



National Health Policy Group

Improving Payment and Performance for High-Risk Beneficiaries

MEMORANDUM

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National Alliance of Specialty Healthcare Programs

Date: January 9, 2006

Re: Performance Measures for Special Needs Plans

The National Alliance of Specialty Healthcare Programs is a national leadership organization whose mission is to improve the long-term business viability of Special Needs Plans (SNPs). We appreciate CMS' interest in exploring alternative performance measures for SNPs, given their focus on a high-risk, medically complex population, and the opportunity to provide CMS comments on potential SNP performance measures. The SNP Alliance's Medical Director Work Group has held a series of conference calls over the past eight months to identify quality indicators that we believe are more relevant to SNPs than standard acute care measures. Our first set of recommendations was sent to Tony Hausner in August of 2005. We sent a second set of comments to Tony last month in draft form in response to a specific request for feedback on potential SNP performance measures and approaches. This draft has been updated based on a final review by SNP Alliance Medical Directors.

Below is a summary of our response to the CMS inquiry. Attachment A includes more detailed comments on the specific performance measures and approaches of interest to CMS. Attachment B lists the quality domains and indicators submitted to CMS in August 2005. Attachment C lists the Alliance medical directors involved in the development of our recommendations and their respective organizations. The attached comments should be considered preliminary. While Alliance Medical Directors have given a good deal of thought to appropriate measures, we believe a more comprehensive analysis of existing measures and new options is critical. As requested previously, we urge CMS to establish a CMS Work Group on SNP Performance Measurement to carry out this task. The preliminary recommendations the Alliance submitted in August, combined with the comments contained herein, represent a useful starting point for a CMS work group including representation from all SNP categories, experts from NCQA and relevant professional associations such as the Alliance for Community Health Plans (which has done a great deal of work on quality measurement) and the American Geriatric Society and other relevant stakeholders.

Summary of SNP Alliance Comments on SNP Performance Measurement

- The starting point for SNP Performance measurement should be to *identify uniform measures that can be used across all SNPs* since chronic illness, disability, frailty and comorbidities are common characteristics of beneficiaries in all SNPs. A limited number of SNP-specific measures also should be explored.
- *Measures should be identified that evaluate performance and encourage plans to improve outcomes in relation to care of persons with complex chronic conditions.* Performance measures historically have focused on acute conditions. The Rand Corporation initiated the “Assessing Care of Vulnerable Elders” study recognizing that objective measures for evaluating care for this population were missing from current quality of care measurement systems. A recent Johns Hopkins study indicated that use of existing clinical practice guidelines could actually be harmful to those with comorbid conditions. Clearly, alternative measures for frail seniors are needed.
- *A combination of process and outcome measures should be used for SNP performance evaluation.* All SNPs should report on inpatient admissions for ambulatory care sensitive conditions, emergency room admissions and long-stay nursing home admissions (90 days or more). These outcome measures should be risk adjusted to account for expected utilization differences among medically complex beneficiaries. SNPs process measures should be chronic-care oriented, including end-of life care, continuity of care, safe and effective care transitions, functional independence, member choice/quality, medication management, population-specific conditions, comorbidity management, mental illness/behavioral health, family caregiver support.
- Until SNP benchmarks are established, *a Continuous Quality Improvement (CQI) approach to SNP performance measurement should be employed.* CQI should also become part of a long-term SNP performance evaluation system.
- *A limited set of HEDIS measures should be collected for plans targeting frail elderly* including annual monitoring for patients on persistent medications; drugs to be avoided in elderly; flu shots for older adults; pneumonia vaccine; osteoporosis management for women with previous fracture; and antidepressant medication management. HEDIS measures are not the most relevant measures for frail seniors. They were developed for the commercial workforce, have not been validated for the over-75 and are not conducive to timely interventions for enrollees whose health can change frequently.
- *Plans should encourage their provider networks to incorporate ACOVE guidelines into their clinical practice.* HEDIS, DOQ and ACOVE measures are all physician-oriented and require modification to enhance relevance to plan performance for chronically ill enrollees. ACOVE measures, in general, however, appear to be the most relevant to SNPs serving seniors.
- *Alliance members support a number of measures for adults with disabilities recommended by Dr. Susan Palsbo* such as selected HEDIS, Preventive Care and Community Integration measures. We also favor Palsbo mental health measures over the SAMSHA measures which are not as relevant and well developed.

