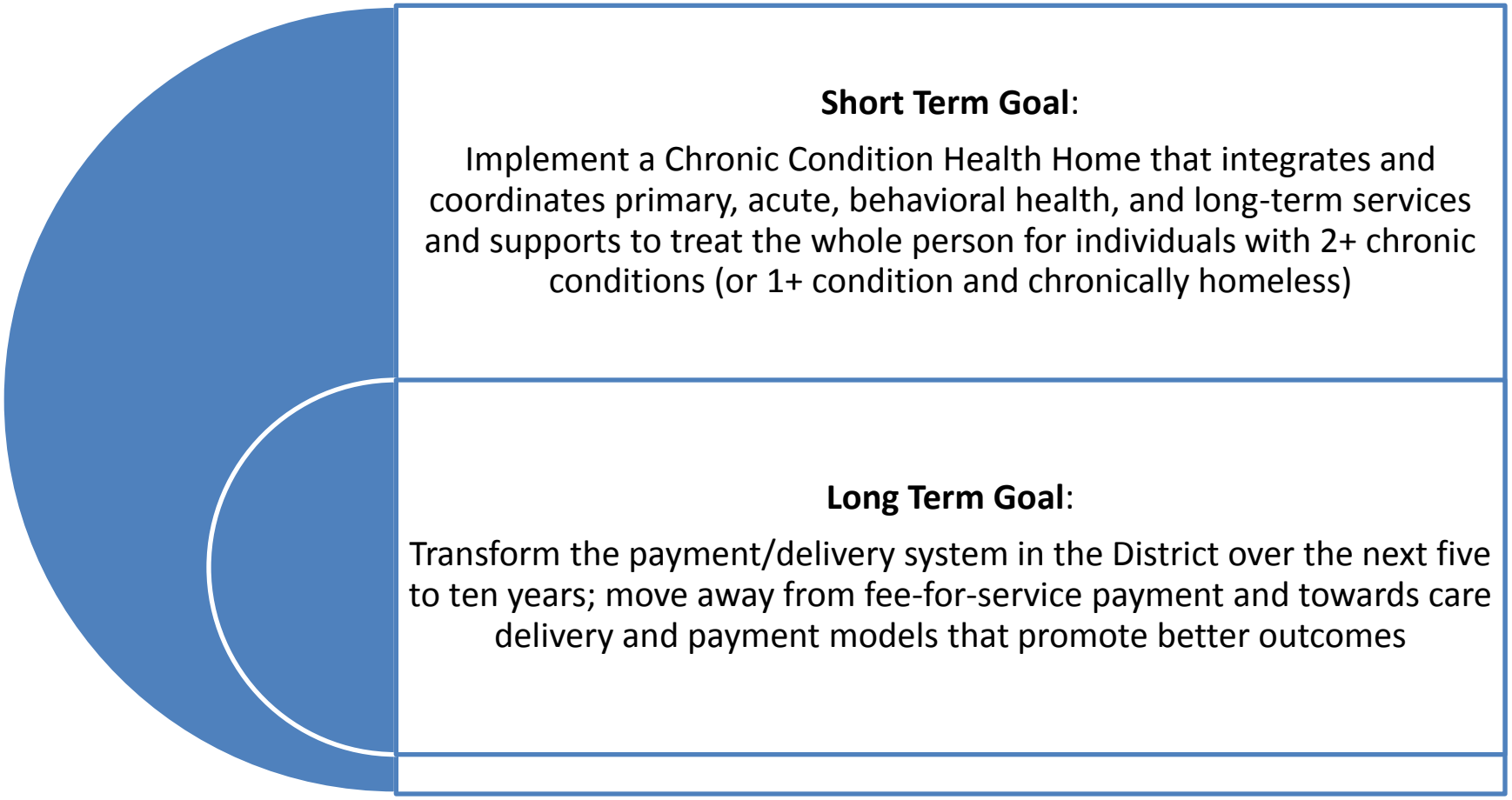
SIM
Quality Metrics
Work Group

November 16, 2015

Agenda

- Introductions
- SIM and Care Coordination Overview
- Overview of Quality Metrics Work Group
- Discussion on Quality Performance Reporting Initiatives

SIM to Support Short and Long Term Health Reform and Innovation Goals



Chronic Condition Management Initiatives

Medicaid Health Home

- Program Summary: Pays providers to integrate and coordinate primary, acute, behavioral health, and long-term services and supports to treat the whole person

- Patient Eligibility:
  - Have 2 or more chronic conditions
  - Have 1 chronic condition and are at-risk for a 2nd
  - Have 1 serious & persistent mental health condition

- Mandatory Services:
  - Comprehensive care management
  - Care coordination
  - Comprehensive transitional care/follow-up
  - Health promotion
  - Patient & family support
  - Referral to community & social support services

- Eligible Providers:
  - Designated provider (e.g. physician, group practice, clinic)
  - Team of health professionals (e.g. physicians, nurse care coordinators, nutritionists, social workers)
  - Health team (e.g. specialists, nurses, pharmacists, nutritionists, dieticians, social workers)

Medicare Chronic Care Management (CCM)

- Program Summary: Pays physicians ~$40 PMPM for care management (outside of face-to-face visits) that includes at least 20 minutes of clinical staff time

- Patient Eligibility:
  - Patients with 2 or more chronic conditions lasting at least a year

- Mandatory Services:
  - 24/7 care management services
  - Continuity of care via a designated practitioner
  - Care transition management
  - Creation of an electronic patient-centered care plan
  - Enhanced chances to communicate with provider
  - Home and community-based services coordination
  - EHR utilization for structured recording of clinical data

- Eligible Providers:
  - Physicians and non-physician practitioners (Certified Nurse Midwives; Clinical Nurse Specialists; NPs; and PAs) may bill the CCM code
  - Clinical staff can provide the CCM service incident to the services of the billing physician under general supervision of a physician

Components of Care Coordination

- A Health Care Home
  - Establishes accountability and responsibility
  - Aligns resources with patient and population needs
- Interdisciplinary teamwork
- Comprehensive care management
  - Individual assessment
    - Needs and goals
  - Proactive care plan
  - Monitoring and responsive follow up
  - Support for self-management goals
  - Management of care transitions
  - Linkage to community resources
  - Medication management
  - Health promotion and wellness
- Health Information Technology and Exchange

Potential Health Home Populations

Suggestions from the Care Delivery Work Group:

- Chronic Kidney Disease
- Diabetes
- Heart Disease: Congestive Heart Failure, Hypertension
- HIV/AIDS
- Homeless
- Intellectual Development Disabilities
- Transplant patients

Quality Metrics Work Group

Mandate

- The Quality Metrics Work Group will develop recommendations for the Advisory Committee to design a plan that would seek to streamline quality reporting across all District payers; promote agreement on a shared set of measures; identify quality report infrastructure needs; and strategies for quality improvement.

Key Questions for Work Group Recommendations

- How does the District promote more coordinated and streamlined quality reporting?
- What measures are needed to evaluate improved outcomes for specific target populations?
- What options are available to promote a quality reporting data infrastructure?
- What infrastructure do providers need to report quality measures?
- How does the District spread the reporting of existing quality measures to more practices?
- What are the specific metrics required to support the proposed payment model?

Discussion

- What is the currently happening in quality performance reporting in the District?
- What are the challenges to quality performance reporting?
- In an ideal world, what would you like to see accomplished and how can we use SIM to get us on that path?