

Long-Term Care Quality Alliance

DRAFT SIX-MONTH PLAN

Discussion Document for the 2nd Stakeholder Meeting

December 17, 2008

Introduction

Several organizations have expressed interest in establishing a Long-Term Care Quality Alliance* (LTCQA) which will seek further progress toward achieving high-quality and sustainable long-term care, as well as post-acute care and related supportive services. Based on an initial stakeholder meeting held in late August 2008 and on subsequent discussions with numerous stakeholders, there is consensus that the LTCQA should be a broad-based organization encompassing a range of stakeholders, including those representing individuals, families, caregivers, providers, government leaders, and others. Further, it should focus on supporting quality improvement that is person-centered regardless of age, place of residence, or setting of care.

This memo provides an overview of suggested initial focus areas and activities, raises several organizational questions and considerations, and proposes a timeline for the next several months of the LTCQA. We intend for this memo to be viewed as a “straw-man” informed by conversations with many stakeholders over the last several months; its purpose is to solicit reactions and to facilitate discussion at a second stakeholder meeting on December 17, 2008 about how to make further significant organizational and substantive progress as soon as possible.

Goals and Initial Activities

The primary goal of the LTCQA will be to support improvements in care quality centered on individuals who need long-term and post-acute care and supportive services regardless of setting. Using existing assessment tools and other data resources, there are some potential opportunities to identify and develop new quality improvement programs or demonstrations on behalf of individuals with particular needs,

* Based on feedback from several stakeholders over the last several weeks, the name "Long-Term Care Quality Alliance" may not adequately capture the wide range of care settings and populations that could or should be included in this Alliance (e.g., home health). We are certainly open to any suggestions for a different name for the organization that better reflects its mission and wide range of stakeholders.

such as those needing assistance with activities of daily living and managing chronic conditions, those with disabilities, and those who have specific diagnoses (e.g., advanced dementia), including the non-elderly who need long-term or post-acute care services and supports. **Appendix A** outlines examples of technical options for identification of such persons.

To support this overall goal, the LTCQA will develop efforts to support broader and more consistent adoption of person-centered performance measures in a set of key domains. Without being able to identify measurements and related data systems that can support high-quality, person-focused care, it is difficult to support better overall quality using new performance improvement campaigns and interventions, and hard for individuals and families and other caregivers to choose the best options available to them. Thus, the LTCQA will in general seek to answer fundamental questions about how best to measure and support quality improvement that is person-centered regardless of care setting. This will include identifying gaps in measures, data systems, and assessment tools that can support person-centered performance assessment, and devising recommendations to help fill these gaps.

However, the LTCQA will not primarily or exclusively be a national quality measurement advisory body. The LTCQA will be as implementation-focused as possible, using the above steps on supporting better and more consistent quality measurement that is person-centered to develop or support pilots, demonstrations, and initiatives that can tangibly improve performance and generate better evidence on reforms that work. Supporting existing efforts or developing new pilots and demonstrations will thus be a core part of the initial stages of the LTCQA.

In summary, we propose the following as the initial scope of activities for the LTCQA:

- Establish an ongoing technical collaboration of experts and stakeholders focused on identifying opportunities to assess quality that is person-centered, which will entail establishing venues to address the following technical and strategic questions on an ongoing basis:
 - What are the most appropriate, well-validated quality measures, assessment tools, and related data systems that have the most promise in the short- and medium-term to assess and improve quality at the person level?
 - What steps can be taken to support broader and more consistent implementation and use of available measurement and performance improvement strategies?
 - What specific gaps exist in our ability to measure and support person-centered quality (e.g., absence of or incomplete data)?
 - What are specific steps that can be taken to close these gaps?
- Implement an implementation-focused collaboration for supporting specific, identifiable improvements in quality, cost, and experience in long-term care, which may include:
 - Supporting broader and more consistent implementation and use of existing person-focused measures and related quality-improvement campaigns/interventions to support performance improvement
 - Adopting, evaluating, and building evidence from measures, campaigns/interventions, best practices, or other resources to help achieve performance improvement in pilot areas
 - Disseminating results to promote broader improvements in care delivery

Initial Focus Areas

Overview

Based on feedback received to date from a range of stakeholders, we propose an initial focus on efforts related to:

- Preventable or discretionary re-hospitalizations
- Person-focused experience with care
- Care coordination and transitions

These initial priority areas may be augmented by other quality and cost measures, including staffing ratios, turnover, or others. However, these initial areas would involve developing specific pilot efforts that have a high degree of relevance that could unify a broad group of stakeholders in the LTCQA and, more importantly, support high-priority improvements in care. Given the challenges of our fragmented health care system, these initial focus areas can have considerable potential for gaining improvements in health care quality, efficiency, and client experience within specific settings of care and across the health care system.

