

## CCO Criteria Work Group October 18, 2011 Meeting Summary

### Discussion Topics: Governance and Financial Solvency

Shannon M. McMahon, Director of Coverage and Access at the Center for Health Care Strategies (CHCS), gave a presentation on qualification criteria and standards for CCOs. The presentation described a framework of health reform in terms of state regulation, local government involvement, and community engagement for exploring considerations in CCO governance and financial solvency. Shannon identified best practice and considerations from experience in other states, including Minnesota, Colorado, New Mexico, and Maine.

Regarding governance and community engagement, key factors to consider included:

- Governing board composition
- Structure of health plans and delivery systems
- Community advisory board composition
- Scope of advisory board recommendations

Regarding financial solvency standards, key factors identified included:

- CMS requirement that Medicaid managed care organizations at-risk for hospital care meet state solvency standards
- CCOs solvency might be safeguarded through such tools as
  - Reinsurance
  - Initial net worth requirement
  - Third party liability
  - Surety/fidelity bond requirement
  - Solvency reserve/deposit requirement
  - Medical loss ratio limit
  - Covered lives threshold

The Maine Guaranteed Access Reinsurance Association was identified as an example of a state administered program for spreading the cost of high claims across participating health plans. This program covers losses above identified thresholds. CHCS will provide additional information on the Maine reinsurance program. The presentation also identified legal entity options for the CCOs such as corporation (for profit or not-for-profit), partnership, and foundation.

Key considerations identified in the presentation included:

- Determination of the type and extent of community engagement in the CCO governance structure

- Financial solvency criteria sufficiently stringent to indicate the ability of the CCO to assume risk, meet the health care needs of covered populations, and achieve sustainability
- Consideration of a tiered system for CCO qualification beyond the core competency requirements, including allowances for building risk reserves over time, as shown to be feasible through programs in Minnesota and Maine and proposed in ACA COOPS (creation of non-profit, member-run health insurers financed through federal loans and grants).

### **Key Input for Oregon Health Policy Board**

Small group discussion provided the following input

#### **Governance**

##### Areas of agreement:

Governance structure and community engagement should be determined by an assessment of community needs and the CCO's transformation goals.

CCO governing board should be newly constituted and not a carry-over of a pre-existing board for an organization choosing to become a CCO.

The OHPB should consider a requirement that a member of the Community Advisory Council sit on the governing board, and vice versa.

CCOs might be either for-profit or not-for-profit as long as they met the criteria.

There should be accountability for the governing board's consideration and adoption of Community Advisory Council policy recommendations.

Care should be taken that behavioral health concerns are not under-represented on either the governing board or the Community Advisory Council.

##### Areas of tension:

If a COOP model is pursued in which risk partners contribute to reserves with relationally defined levels of authority, then no clear path for full county participation absent capital to contribute to reserves.

What is meant by "a majority consisting of the persons that share in the financial risk of the organization" is open to varying interpretations. Should county governments and local public health authorities be counted in this category since they will be at risk should the CCO not prove sustainable?

How can the insurance function be aligned with health systems transformation goals?

### Surprises:

Locally owned and/or domestically headquartered entities are preferable as CCO candidates.

OHA might develop different governance and community engagement criteria for not-for-profit and for-profit CCOs to address the effects of the profit motive.

An assessment should be conducted to determine the types of providers available in a CCOs service area to determine provider members of governing board, and a similar assessment to determine community-at-large perspectives needed on the board in order to reflect the root causes/social determinants of health.

CCO governing board should develop an annual plan for aligning CCO business practices/requirements with the health needs of the community, and this plan should be reviewed for its appropriateness and effectiveness by OHA. In years when the CCO shows retained earnings, a portion of those retained earnings should be used to fund a health promotion project identified by the Community Advisory Council.

“Major components of the health care delivery system” should be defined in terms of broad categories of care rather than by provider types.

The application of the *Labby Theorem* in solving the calculus of evaluating a proposed CCO governing board. To wit, the following screens should be applied, in this order:

1. What are the needs of the community, as determined by a community health risk assessment?
2. How does the CCO intend to transform the health-and-health-care system, by improving which health disparity metrics How does the proposed governance structure support this transformation work, and what composition of membership is called for by a logic model specific to the CCO
3. Does the proposed governance structure meet HB 3650 requirements? What is the CCO process for ensuring involvement by the community-at-large, at the time of certification and into the future?