The SNP Alliance appreciates the opportunity to provide preliminary comments on SNP performance measures. We hope CMS will establish a Work Group on SNP Performance Measurement to identify measures that will set a standard for SNP program operations and improve SNP cost and quality performance. There are a number of commonalities among measures proposed by the SNP Alliance, Palsbo, ACOVE and noted geriatrician researchers to provide a good starting point for discussion.

We look forward to working with CMS on this important agenda in the coming year.

ATTACHMENT A

National Alliance of Specialty Healthcare Programs Comments on SNP Performance Measurement

I. GENERAL COMMENTS

Medical directors and researchers for special needs populations indicate that, too often, measures are selected because they are available, easy to collect and/or comparable to existing benchmarks for FFS and/or mainstream managed care programs. The long-term business viability of Special Needs Plans (SNPs) is dependent, in no small part, on how they are evaluated. Unless SNPs can demonstrate superior cost and quality performance, it will be difficult to justify a unique Medicare Advantage (MA) category. Further, in the long-run, SNPs and other plans are likely to be compensated under pay-for-performance systems and fair compensation will be dependent on relevant performance measures.

While some HEDIS measures and other existing quality indicators may be appropriate for chronic care performance measurement, Rand, Fried, Boulton and other prominent researchers and geriatricians have called for alternative measures for special needs populations. For example:

- According to Rand, “vulnerable elders are a particularly important group for quality-of-care evaluation because of their risk for serious declines in health and function from poor quality care and their disproportionate use of health care resources. Objective measures to evaluate their care are not adequately represented in current quality-of-care measurement systems.¹”
- According to Boulton et al, the use of alternative performance measures for frail elderly will become increasingly important in light of pay-for-performance initiatives. Relevant measures will be critical to prevent providers from being evaluated unfairly and to eliminate disincentives for serving high-risk Medicare beneficiaries².
- Research conducted by Fried et al regarding frailty, disability and comorbidities as three inter-related, but distinct clinical entities has important implications for performance measurement³. The ability to differentiate among these three distinct entities is critical to developing interventions that can prevent cascading from one condition to another leading to further disability progression. Fried and others have identified alternatives to functional indicators for identifying frailty such as advanced age, unintentional weight loss, slow gait speed, blood tests, etc. Further refinement of frailty and related measures would enhance performance and measurement.

These and other studies underscore the importance of alternative quality indicators for SNPs. The challenge facing plans, providers and regulators will be in implementing new data collection systems for performance measurement. Data for measuring disabilities, frailty and comorbidities are not collected routinely by Medicare and Medicaid even though they are central to the healthcare problems of high-risk Medicare and Medicaid beneficiaries. Until alternative measures and data sources are identified for SNPs, judicious use must be made of existing administrative data and, to the extent possible, electronic medical records, to ensure fair evaluations.

¹Shekelle, PG et al. “Assessing Care of Vulnerable Elders: Methods for Developing Quality Indicators,” *Annals of Internal Medicine*, Volume 135, Number 8 (Part 2), October 16, 2001, p. 647.

²Boyd, CM, Darer, J, Boulton, C et al: “Clinical Practice Guidelines and Quality of Care for Older Patients with Multiple Comorbid Conditions: Implications for Pay for Performance.” *Journal of American Medical Association*: 296(6): 716-724, 10 August, 2005.

³Fried, LP, Ferrucci, L et al: “Untangling the Concepts of Disability, Frailty, and Comorbidity: Implications for Improved Targeting and Care.” *Journal of Gerontology: Medical Sciences* 2004, 59(3): 255-263.

II. CMS QUESTIONS ABOUT EVALUATION METHODS

A. To what extent should CMS use process measures vs. measures that capture outcomes and clinical effectiveness?

The Alliance supports a combination of process and outcome measures. The quality domains and preliminary indicators we submitted in August (Attachment A) focus mostly on process. The dashboard indicators we are recommending on an interim basis focus on outcomes. CMS needs a starting point for collecting performance related data while developing more appropriate long-term measures, once sufficient data/experience is accumulated to establish SNP-specific benchmarks. We recommend that CMS identify some short-term “bridging measures” that already are being collected by plans. The three preliminary “dashboard indicators” we recommend collecting across all SNPs include inpatient hospital bed days for ambulatory care sensitive conditions (ACSCs); emergency room admissions rates; and nursing home admission rates for long-stays. We define long-stays as 90 days or more, consistent with the definition used for institutional SNPs.