Rationale and Approach

Researchers and policy leaders have identified problems associated with re-hospitalizations in a range of care settings. For example, research has documented wide variations between states in adjusted rates of re-hospitalizations.¹ And in many areas of health care, trends appear to be worsening. For example, a recent report documented that risk-adjusted facility re-hospitalization rates for Medicare skilled nursing facility (SNF) residents in the first 100 days after SNF admission increased from 11.8 percent to 17.0 percent between calendar years 2000 and 2004.² While not all hospitalizations are preventable or discretionary, this trend, as well as state-by-state variation in bounce-backs related to preventable complications, has implications for quality, care experience, and cost. As several researchers have noted, reducing discretionary and avoidable hospitalizations has the potential to improve health outcomes while also lowering overall costs.³

Related to the issue of re-hospitalizations, our health care system often provides limited support and incentives for ensuring safe, effective, and high-quality care transitions as persons transfer between different locations or different levels of care within the same location.⁴ Yet the quality of care transitions is critical. Between 1997 and 2006, the rate of patients discharged from hospitals who still needed home health care increased 53 percent (from 2 million to 4 million).⁵ During this same period, the rate of patients discharged to nursing homes or rehabilitation facilities also increased by 30 percent (from 4 million to 5 million).⁶ Among hospitalized patients age 65-85 years of age, 23 percent are discharged to a long-term care or post-acute care residential setting (or nursing home and rehabilitation facilities); 15 percent are discharged with home health care.⁷

The Agency for Healthcare Research and Quality (AHRQ) reports that this increase in discharges to home health care and nursing homes is due to the rising number of hospital patients who are acutely ill or cannot take care of themselves after being discharged from the hospital.⁸ For example, between 1997 and 2006, hospitals discharges for all conditions rose 14 percent (from 35 million to 40 million).⁹ At the same time, discharges for patients who did not need any additional care increased only nine percent

(from about 27 million to 29 million) and the number of patients who died while in the hospital fell five percent (from 852,000 to 805,000).¹⁰ Patients transitioning from one care setting to another are vulnerable to a wide range of problems, including medication errors and lack of follow-up care. There are cost/efficiency implications as well, including the possibility of redundant lab tests, diagnostic imaging, and other costly problems.

A number of promising efforts have been developed to improve transitions of care in ways that may help avoid adverse outcomes such as re-hospitalizations related to avoidable complications. This includes the development of new experience-based measures and resources related to care transitions. For example, the University of Colorado Health Sciences Center developed the Care Transitions Measure (CTM), which is a patient-reported measure of care experiences during care transitions. The CTM has been demonstrated to discriminate among hospitals and to predict re-hospitalization or return to the emergency department. The National Quality Forum has endorsed the use of the CTM in national public reporting and for use in efforts seeking to assess and improve quality.

Despite the emergence of promising new methods for measurement, a persistent challenge is the current limitation of broad and consistent implementation of such efforts. There is not yet broad adoption or widespread tracking of results from measures like CTM that can assess quality of care in transitions and related impacts on quality and cost. It is also not clear how best to augment person-centered experience data (such as those available through CTM) with Medicare and other data on, for example, readmissions within 90 days of discharge with measures constructed at the hospital level and at the level of post-acute institutions who received patients.

As a basis for new pilots, the LTCQA could begin with collecting and analyzing longitudinal administrative data plus existing quality and adverse event reporting systems as well as any existing person- or family-based experience surveys. Staffing ratio or turnover measures could further augment these data, where available. This could be used as an initial platform to support adding new measures and data systems related to coordination/transition issues, re-hospitalizations, and other person-centered care experience measures. In turn, this system could support a range of new interventions designed to improve care and build evidence that could inform the expansion of pilot efforts and also inform policy.

Building On, Learning From, and Supporting Existing Efforts

Fortunately, there are increasing numbers of new initiatives sponsored by government, non-profits, foundations, and the private sector with goals and focus areas that are consistent with those outlined in this memo.

A small sample of such initiatives is displayed on the following page.

