Setting Quality Goals that Matter – Part 1

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- California Dementia Healthcare Summit: Putting Tools & Resources into Practice
- May 3, 2018

The Power to Redefine Aging.

Hebrew SeniorLife

HARVARD MEDICAL SCHOOL AFFILIATE

Disclosures

- Brown University: Alpert Medical School; School of Public Health
- Beth Israel Deaconess Medical Center
- Butler Hospital
- The Rhode Island Foundation
- NIMH
- NHLBI
- NSF
- Dementia Caregiving Network
  - John A. Hartford Foundation
  - Gerontological Society of America
- ASPE: U.S. Dept. of HHS's Advisory Council for Alzheimer's Research, Care and Services
- The Health and Aging Policy Fellows Program
  - Placement with CMS Division of Nursing Homes within the Center for Clinical Standards and Quality; Quality and Safety Oversight Group

Selected History of Quality Measures for Dementia

See: https://aspe.hhs.gov/advisory-council-alzheimers-research-care-and-services-meetings#Apr2018

- Primer on Quality Measures
- Assessing Care of Vulnerable Elders (ACOVE; RAND Co.)
- Physician Quality Reporting System (PQRS) & Quality Payment Program (QPP)
- National Quality Forum (NQF)
  - Prioritizing Measure Gaps: Alzheimer's Dis & Rel Dementias
- UK: National Institute for Health & Care Excellence (NICE)
- ICHOM: International Consortium on Health Outcome Measures
- Examining Models of Dementia Care (RTI and ASPE)
- CMS: Meaningful Measures

What are Quality Measures?

"Quality measures are tools that help us measure or quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care. These goals include: effective, safe, efficient, patient-centered, equitable, and timely care."

- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/index.html

To consider as priority areas for quality measurement

- Establish Diagnosis (document).
- Identify a Family Member / Caregiver (document).
- Provide Referrals and Coordination of Care (or, at least document follow-up from referral).

Physician Quality Reporting System (PQRS) Updated to Merit-based Incentive Payment System (MIPS) and located in the Quality Payment Program (QPP)

2015 PQRS MEASURES IN DEMENTIA MEASURES GROUP (now in MIPS / QPP):

- #47 Care Plan
- #280 Dementia: Staging of Dementia
- #281 Dementia: **Cognitive Assessment**
- #282 Dementia: **Functional Status Assessment**
- #283 Dementia: **Neuropsychiatric Symptom Assessment**
- #284 Dementia: **Management of Neuropsychiatric Symptoms**
- #285 Dementia: Screening for Depressive Symptoms
- #286 Dementia: **Counseling Regarding Safety Concerns**
- #287 Dementia: Counseling Regarding Risks of Driving
- #288 Dementia: **Caregiver Education and Support**

https://mdinteractive.com/files/uploaded/file/CMS2015group/Dementia-2015.pdf
https://qpp.cms.gov/mips/quality-measures

National Quality Forum (NQF) - Prioritizing Measure Gaps: Alzheimer's Disease & Related Dementias

- Comprehensive Patient Measure
  - diagnosis, function, resources, driving, AD, proxy, caregiving needs
- Comprehensive Caregiver Measure
  - caregiver's needs, expectations, communication, training, education, advocacy
- Dementia Capability
  - Levels: Healthcare System; Community

http://www.qualityforum.org/Prioritizing_Measure_Gaps_-_Alzheimers_Disease_and_Related_Dementias.aspx

UK: National Institute for Health & Care Excellence (NICE) - Dementia

- Anti-psychotic medication
- Laboratory Assessment
  - complete blood count, calcium, glucose, renal and liver function, thyroid function, B12 and folate
- Care plan reviewed in face-to-face meeting
- Contact details of named carer on record
- Attendance at a memory assessment service

https://www.nice.org.uk/standards-and-indicators/index/All/Dementia

J.W. Wiener; RTI and HHS ASPE Examining Models of Dementia Care

TABLE 2-1. Dementia Care Framework Components	
1. Detection of Possible Dementia	Examine for cognitive impairment when there is a decline from previous function in daily activities, occupational ability, or social engagement.
2. Diagnosis	Obtain a comprehensive evaluation and diagnosis from a qualified provider when cognitive impairment is suspected.
3. Assessment and Ongoing Reassessment	Assess cognitive status, functional abilities, behavioral and psychological symptoms of dementia, medical status, living environment, and safety. Reassess regularly and when there is a significant change in condition.
4. Care Planning	Design a care plan that will meet care goals, satisfy the person's needs, and maximize independence.
5. Medical Management	Deliver timely, individualized medical care to the person with dementia, including prescribing medication and managing comorbid medical conditions in the context of the person's dementia.
6. Information, Education, and Informed and Supported Decision Making	Provide information and education about dementia to support informed decision making including end-of-life decisions.
7. Acknowledgement and Emotional Support for the Person with Dementia	Acknowledge and support the person with dementia. Allow the person's values and preferences to guide all aspects of the care. Balance family involvement with individual autonomy and choice.
8. Assistance for the Person with Dementia with Daily Functioning and Activities	Ensure that persons with dementia have sufficient assistance to perform essential health-related and personal care activities and to participate in activities that reflect their preferences and remaining strengths; help to maintain cognitive, physical, and social functioning for as long as possible; and support quality of life. Provide help as needed with medication management and pain control.

https://aspe.hhs.gov/report/examining-models-dementia-care-final-report

J.W. Wiener; RTI and HHS ASPE Examining Models of Dementia Care

9. Involvement, Emotional Support, and Assistance for Family Caregiver(s)	Involve caregiver in evaluation, decision making, and care planning and encourage regular contact with providers. Provide culturally sensitive emotional support and assistance for the family caregiver(s).
10. Prevention and Mitigation of Behavioral and Psychological Symptoms of Dementia	Identify the causes of behavioral and psychological symptoms, and use nonpharmacological approaches first to address those causes. Avoid use of antipsychotics and other medications unless the symptoms are severe, create safety risks for the person or others, and have not responded to other approaches. Avoid physical restraints except in emergencies.
11. Safety for the Person with Dementia	Ensure safety for the person with dementia. Counsel the person and family as appropriate about risks associated with wandering, driving, and emergency preparedness. Monitor for evidence of abuse and neglect.
12. Therapeutic Environment, Including Modifications to the Physical and Social Environment of the Person with Dementia	Create a comfortable environment, including physical and social aspects that feel familiar and predictable to the person with dementia and support functioning, a sustained sense of self, mobility, independence, and quality of life.
13. Care Transitions	Ensure appropriate and effective transitions across providers and care settings.
14. Referral and Coordination of Care and Services that Match the Needs of the Person with Dementia and Family Caregiver(s) and Collaboration Among Agencies and Providers	Facilitate connections of persons with dementia and their family caregivers to individualized, culturally and linguistically appropriate care and services, including medical, other health-related, residential, and home and community-based services. When more than 1 agency or provider is caring for a person with dementia, collaborate among the various agencies and providers to plan and deliver coordinated care.

https://aspe.hhs.gov/report/examining-models-dementia-care-final-report

To consider as priority areas for quality measurement

- Establish Diagnosis (document)
  - Annual Wellness Visit
  - Dementia eCQM – Cognitive Assessment
- Identify a Family Member / Caregiver (document).
  - Dementia eCQM – Documentation of a Health Care Partner
- Provide Referrals and Coordination of Care (or, at least document follow-up from referral).
  - IMPACT Act
  - Meaningful Measures

Thank You

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