These dashboard indicators should be risk adjusted to account for different expected outcomes for those with multiple complex and often late stage chronic conditions than for healthier enrollees. They should also be linked to some of the process measures identified by the Alliance. For example, one end-of-life quality indicator identified by the Alliance is comprehensive advance care planning for enrollees with late stage conditions such as CHF or COPD. Dashboard indicators could be used to monitor whether patients with end stage conditions undergo repeated hospital admissions during the last six months of life.

Until SNP-specific benchmarks can be established, plan performance should be measured in relation to quality improvement, or the degree to which a plan improves performance from its previous evaluation. As such, each plan effectively becomes its own benchmark. This “continuous quality improvement” or CQI approach provides for the establishment of achievable targets related to the special needs population and data collection methodology limitations. It also provides a vehicle for CMS to identify and share best practices. In fact, we recommend that CQI be included as a standard part of performance evaluation, even after SNP benchmarks are established.

Assuming that CMS develops SNP-specific benchmarks, it is critical that the benchmarks be risk adjusted to account for differences in risk levels and expected outcomes across plans. Since SNPs exclusively or disproportionately serve high-risk beneficiaries, one would expect outcomes to differ from mainstream plans. Risk-adjusted benchmarks are necessary to prevent plans from being penalized for serving a high risk population. For example, one could expect a greater risk of pressure sores in a plan exclusively serving nursing home residents or wheel-chair bound disabled adults. Benchmarking also should be adjusted for other relevant plan-to-plan differences such as plans that offer integrated products for duals versus plans that offer only Medicare or Medicaid products (or plans that offer both products with no attempt to integrate or coordinate benefits and services).

While outcome measures are important indicators of quality, there is a great deal of support in the literature for process oriented quality indicators for vulnerable elders. A number of the ACOVE (Assessing Care of Vulnerable Elders) measures developed by Rand et al are process oriented. According to Shekelle et al⁴, process measures have the following advantages:

- they are a more efficient measure of quality;

⁴ Shekelle, PG et al. “Assessing Care of Vulnerable Elders: Methods for Developing Quality Indicators,” *Annals of Internal Medicine*, Volume 135, Number 8 (Part 2), October 16, 2001, p. 647.

- they recognize the insufficiency of medical record data and the paucity of validated models to adequately adjust outcomes for differences in case mix between providers; and
- processes of care are amendable to direct action by providers.

Alliance medical directors also believe that, in the absence of clinically validated measures, plans that follow practices believed by a preponderance of physicians and specialists to contribute to positive outcomes will improve care and outcomes. This view is supported by Wenger et al who conclude that “measurement of processes of care is thought to be a more direct assessment of quality than measurement of outcomes⁵.”

A study by Min et al on the impact of care processes on quality of care similarly concludes that the evaluation of care process has become increasingly common and that older persons whose care requires “time consuming processes such as history taking and counseling” are at risk for worse quality and should be a target for interventions to improve care.”⁶ These findings suggest that process measures are not only a good indicator of quality for special needs beneficiaries, but also can serve as an important care management tool.

B. What is the preferred approach to performance measurement across SNPs? (measures that cut across SNPs, measures specific to type of SNP, or both)

The Alliance supports SNP-specific quality measures that differ among the three plan types. The starting point for SNP performance measurement, however, should be a *uniform* set of chronic illness care measures that cross SNPs. Chronic illness, disability, frailty and comorbidities are common characteristics of all SNP beneficiaries. In addition to a uniform set of SNP measures, CMS should evaluate the need for additional measures that are specific to type of SNP and/or specific chronic conditions. This does not mean simply replicating disease management guidelines that focus on a single condition; it means measuring SNPs’ unique focus on complex medical management and the interrelationships among multiple chronic conditions.

C. Have the measures proposed by the SNP Alliance (NHPG) and Dr. Susan Palsbo of George Mason University have been tested for reliability and validity?