Examples of Ongoing Patient-Focused Initiatives

Home Health Quality Improvement (HHQI) National Campaign	A partnership including CMS and the Home Health Quality Improvement Organization Support Center launched a new campaign in 2007 to provide home care agencies with free best practice intervention packages that include educational tools and resources, guidelines, success stories and best practice education to reduce avoidable hospitalizations.
Quality Improvement Collaborative: Improving Care Transitions	The 18-month Improving Care Transitions program asked 13 teams composed of hospitals, assisted living facilities, and nursing homes to devise strategies for reducing injury and improving outcomes among elderly patients transitioning between care settings.
The Care Transitions Program	The Care Transitions Intervention provides patients with complex care needs with specific tools supported by a Transition Coach including promoting self-management skills to ensure their needs are met during the transition from hospital to home.
CMS Quality Improvement Organization (QIO) Program: Care Transitions Local Intervention	QIOs under the Care Transitions project are working in 14 states to coordinate care and promote seamless transitions across settings – including from the hospital to home, skilled nursing care, or home health care – and to reduce unnecessary hospital readmissions.
National Transitions of Care Coalition (NTOCC)	The NTOCC has developed care support tools, including a “Transitions of Care Checklist” and a “Taking Care of My Health Care” guide on essential information to provide health care professionals.
CMS Post Acute Care (PAC) Payment Reform Demonstration	This initiative aims to standardize patient assessment information from PAC settings to inform Medicare payment policy. The Continuity Assessment Record and Evaluation (CARE) tool was developed for use at acute hospital discharge and at PAC admission and discharge to measure the health and functional status of Medicare acute discharges and measure changes in severity and other outcomes for Medicare PAC patients.

As a broad-based “umbrella” organization, the LTCQA would seek to support and exchange information about these and many other existing, ongoing efforts with similar goals. This would in fact be an important contribution of the LTCQA. The LTCQA would obviously seek to avoid duplication with existing pilot or measurement implementation efforts, and would seek to support and build on promising efforts that already exist. For example, the LTCQA might promote the exchange of ideas and best practices among existing pilots and programs, identify efficient ways to increase the consistency and comprehensiveness of measures used, and develop a shared path toward providing and using person-centered quality information.

Key Questions and Issues

Developing new pilots to examine how best to address these challenges, initially through better and more consistent application of performance measures on re-hospitalization, person-centered experience with care, and care transition issues, raises a number of questions, outlined below:

Defining Pilots

- What collaborative efforts with providers, government entities, and other stakeholders can be developed or expanded to collect and analyze data on re-hospitalization and care coordination or transitions?
- How can the LTCQA collaborate with other quality alliances and initiatives focusing on other areas of care to measure and improve performance, particularly since some of these measures are already a focus of activity in other quality alliance initiatives (e.g., care coordination measures by Quality Alliance Steering Committee, the HQA, and the AQA)?
- What partners or stakeholders (e.g., CMS, QIOs, states, providers) should participate or collaborate in these efforts, and how?
- Should initial pilot efforts target multiple care settings within defined geographic regions/communities?
- Alternatively, should pilots address these issues within an initially limited number of care settings across broader geographic areas?

Data and Other Resources

- What relevant data, information systems, or other resources are currently available to support new pilots?
- To what degree are consistent, well-validated measures available and in use (e.g., consistency and adequacy of measures for re-hospitalizations across multiple care settings)?
- Could appropriate initial measures be constructed using existing data sets (e.g., Minimum Data Set)?
- What are the best opportunities to build on existing access to Medicare data for pilot/demonstration purposes?
- Should measurement efforts focus on all target individuals in the pilot area or only those identified as “high risk”?
- What specific technical barriers need to be overcome for additional person-focused measurement activities across different types of care settings (e.g., technical challenges such as lack of consistent patient identifiers, lack of ability to aggregate data)
- What options are available for appropriate case-mix adjustments of measures based on patient characteristics?
- What are appropriate methods for normalizing or benchmarking results (e.g., how can we define what are “normal” or “good” rates of re-hospitalizations)?

Applying Results

- Building on initial measurement efforts in pilot sites, states, or, regions to establish baselines and track performance, what specific interventions, quality improvement campaigns, or resources can

be identified to help achieve better performance in reducing unnecessary re-hospitalizations and improving care coordination/transitions?

- How can regular performance reports be produced and fed back to providers in different care settings with relevant case-mix adjusted benchmarks?
- How or should results be linked to public reporting information or used to facilitate other quality improvement activities?
- How can the results of the pilots or demonstrations suggest other reforms in reporting requirements, payment, information systems, or other policies or resources?