### **Financial Solvency**

#### Areas of agreement:

DCBS is the most reasonable choice for the single state agency receiving financial reports from CCOs.

Reinsurance and risk reserves are the most effective tools for assuring financial solvency, but other factors such as risk sharing with providers and proposed enrollment levels are also important.

No standard lower than the current OHP MCO standard should be considered.

Larger CCO enrollment helps to buffer the risk of insolvency, but it is difficult to know where to set a minimum enrollment threshold.

Areas of tension:

Should financial solvency standards for CCOs be a) the same as for MCOs currently in the Oregon Health Plan as administered by OHA, b) the same as for commercial and Medicare Advantage plans as administered by DCBS, c) something different, administered by a single state agency.

How does financial solvency relate to licensure? Should there be a new licensure category for CCOs, and if so should it be through DCBS?

Surprises:

When PEBB and OEBS are brought into health systems transformation and CCOs, there needs to be a new round of discussion about financial solvency. Current discussions should be relevant to OHP membership only.

CCOs should be required to develop a blueprint for how they will use their revenues to finance health care services that meet the needs in their service area.

Quality of care should be a factor in determining financial solvency.

**Additional Considerations Emerging from Discussion Groups**

Should OHA consider allowing a CCO to implement with Medicaid enrollees only for a limited period, and then enroll dually eligible members? If so, what are the implications for licensure and financial solvency?

## Global Budget Methodology Work Group October 17, 2011 Meeting Summary

### Discussion Topics: Risk Adjustment and Quality Incentives

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Ross Winkelman, Managing Director and Senior Consulting Actuary at Wakely Consulting Group, presented an overview of risk adjustment practices that could be used to recognize differences in CCOs morbidity and protect against CCOs cherry-picking healthy members and avoiding individuals with chronic diseases. He stressed that risk adjustment should be accurate, unbiased and transparent while avoiding unnecessary administrative burden. He expressed that Oregon's current risk adjustment system, Chronic Illness & Disability Payment System (CDPS), performs well when member enrollment is relatively stable.

K. John McConnell, associate professor and health economist at Oregon Health & Science University, presented on types of quality incentives that could potentially be incorporated into CCO global budgets. He emphasized the following elements in designing a quality incentive program:

- The right amount of reward payment;
- Selecting high-impact performance measures;
- Structural designs, e.g. making payment reward all high-quality care by setting up multiple thresholds (thus avoiding distorted incentives in the all-or nothing approach), rewarding improvement as well as achievement, and rewarding for each patient that receives recommended care
- Prioritizing quality improvement for underserved populations.

Prof. McConnell presented Blue Cross Blue Shield of Massachusetts's Alternative Quality Contract as an illustrative model of quality incentives.

### Key Feedback for Oregon Health Policy Board

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The small groups provided the following feedback

#### Risk Adjustment

Areas of agreement:

- Risk adjustment is needed and the current system is a good starting point.
- OHA should explore the possibility of including pharmacy data in CDPS. This may improve the sensitivity of risk adjustment systems towards mental health.
- Additional demographic factors such as race, ethnicity, language and income should be considered.

Areas of tension:

- Some work group members emphasized the potential pitfalls of risk adjustment that need to be avoided:
  - Penalizing positive outcomes (i.e., paying less to plans that improve population health) or areas with more effective delivery systems already in place.

- Encouraging CCOs to upcode or otherwise game the system rather than focus on improving health outcomes, which was perceived to be a problem with Medicare Advantage.

Surprises:

- Various work group members expressed concern as to how well the current risk adjustment system reflects the mental health status of MHO members.
- One break out group felt that while risk adjustment was important in the short term, it may be preferable to phase it out over time as we increasingly focus on population health.