One of the key challenges facing CMS and SNPs is the paucity of “generally accepted” and validated chronic care measures. Most quality indicators used for performance measurement today focus on process and outcomes for acute conditions, not chronic conditions. According to Shekelle et al⁷, one factor contributing to lack of validated measures is that vulnerable elders typically are excluded from clinical trials. For this reason, the ACOVE measures were developed by “content experts” and “expert opinions” from practicing geriatricians and others. Likewise, the quality domains and indicators identified by the SNP Alliance were recommended by practicing specialty physicians and medical directors of specialty health plans.

D. Identify generic measures that could be used across chronic conditions.

The Alliance recommends the following generic measures for evaluating quality across SNPs:

- Interim dashboard indicators: inpatient hospital bed days for ACSCs; emergency room admissions; long-term nursing home admissions (90 days or more);
- Alliance-proposed quality domains and indicators (see Attachment A)

⁵ Wenger, NS et al. “The Quality of Medical Care Provided to Vulnerable Community-Dwelling Older Patients,” *Annals of Internal Medicine*, Volume 139, Number 9, p. 740.

⁶ Min, LC et al. “Predictors of Overall Quality of Care Provided to Vulnerable Older People,” *Journal of the American Geriatric Society*, Volume 53, Number 10, October 2005, p.1705.

⁷ Shekelle, p. 647.

- A limited set of HEDIS measures for frail elderly across SNPs (see HEDIS recommendations below).
- A limited set of measures for adults with disabilities across SNPs:
 - ✓ Nationally used preventive care measures identified below.
 - ✓ Community-integration measures identified below.
 - ✓ Alliance-specified measures for adults with mental illness identified below.

III. COMMENTS ON SPECIFIC PERFORMANCE MEASURES

CMS asked the SNP Alliance to comment on the appropriateness of selected measures for chronic care SNPs and indicate why we think these measures are appropriate or inappropriate for beneficiaries with severe or disabling chronic conditions: HEDIS, Doctor Office Quality (DOQ), NHPG/SNP Alliance recommendations, recommendations from Dr. Susan Palsbo, a well-known researcher from George Mason University specializing in disability research, Substance Abuse and Mental Health Services (SAMSHA) indicators and core indicators related to developmental disabilities developed by the National Association of State Directors of Developmental Disability Services. Below are comments on these measures.

A. HEDIS

Alliance comments on HEDIS are directed toward SNPs serving frail elderly. HEDIS is not the most appropriate tool for measuring SNP performance in serving this group. HEDIS was developed for the commercial workforce to help large employers minimize absenteeism due to illness. Important limitations of HEDIS are that the measures have not been validated for frail older persons (e.g., 75) and the annual reporting cycle does not provide for “actionable” and timely quality improvement interventions for populations whose health status can change frequently. In addition, the measures do not focus on a number of care components most relevant to frail seniors with multiple chronic conditions and complex medical needs (e.g., continuity of care, care transitions, geriatric syndromes, end-of-life care needs, comprehensive advance care planning, etc.). Since CMS needs a starting point for performance measurement while it is exploring more appropriate long-term SNP measures, the Alliance recommends that SNPs work with CMS to develop customized HEDIS reports. These reports would include a limited set of uniform measures to be collected by all SNPs and a limited set of SNP-specific measures identified by plans that are relevant to the target population served. The Alliance medical directors recommend that the following uniform HEDIS measures for plans serving frail elderly:

- Annual monitoring for patients on persistent medications
- Drugs to be avoided in the elderly
- Flu shots for older adults
- Pneumonia vaccine
- Osteoporosis management in women who had a fracture
- Antidepressant medication management

Each plan also should identify 3-5 population-specific measures relevant to the target SNP population. For example, an institutional SNP might monitor pressure ulcers for patients that are wheelchair and/or bed bound. A plan targeting beneficiaries with diabetes would likely monitor A1 hemoglobin levels. We believe that this combination of a limited set of uniform SNP measures and population specific measures would provide a useful starting point for SNP performance measurement.

B. Doctor Office Quality

Doctor Office Quality measures do not appear to add significantly to HEDIS measures.