Appendix B highlights other examples of promising measures and measurement areas for possible focus by the LTCQA, either initially or over time.

Organization of the LTCQA

To accomplish the objectives of the LTCQA described above, the next six months of the LTCQA will encompass several key components that seek to combine the expertise and collaboration from a wide range of stakeholders, including a Steering Committee and several workgroups:

- **“Planning Group”:** The early stages of the LTCQA have been supported by an initially small and informal group of organizations and convened by the Brookings Institution’s Engelberg Center for Health Care Reform. This unofficial “planning group” has gradually expanded to reflect the diverse perspectives of a broader range of stakeholders, including providers, consumer and family advocates, government, and others. As the key goals and activities of the LTCQA take shape, and as many more stakeholders have become involved, the initial planning committee will help support the development of a more formal Steering Committee structure through a transparent process that will ensure adequate representation from a broad range of stakeholders.
- **Steering Committee:** As noted above, the LTCQA Steering Committee will be established through a transparent process to ensure diverse representation from a wide range of participating stakeholder groups. The Steering Committee will:
 - Be responsible for the overall mission, strategic direction, and operations of the LTCQA;
 - Help guide and coordinate the work of workgroups (discussed below);
 - Engage actively with partner or supporting organizations to ensure that the work of the LTCQA is well coordinated and supportive of other efforts. This will include other quality alliances supporting similar goals, including the Hospital Quality Alliance (HQA), the AQA (formerly the Ambulatory Care Quality Alliance, the Pharmacy Quality Alliance (PQA), as well as other initiatives;
 - Encourage other stakeholders to participate in the LTCQA’s efforts, including welcoming new members to the workgroups;
 - Interact with and support new or existing initiatives that can help further the mission of LTCQA, including ongoing sector-specific initiatives seeking to improve care delivery as well as efforts spanning sectors within long-term care.
- **Workgroups:** The Steering Committee will establish several workgroups that will help advance the major work of the LTCQA. Possible initial workgroups may include:
 - Governance/operations workgroup(s): This group or set of groups will support the Steering Committee by considering and developing options for financing, outreach, and other issues; make recommendations concerning the LTCQA’s mission, scope of activities, and policies.
 - Technical workgroups: These groups will help develop and support pilots or demonstration projects to expand the use of consistently applied measures of cost, quality, and experience in long-term care and related areas of health care and supportive services; develop recommendations for specific measurement instruments and related data systems; and provide technical assistance/evaluation. Depending on the development

of initial pilot areas, this might require multiple technical workgroups organized around particular measurement areas or specific initiatives.

- **LTCQA staff support:** The LTCQA will seek initial funding to support basic operational support, including eventually hiring an Executive Director and a small number of initial staff that may be augmented by consulting support from outside individuals or organizations. The Executive Director and other staff will be selected by the Steering Committee in conjunction with achieving fundraising and other organizational goals. Among other tasks, the Executive Director will organize logistical, operational, and practical assistance to support the work of the workgroups and the Steering Committee. In addition, the Executive Director and other staff will coordinate LTCQA activities with other related initiatives (e.g., Advancing Excellence Campaign) and other quality-improvement initiatives or organizations. This will help ensure that the LTCQA serves as an effective “umbrella” organization that supports coordinated activities to advance quality improvement in long-term care and related supportive services.

Proposed Next Steps for the LTCQA

Overview

We propose the following next steps to support the launch and initial development of the LTCQA:

- **Start-up Process:** The Brookings Institution's Engelberg Center for Health Care Reform will continue to facilitate the formation of the LTCQA during its start-up phase, in partnership with the “planning group”. This will include providing day-to-day direction, convening stakeholders, supporting the development of an organizational structure, developing materials, and assisting in identifying initial funding sources. However, Brookings’ role will transition to serving as an equal among many participating stakeholders in the process once the initial organizational structure and the Steering Committee are established and once initial seed funds are identified that can ensure the early success and sustainability of the LTCQA.
- **Convene Stakeholders:** Brookings, working with the Steering Committee, will continue to facilitate calls and meetings over the next six months, the purpose of which will be to further refine specific goals/activities, launch them, and identify/mobilize leaders who can help support the transition and operation of the LTCQA as a free-standing entity. Stakeholder calls and meetings will also be used to make progress on organizational aspects of the LTCQA.
- **Contract with Independent Consultant(s):** To support tangible next steps, we propose contacting with an individual and/or organization with relevant expertise to make specific, short- and medium-term recommendations regarding the development of pilots or demonstrations as outlined above. This work will culminate in a report with key technical, organizational, and other considerations and a set of practical recommendations for proceeding with the activities and focus areas outlined above. The timeline for this work will include a start date in early January 2009 with a report due in April 2009. A proposed May 2009 stakeholder meeting will be used to receive and discuss these recommendations and proceed with the development of initial pilots.