## Quality Incentives

Areas of agreement:

- Work group members generally agreed that quality incentives should be used to protect against loss of access and reward good performance.
- Over the long term, incentives should center around measures of health outcomes
- Some form of staging or ramp-up period is likely necessary (e.g., establishment of baseline, number of measures, type of measures, size of incentive)

Areas of tension:

- Some felt that quality incentives would need to be phased in over time because improved health outcomes take time to realize. Others expressed the importance of including incentives from the outset to ensure that poor quality services do not persist over time.
- Different work group members expressed different opinions about the appropriate size of incentives. Some emphasized that small incentives (e.g., 1%-2%) could change behavior whereas others felt that an incentive of 10% or more would be needed to properly motivate CCOs.
- One group expressed that incentives should be at the CCO level, but some members felt that providers would need to have skin in the game in order for incentives to have an effect.

Surprises:

- Another group proposed the use of incentives focusing on CCO planning and investment in the health of its population longer term, perhaps with a focus on child health. This discussion suggested that such an incentive program could support the development of CCO relationships and planning to improve community wide health.
- One break out group suggested non-financial incentives such as reduced reporting requirements could be provided to high-performing CCOs.

## Small Group Discussion

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### 1. Risk Adjustment Models: Important but Limited to Addressing Selection

Risk adjustment is necessary to protect vulnerable populations, but does not ensure quality

All groups acknowledged a role for using risk adjustment to ensure that CCOs do not avoid expensive or vulnerable populations. In addition, each group expressed interest in investigating the use of additional demographic risk adjustment factors. Each group mentioned race, ethnicity and language as possibilities; two groups also mentioned income and geographic location. Despite broad interest in risk adjustment, each group also expressed concerns that risk adjustment could in fact penalize improvements in members' health outcomes or areas of the state that have well-functioning delivery systems in place. One group noted that other measures such as quality incentives would be needed to offset any negative incentives created by risk adjustment, and that in the long run it may make sense to move away from risk adjustment altogether.

The current CDPS risk adjustment system should be used as a starting point; potentially include Rx data

Each break out group acknowledged that the current CDPS risk adjustment system was the logical starting point for CCO risk adjustment, but expressed interest in including pharmacy data or at least exploring the option to do so. Improving CDPS's sensitivity to mental health diagnoses was the primary motivation expressed for including pharmacy data. Two break out group noted that Oregon's use of CDPS compares favorably to the Medicare Advantage risk adjustment because our process does not incentivize upcoding, and one added that the recent patient centered primary care home (PCPCH) adjustment is commendable.

Concerns regarding mental health risk adjustment, weighting and implications for Rx drug use

Two of the break out groups expressed concern that mental health diagnoses would be properly risk adjusted and weighted relative to physical health diagnoses under an integrated system. While incorporating prescription data could improve how well mental health diagnoses are picked up by a risk adjustment system, it also may encourage inappropriate use or reliance on psychotropic drugs. This was a particular concern with respect to the treatment of children.

Additional topics raised

- Whether or not the risk adjustment system can properly handle churn.
- Whether or not the risk adjustment system properly accounts for the differences in rural areas.
- One group expressed a preference for a transparent risk adjustment methodology.
- One work group member proposed that risk adjustment should be based on health burden of disease rather than cost of treatment.

## **2. Quality Incentives:**

Outcome measures should be emphasized, but this may be difficult at the outset

All three breakout groups emphasized that quality incentives should ultimately center on outcome measures that are within CCOs control. However, each group also recognized that this would be difficult to implement from the outset given that achieving improved health

outcomes takes time. For this reason, one group suggested that process measures may need to take precedence initially. Another breakout group suggested that process measurement should be minimized and instead the number of metrics and size of bonuses should start small but increase over time (e.g., 1% in year one, 2% in year two, etc.).

#### Opinions vary on the proper size of incentives

As mentioned, one group suggested a 1% incentive that increased by 1% point annually until it reached 5%. A member of a different breakout group suggested that incentives of at least 10% would be needed to get people's attention. Others worried about that a large incentive may be difficult given already slim margins. Other workgroup members felt that a small incentive (e.g., 1%-2%) could be large enough to change behavior, at least for some service categories (e.g., mental health). One group pointed out that the Medicare Advantage STARS program, which provides 3% bonuses, appeared to provide a large enough incentive to command attention. Finally, one group felt that progressive improvement should be rewarded with progressive bonuses.

#### Incentive payments should support long-term initiatives

One group agreed that if the goal is better health than at least a portion of CCO incentives should focus on CCO planning and investment in the health of its population longer term, perhaps with a focus on child health. This discussion suggested that such an incentive program could support the development of CCO relationships and planning to improve community wide health.