C. NHPG/SNP-Alliance Recommendations

NHPG submitted recommendations regarding two types of SNP performance measures on behalf of the SNP Alliance Medical Directors in August 2005:

- Quality Domains and Indicators (Attachment A)
- Dashboard Indicators (discussed above in Section II.A)

The Alliance has not made changes to Attachment A. We believe that this set of domains and indicators represents a “good start” for identifying performance measures for all SNPs and that the next step should be to review this document among a broader stakeholder group, including representatives from the 3 SNP categories, CMS, NCQA and other relevant parties. The Alliance did narrow the list of dashboard indicators from 5 measures to 3: we recommend collecting utilization data on inpatient hospital bed days for ambulatory care sensitive conditions, emergency room visits and long-term nursing home admissions. We eliminated medical management and consumer satisfaction from the original list because these measures are included in our quality domains and indicators and the group did not have sufficient time to develop concrete measures for these two items as dashboard indicators. We recommend that both be revisited by a broader stakeholder group.

D. ACOVE

ACOVE measures focus on clinical practice areas that require special attention for the geriatric population. Alliance Medical Directors reviewed ACOVE’s 22 topic areas that function much like the Alliance’s “domains” and found a great deal of continuity between the two; e.g., appropriate use of medications, continuity and coordination of care, end-of-life care, etc. The Alliance grouped more clinical issues under single domains while ACOVE created more individual categories. We regard this as a structural difference, not a material difference, as the care issues are identified by both groups as important indicators of quality. For example, the Alliance has a domain called “population specific medical conditions” that focuses on falls, incontinence, pain management, dementia and other conditions specific to special needs beneficiaries whereas ACOVE lists a series of diseases and syndromes individually.

The timeframe for CMS comments did not permit a thoughtful review the 200+ specific guidelines comporting with the 22 topic areas. This review would better be addressed by a broader work group of CMS and stakeholder representatives. In the interim, the Alliance suggests that CMS encourage plans to work with their providers to incorporate ACOVE clinical guidelines into their clinical practice. Since ACOVE, like HEDIS and other measures, is physician-oriented, we also recommend that CMS consider modifications to ACOVE measures that make the measures more “plan friendly” for purposes of evaluating plan performance.

E. Recommendations from Dr. Susan Palsbo, George Mason University

There is a lot of consistency in the domains and measures recommended by Palsbo and the measures developed by the SNP Alliance even though Palsbo and the Alliance organize the domains and indicators a bit differently. One fundamental difference between Alliance and Palsbo recommendations relates to measurement. Palsbo suggests extensive use of existing measures (which may not be the best measures and the scope could represent a data burden) and the Alliance recommends limited targeting of existing measures and the identification of new, more relevant measures.

- 1. Nationally-Used Preventive Care Measures:** The Alliance recommends collecting a subset of the preventive measures proposed by Palsbo:

- Annual comprehensive health assessment

- Annual depression screen
 - Bone density, possibly for osteoporosis or other conditions
 - Mammograms for women
 - PAP test for women
 - Antidepressant Medication management
 - Cholesterol management after acute cardiovascular events
 - Immunizations for influenza and pneumococcal disease
 - Dental Evaluation*
- * Alliance recommendation

2. Community Integration Measures: Many of Palsbo’s proposed indicators are consistent with Alliance recommended quality domains and indicators. While these data are extremely important, data collection burden is significant and needs to be taken into account. The Wisconsin Partnership Program collects this data through a face-to-face survey of consumers (random sample) as well as a mail survey to providers. To reduce data burden while initiating collection of important data, the Alliance identified five measures of particular interest from the list, with priority for the first 3 measures:

- Program responsiveness
- Client-driven services and support
- Personal dignity
- Living status
- Quality of Relationships

3. Widely-used Quality Measures for Prevalent Secondary Conditions and Supplemental Measures for People with Physical Disabilities: The group did not feel that measures for prevalent secondary conditions or supplemental measures added significantly to what the Alliance already is recommending in the area of “population specific” medical conditions; e.g., geriatric syndromes, mental health issues and other conditions unique to special needs beneficiary categories.

4. Cost and Utilization Measures: Some of the cost and utilization measures such as hospital and nursing home use and pharmacy/medication management are included in the Alliances “dashboard indicators.” The group deferred to the Alliance’s benchmark measures.

5. Substance Abuse and Mental Health Services Measures: In general, Alliance medical directors did not find the SAMSHA measures particularly useful mental health measures as they are underdeveloped and may be difficult to collect. They found the Palsbo recommendations to be more appropriate for measuring mental illness quality and also identified a few additional measures. Below are the mental illness indicators the Alliance would recommend:

- Reduced use of psychiatric inpatient beds (SAMSHA);
- Increased access to services (SAMSHA) (Need to determine how to measure; plans could track providers to determine how many are providing services and follow trend data for specific services over time);
- Inpatient hospitalization and rehospitalization (HEDIS- Palsbo);
- Readmissions within 7 and 30 days (HEDIS- Palsbo);
- Appropriate use of psychiatric medications, including compliance, especially for those with behavioral problems (Alliance);
- Sentinel health events (JAHCO- Palsbo);
- Ability to identify mental health care team/team member (Alliance).