- **Develop Organizational Structure:** Over the next few months, Brookings will work with LTCQA participants to establish an initial Steering Committee and workgroups, as outlined above.
- **Funding and Sustainability:** The LTCQA will ultimately become a self-sustaining membership organization. To launch the LTCQA and to demonstrate initial progress, however, initial seed funding will be sought from grant-making foundations with a mission to support improvements in quality in long-term care and/or initial investments from founding members of the organization.

Six-Month Deliverables

We will seek to achieve the following specific objectives during the six-month start-up period.

- Establish the organizational structure of the LTCQA, including a broad-based Steering Committee, working groups, and identification of needed staff support or other resources
- Identify and secure additional funding from foundations and/or a membership structure that can ensure the financial sustainability of the initiative while also ensuring broad participation from a range of organizations
- Contract with one or more individuals or organizations to make very specific, actionable recommendations at the end of the six-month start-up period on the following issues:
 - Establishing a workplan or process to identify gaps in our ability to assess and improve quality that is person-centered in LTC as well as related supportive services and post-acute care
 - Clarifying opportunities and resource requirements for implementing top-priority quality measures, including needed measure development and pilot testing
 - Identifying the best ways to build on existing reporting infrastructures
 - Identifying opportunities for increased public awareness and quality improvement based on these measures
- Facilitate another stakeholder meeting in the Spring of 2009 to summarize results, receive additional feedback, and transition the organization toward a self-sustaining entity.

The proposed six-month timeline on the following page outlines key tasks, deliverables, and milestones.

Proposed Six-Month Plan for the LTCQQA

Task	Dec 08	Jan 09	Feb 09	Mar 09	Apr 09	May 09
Establish LTCQQA						
Identify/engage stakeholders						
Identify initial funding options						
Hold stakeholder meeting						
Establish organizational structure						
Establish initial steering committee						
Organize/convene initial workgroups: <i>Governance/operations workgroup(s)</i> <i>Technical workgroups</i>						
Develop/refine initial goals/activities						
Launch Initial Activities						
Contract with individuals or organizations to make initial recommendations about pilot sites and strategies						
Develop initial pilots/demos						
Receive report and recommendations from consultant(s)						
Communications: Next Steps						
Conduct progress report conference calls						
Convene stakeholder meeting(s) to report preliminary/final results and next steps						

References

¹ Kramer A. et al. "Understanding Temporal Changes in and Factors Associated with SNF Rates of Community Discharge and Re-hospitalization: A study conducted by staff from the University of Colorado at Denver and Health Sciences Center for the Medicare Payment Advisory Commission." June 2007 (Available at: http://www.medpac.gov/documents/Jun07_SNF_contractor_CC.pdf).

² Donelan-McCall N. et al. "Small Patient Populations and Low Frequency Event Effects on the Stability of SNF Quality Measures: Report for MedPAC Contract E4015951. 2006. Division of Health Care Policy and Research, University of Colorado at Denver and Health Sciences Center; Kramer, A. et al. (2007).

³ Konetzka R.T., W. Spector, and M. Limcangco, "Reducing Hospitalizations From Long-Term Care Settings." *Medical Research and Review*. Vol. 65. No 1. February 2008.

⁴ Coleman, E.A. "Background Paper on Transitional Care Performance Measurement." *Institute of Medicine*. January 2005.

⁵ Agency for Health Care Research and Quality. "AHRQ News and Numbers: Hospital Discharges to Home Health, Nursing Homes Increasing." 23 October 2008.

⁶ AHRQ 2008.

⁷ 2006 National Statistics: Outcomes by Patient and Hospital Characteristics for All Discharges. H-CUPnet, National and Regional Estimates on Hospital Use for All Patients from the HCUP Nationwide Inpatient Sample (NIS). Rockville, MD. Agency for Healthcare Research and Quality, available at <http://hcupnet.ahrq.gov/>

⁸ AHRQ 2008.

⁹ AHRQ 2008.

¹⁰ AHRQ 2008.