#### Reducing reporting requirements could serve as an incentive

One group mentioned that one way to incentivize quality without requiring new finances or a withhold of current finances would be to reduce the regulatory burden of CCOs that are performing well. For example, CCOs that met specific thresholds for quality incentives could submit non-essential reporting on a biennial rather than annual basis.

#### ***Additional thoughts that emerged from workgroup discussions***

- Incentives should be at the CCO level, but providers will need skin in the game in order for incentives to work.
- Rewards for quality should be contingent upon reducing costs.
- Consistency of metrics across CCOs is important given that some provider groups will participate in more than one CCO.
- Some measurement systems can be very expensive to license and administer.
- There needs to be a plan of action for dealing with CCOs that fall below minimum quality standards.

## Outcomes, Quality, & Efficiency Metrics Work Group

### October 17, 2011 Meeting Summary

#### Discussion Topics

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Oregon Health Policy Board members Dr. Carlos Crespo and Dr. Chuck Hofmann gave a re-cap of the September meeting, summarized feedback from the Board and members of the public, and described some relevant discussions from other HB 3650 workgroups. Workgroup members also heard a presentation from Carol Robinson, Administrator of the Office of Health Information Technology, on the current environment for EHR adoption and HIE functionality in Oregon.

The group subsequently divided into three smaller discussion groups to consider potential CCO performance measures under seven headings: overall outcomes, mental health, addictions, oral health, primary care, hospital care, and end-of-life care. Members were asked to address three questions in relation to the example measures listed (*see meeting materials*):

- Which indicators are “must-haves” for CCO accountability?
- Which indicators are not good candidates for CCO performance measures?
- What other indicators should be considered?

#### Key Points for the Oregon Health Policy Board

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##### *Consensus*

- Workgroup members seemed to agree about the need for greater clarity on a few topics:
  - CCOs’ level of responsibility for community-level prevention and population health, vs. the responsibilities of local government, public health departments, and the State.
  - Expectations for CCOs vs. expectations for the work of providers and practices within CCOs.
- In general, there continues to be consensus about the desire to focus on outcomes (and outcome measures) and to avoid being too prescriptive about the ways in which CCOs achieve those outcomes. However, the group is struggling to balance this desire with feasibility concerns; see “tensions” below.
- There seems to be consensus that the initial list of required CCO measures should be quite small and fairly high-level. There would be room for more measures and more granularity in menu and/or developmental sets.

### *Tensions*

- The workgroup is struggling to balance its interest in strong outcome measures and in making space for innovation at the CCO level with:
  - Concerns about the feasibility of measuring outcomes and the adequacy of CCOs' HIT capacity.
  - A desire to align with performance measures that are or will be required by CMS, NCQA, and others in order to make measurement more affordable and efficient. The difficulty here is that other measure sets may not emphasize outcomes and transformation to the same extent as the workgroup wishes to do.
  - An interest in being very clear about the standard of care that CCO must provide. For example, the October breakout group discussions generated these and other expectations for standards of care or services:
    - CCOs describe how they will proactively use data, screenings, and assessments to identify and address "hot spots" (high risk groups or patterns of high utilization) or disparities;
    - CCOs demonstrate sufficient network capacity, particularly for specialty care, and the ability to provide integrated across domains and settings
    - CCOs use patient education as a core component of prevention, particularly for cardiovascular disease and breast cancer
    - CCOs hold their primary care practices accountable to Oregon Patient-Centered Primary Care Home Standards
    - CCOs include families and service recipients in mental health treatment teams.

A careful staging strategy for CCO performance issues may help address the first two concerns. The third interest could be met by addressing the suggestions via CCO criteria rather than metrics.

### *Surprises*

- None.

### **HIT and HIE Capacity Presentation**

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Key points from Carol Robinson's presentation included:

- Fully functional EHRs are still not common among small, private practices. Large health systems and hospitals are much more likely to be using EHRs. New Medicaid incentive program (launched on September 26<sup>th</sup>) may help.
  - Dentists are eligible but not long-term care or behavioral health providers.