- 6. National Association of State Directors of Developmental Disability Services Indicators:** The Alliance Medical Directors do not have the experience-base in this area to render an “expert opinion” on these measures.

Attachment B

Proposed Domains and Quality Indicators for Special Needs Plans

“The goal of medical care for the elderly has progressed beyond survival to maximizing quality of life, yet little attention has been paid to the overall quality of medical care that older people receive. In fact, existing measures of quality or health status are often inappropriate for the elderly.”

Rand Health

The Medicare Modernization Act of 2003 established Medicare Advantage Special Needs Plans (SNPs) to serve high-risk beneficiaries including those who are permanently institutionalized, dually eligible for Medicare and Medicaid and those with severe or disabling chronic conditions. The quality domains listed below were identified by the National Alliance of Specialty Healthcare Programs (SNP Alliance) through a consensus process based on the experience of medical directors of plans specializing in programs for frail elders and adults with disabilities. Each domain includes a brief goal statement and recommended quality indicators related to the goals. These measures are intended as a framework for performance measurement that more appropriately reflects the health care needs of vulnerable, high-risk beneficiaries with multiple chronic conditions and complex medical problems.

1. **End of life care:** To enhance comfort and improve the quality of an individual’s life during the last phase of life.

Preliminary Quality Indicators:

- *Comprehensive advanced care planning is carried out, with evidence that:*
 - ✓ *advance directives have been reviewed and signed;*
 - ✓ *conditions, trajectory of diseases and treatment options have been discussed;*
 - ✓ *treatment and care plans are modified as conditions evolve or circumstances change.*
- *Palliative care is provided in setting of choice.*
- *A comprehensive palliative care plan is developed that includes, but is not limited to, pain management, symptom control and access to appropriate supportive services.*

2. **Continuity of care:** To ensure coherent, consistent and connected collective performance among patients and family caregivers and primary, acute and long-term care providers in addressing the needs and interests of individuals as their conditions evolve over time and across care settings.

Preliminary Quality Indicators:

- *An identified individual health professional or team member with primary responsibility for care management/care coordination across settings.*
- *Demonstrated evidence of interdisciplinary care teams and collaboration.*
- *Individual care plan shared by all care providers involved in the patient’s care.*
- *The ability of the beneficiary or his/her family caregiver to identify and name their primary care manager, or contact, and know how to access them.*

3. **Safe and effective care transitions:** To ensure that people move safely and easily from one place to another, from one level of care to another, and/or from one health care practitioner to another.

Preliminary Quality Indicators:

- *A member of the health care team sees or communicates with the patient or informal caregiver within 72 hours of discharge to a new care setting.*
- *A review of patient medications will be conducted within 24 hours of discharge.*
- *A member of the health care team facilitates communication between providers in a timely manner to ensure safe and effective care transitions.*
- *If a member is discharged from a hospital to home and has received a new prescription medication or a change in medication before discharge, then the outpatient medical record should acknowledge the medication change in a timely manner.*
- *If a member is transferred between emergency departments, acute care facilities, and/or long-term care facilities, or from one of these entities to another, then the medical record at the receiving facility should include medical records from the transferring facility or should acknowledge transfer of such medical records.*

4. **Functional independence:** To optimize the ability to perform self-care, self-maintenance and physical activity, including addressing issues of disability, impairment, and/or frailty.

Preliminary Quality Indicators:

- *Plans screen all members to identify risk of impairment in physical and cognitive functioning and have triggers in place regarding the need for comprehensive assessments.*
- *Health plans have policies for timing of assessments of physical and cognitive functioning which include appropriate triggers for reassessment.*
- *Health plans have capacity to conduct home safety evaluations in relation to physical functioning and triggers for when such assessments are appropriate.*
- *Health plans have a process for maximizing functional independence.*

5. **Member choice and quality:** to ensure consumer satisfaction as measured by consumer defined goals.