- EHRs are critical components but CCOs really need HIE to be successful, to exchange information as needed for care coordination.
  - The federated model for HIE that Oregon stakeholders preferred does carry the risk for gaps or white space between systems. The pace of HIE infrastructure development has been slower than anticipated 2 years ago.
  - Direct—a secure direct email service for information exchange between providers—may help mitigate the HIE white space.
- The Health Policy Board has asked HITOC (the Health Information Technology Oversight Council) to bring them a proposal for minimum HIT capacity for CCOs.

### **Small Group Discussion**

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*Note: Comments that pertain specifically to individual performance measures listed in the meeting discussion document can be found in a table following this section.*

#### **General Comments**

- The core list of required measures should be very tight – the lists of potential measures for consideration are very long. Measurable, meaningful, and affordable should be the primary criteria. The set of developmental measures can be longer and more innovative.
- As we move toward measuring outcomes, OHA should be prepared to offer technical assistance to help CCOs achieve those outcomes.
- Members reiterated the importance of connecting selected CCO performance measures to the Triple Aim
- The workgroup continues to be very interested in prevention-focused measures.
- The issue of churn—members switching CCOs during a single measurement or budget period—was raised again as a complicating factor for measuring CCO performance.
- ED use may be useful as a measure of poor access and lack of prevention across a range of topic areas.
- Members noted that technical specifications will need to be adopted or developed once the initial set of measures is selected

#### **Comments on potential overall outcomes measures**

- Members in one group had some concerns about the reliability & validity of some of the patient- or member-reported indicators listed in this section.
  - To the extent that member-reported indicators are selected, they should be already included or easy to incorporate into data collection tools that systems already use, such as CAHPS

- Another group felt that the focus for overall health outcomes should be on a comprehensive measure(s) that integrates all domains: physical (primary and specialty), oral, addictions and mental health, etc.
- Tobacco, birth weight, and breastfeeding would be good candidates for prevention-focused outcome measures
- Additional outcomes measures suggested include (these are also listed in the table following this section):
  - Breastfeeding rates

*Comments on potential **mental health** measures*

- One group discussed the pros and cons of separating mental health and addictions measures, even for purposes of discussion, and advocated for combining them for two reasons: 1) to reinforce the need to break down silos; and 2) to recognize that the core things each system has to achieve are very similar.
- Some members felt that the housing, education, and employment outcome measures would be appropriate only as future or development measures, since the events were not sufficiently under the control of CCOs to include. Members did suggest that it would be reasonable for the CCO criteria to include requirements around community connections and partnerships.
  - However, others felt that it was reasonable to hold CCOs accountable for some of these outcomes, especially for Medicaid-billable services like supported employment and supported housing.
  - In addition to alignment with community services, one member suggested that CCOs also be required (via criteria or performance measure) to include families and mental health service recipients on treatment teams.
- Several members argued that basic access and screening measures—as well as engagement--were particularly important because we currently do a very poor job identifying mental health and addictions needs and keeping people in treatment.
- One group commented that the presence of an addictions or mental health-related diagnosis should be used as a stratifying factor to examine performance on other indicators, similar to reporting results by race, ethnicity, or primary language
- Additional mental health measures suggested include (these are also listed in the table following this section):
  - Initiation and engagement in services (for mental health and addictions)
  - Readmissions for mental health diagnoses (also discussed in September)
  - Admission rates for acute psychiatric and residential treatment
  - Follow-up after ER visit or inpatient hospitalization (also discussed in September)

- Utilization of lower-cost options when available (e.g. outpatient rather than inpatient treatment)
- Screening for adverse childhood events

*Comments on potential **addictions** measures*

- Several members argued that basic access and screening measures—as well as engagement--were particularly important because we currently do a very poor job identifying mental health and addictions needs and keeping people in treatment. One group noted that addictions-related costs were driven by people not in treatment.
- Additional addictions measures that were suggested include (these are also listed in the table following this section):
  - Initiation and engagement in services (for mental health and addictions)
  - Penetration rate (also discussed in September)
  - Success rate: % of individuals treated who are clean and sober X months or years later
  - % of infants born with an addiction
  - Use of peer wellness specialists among individuals receiving addictions services
  - Utilization of lower-cost options when available (e.g. outpatient rather than inpatient treatment)
  - Follow-up after ER visit or inpatient hospitalization (also discussed in September)

*Comments on potential **oral health** measures*

- More than one group noted that access was probably the primary concern within oral health and suggested that access metrics be prioritized.
  - Access measures should apply across all ages (not just children)
  - ED visits for dental conditions would be an indirect indicator of poor access
- Some members emphasized the importance of CCO criteria or expectations in the area of oral health, including:
  - Network adequacy for dental care providers;
  - Navigation assistance to access dental care
  - Appropriate referrals for chronic diseases related to oral health issues
- Additional oral health measures that were suggested include (these are also listed in the table following this section):
  - 3<sup>rd</sup> trimester dental visit

- Wait time for dental appointments
- Prevalence of caries in young children (baby bottle tooth decay), as a prevention-focused measure

*Comments on potential **hospital** measures*

- In general, members favored the hospital measures that were also part of Medicare's hospital value-based purchasing initiative, the Medicare Advantage STARS program, or were HEDIS measures. This includes readmissions, healthcare acquired conditions, and skin injuries.
- Additional hospital measures that were suggested include (these are also listed in the table following this section):
  - Influenza vaccination
  - Medication errors

*Comments on potential **primary care** measures*

- Members generally commented that there were too many potential indicators listed in this section. One group proposed that CCOs should choose among a subset of primary care focused options those measures most relevant to their populations.
- While emphasizing that outcome measures should be used as much as possible, some groups expressed concern that the outcome measures in this section (e.g. blood pressure control) would be difficult to achieve without a fully functioning EHR system and/or patient registry, or labor-intensive chart reviews.
  - However, it was noted that the ability to track members by condition and over time (via a registry, EHR, or other means) was an important component of patient-centered primary care home functioning, and that outcome measures support population health and should result in cost savings over time.
  - In general, there seemed to be support for using these kinds of measures while perhaps allowing an interim solution for CCOs without the necessary registry or HIT capacity.
- Some members had questions about the intended level of measurement because many of the indicators listed are most commonly used for provider-level measurement whereas the workgroup is focused on CCO-level accountability.
- Members felt that, as a general rule, primary care performance measures should align with US Preventive Services Task Force guidelines and should have the flexibility to change over time as national guidelines and evidence-based best practices develop.
- Additional primary care measures that were suggested include (these are also listed in the table following this section):

- Some measures of exercise and healthy eating
- Depression screening and treatment
- Access – the number or % of members who are not seeking primary care
- Breastfeeding rates (listed also under overall outcomes)
- A measure of investment in primary care (e.g. increase in % of medical spend on primary care)

*Comments on potential **end-of-life care** measures*

- Several members commented that these measures should be restricted to particular ages and/or conditions, particularly individuals eligible for both Medicaid and Medicare.
  - It was noted that members with the highest costs in the last three months of life tend to be very ill children and those who have suffered accidents. Targeting end-of-life care measures to dual eligibles will reduce noise and make them more actionable.
- Members expressed interest in more measures related to quality of end of life care, as opposed to cost or appropriateness.
- Members in one group commented that it can be difficult for health plans to know when members die; Medicaid does not supply this information.
- Additional end-of-life care measures that were suggested include (these are also listed in the table following this section):
  - Compliance with POLST

For comments on particular measures, please see the table on the following page.

| Measure  | Data type                  | Alignment *   | Comments   |
|--|----------------------------|---|--|
| Overall health outcomes  |                            |   |  |
| <b>Health status improvement</b><br>% members reporting improvement or maintenance of: <ul style="list-style-type: none"> <li>• Physical health</li> <li>• Mental health</li> </ul>  | Patient or enrollee survey | Medicare Advantage  | <ul style="list-style-type: none"> <li>• Too “loose”</li> </ul>  |
| <b>Functional status improvement</b><br>% members covered by both Medicare & Medicaid who show positive change or maintenance in function (Activities of Daily Living as measured by the AM-PAC/SPD CAPS or OASIS)   | Program admin data         | TBD   | <ul style="list-style-type: none"> <li>• What about measuring functional status via member survey (e.g. CAHPS)?</li> </ul>   |
| <b>Healthy Days Measures</b><br>% members rating their health in the past month as “good” or better <ul style="list-style-type: none"> <li>• General health</li> <li>• Physical health</li> <li>• Mental health</li> </ul> % members reporting that poor health limited usual activities during the past month | Patient or enrollee survey | Healthy People 2020; several population health surveys (e.g. BRFSS) | <ul style="list-style-type: none"> <li>• Too “loose”</li> </ul>  |
| <b>Tobacco use prevalence</b><br>% CCO enrollees (not limited to those who have had clinical visit) who use tobacco  | Patient or enrollee survey | Unknown   | <ul style="list-style-type: none"> <li>• Tobacco use is important and cessation has good ROI if done well</li> <li>• May want to use Meaningful Use tobacco assessment measure (see primary care section) in the first few years and then phase this one in</li> </ul> |
| <b>Low birth weight</b><br>Births with infant weighing less than 2,500g, as % of total   | Vital records              | CHIPRA  | <ul style="list-style-type: none"> <li>• Aligns well with all three elements of the triple aim and is relatively actionable in the short term</li> </ul>   |