Preliminary Quality Indicators:

- *To ensure that individual care plans include consumer-defined goals, beneficiaries and/or their caregivers participate in the development of their treatment goals and care plans.*
- *An annual assessment of member and caregiver satisfaction is conducted.*

6. **Medication management;** to optimize compliance and drug performance and minimize adverse drug events, with particular regard for polypharmacy issues.

Preliminary Quality Indicators:

- *Health plans conduct an initial assessment of overuse, underuse, and inappropriate use of medications, reassess medication management at least annually and have triggers for conducting reassessments at other times, as appropriate.*
- *Health plans have a system in place to track and address medication errors.*
- *Health plans have a process for identifying and addressing non-compliance with medications.*
- *Principal care team, all physicians' outpatient records and hospital medical records should have current record of all patient medication.*
- *Health plans have a process for monitoring adverse drug events and the effects of polypharmacy.*

7. **Population Specific Medical Conditions:** to effectively manage falls, incontinence, dementia/delirium, incontinence, pain, pressure ulcers, osteoporosis, and other syndromes unique to special needs beneficiaries.

Preliminary Quality Indicators:

- *Health plans have a process for:*
 - ✓ *monitoring and identifying population-specific medical conditions for high-risk populations, with a focus on disease and disability prevention;*
 - ✓ *assessing and stratifying risk levels and developing appropriate interventions for disease and condition management relative to risk -- from patient education to aggressive treatment plans; and*
 - ✓ *evaluating outcomes of high-risk screening and assessment and treatment protocol and employing continuous quality improvement approaches to further enhance outcomes.*
- *All persons 75 or older and those at risk of falls should have documentation that they were asked at least annually about the occurrence of falls and treated for related risks, as appropriate (ACOVE).*
- *All females age 75 and older and those at risk of osteoporosis should be counseled about osteoporosis risk and pharmacologic prevention at least once.*
- *“Health plans should develop and/or implement population-specific preventive and treatment guidelines”*

8. **Management of multiple and/or co-morbid conditions:** to develop a multidimensional, integrated approach to medical and health care management, including special tools and the integration and adaptation of disease-specific guidelines, to address the interactive effects of multiple chronic conditions and associated health-related challenges of serving people with serious chronic conditions such as complex diabetes, hypertension, congestive heart failure, asthma, chronic lung disease, chronic depression, chronic renal failure, spinal cord injury, multiple sclerosis, fibromyalgia, and cerebral palsy.

Preliminary Quality Indicators:

- *Health plans account for the presence of comorbidities during the screening and assessment processes.*
- *Health plans adapt evidence-based guidelines and best practices for individual diseases in relation age, comorbid conditions, functional limitations, member goals and preferences and other variables affecting special needs beneficiaries’ ability and/or willingness to respond to traditional clinical protocols and approaches.*
- *Health plans develop individual care plans that account for comorbid conditions and other factors that affect traditional treatment approaches.*

9. **Mental illness/behavioral:** to optimize a person’s health and well being, with recognition of chronic depression, Alzheimer’s disease, schizophrenia, AODA and other mental illnesses as a primary and/or as a co-morbid condition in addressing other acute and/or chronic conditions.

Preliminary Quality Indicators:

- *Plans have a system in place to identify members at risk for behavioral health issues and have triggers in place regarding the need and timing for comprehensive assessments and re-assessments*
- *Appropriate members of the health care team conducts a comprehensive assessment of a member’s behavioral health issues and integrates findings into the individual’s plan of care.*
- *Health plans develop and implement appropriate protocols and programs for effective behavioral health management and integrate health and behavioral interventions into beneficiary care plans.*

10. **Family Caregiver Support:** *to recognize the critical role of family caregivers as part of the care team, integrate their support into member care planning and provide support and education that enhances their effectiveness as part of the care team. (Added to the prior list of indicators.)*

Preliminary Quality Indicators

- *Health plans have a process for:*
 - ✓ *HIPAA-compliant routine communication with family and informal caregivers;*
 - ✓ *including them in the care planning process, consistent with patient capabilities and preferences;*
 - ✓ *assessing the needs of the family/ informal caregiver; and*
 - ✓ *providing family/informal caregivers the type of education, training and support they need to be an effective part of the informal caregiving team.*
- *Members of the health care team spend adequate time with patients, treat them with respect and explain information to members and their informal caregivers in a manner that is understandable to them.*