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|--|---|-----------------------------------|---|
| <p><b>Premature death / YPLL</b><br/>Years of potential life lost for individuals who died before age 75 (per 1,000 or other)</p>  | Vital records                             | Healthy People 2020, others       | <ul style="list-style-type: none"> <li>• What kind of risk adjustment does this require? May not be appropriate for CCOs.</li> </ul>  |
| <p><b>Kindergarten readiness</b><br/>As identified by the Early Learning Council</p>   | TBD                                       | TBD                               | <ul style="list-style-type: none"> <li>• Point to this structurally in CCO criteria and integrate it into practice for primary care homes but we probably don't know how to measure it well enough for July 1, 2012</li> </ul>  |
| <p><b>Breastfeeding</b> (initiation or exclusivity at 6 months)</p>  |   |                                   | <ul style="list-style-type: none"> <li>• A good prevention measure</li> </ul>   |
|  |   |                                   |   |
|  |   |                                   |   |
| Service Area: Mental Health  |   |                                   |   |
| <p><b>Appropriate level of care (adults &amp; children)</b><br/>% of individuals receiving higher-level mental health services who are at the appropriate level of care</p>      | Admin data;<br>Client assessment data     | Unknown                           | <ul style="list-style-type: none"> <li>• Why just for higher-level services – everyone should be at the appropriate level of care</li> <li>• Important, but not something to use initially</li> <li>• “Appropriate” could be subjective; would need to specify a standardized and reliable tool. Triangulate with some clinical indicators?</li> <li>• Concern that this could create a perverse incentive for CCOs to push toward scoring people based on what level of services they can afford to offer</li> </ul> |
| <p><b>Improvement in housing status (adults)</b><br/>% adult mental health service recipients in need of housing upon entry to treatment who had stable housing at discharge</p> | Admin data;<br>Patient or enrollee survey | National Outcome Measure (SAMHSA) | <ul style="list-style-type: none"> <li>• Some debate about whether this measure would be too much outside of CCO control</li> <li>• Would need to be “appropriate” housing, if used</li> </ul>  |

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|--|--|---|---|
| <p><b>Improvement in employment status (adults)</b><br/>                 % adult mental health service recipients seeking employment upon entry to treatment who had employment at discharge</p>   | <p>Admin data;<br/>                 Patient or enrollee survey</p> | <p>National Outcome Measure (SAMHSA)</p>  | <ul style="list-style-type: none"> <li>• Some debate about whether this measure would be too much outside of CCO control</li> </ul>   |
| <p><b>Improvement in school performance (children)</b><br/>                 % children whose school performance (attendance) improved after initiation of mental health services</p>   | <p>Admin data;<br/>                 Patient or enrollee survey</p> | <p>National Outcome Measure (SAMHSA)</p>  | <ul style="list-style-type: none"> <li>• Some debate about whether this measure would be too much outside of CCO control</li> <li>• One group would prioritize this as an innovation measure</li> </ul> |
| <p><i>Note: September meeting also included discussion of some mental health-related indicators, namely:</i></p> <ul style="list-style-type: none"> <li>• <i>Follow up after hospitalization</i></li> <li>• <i>Preventive health screening for individuals with behavioral health diagnosis / mental health screening for individuals with chronic disease</i></li> <li>• <i>Readmission rates for inpatient psychiatric</i></li> <li>• <i>Utilization of mental health services</i></li> <li>• <i>Patient experience of care (several elements)</i></li> <li>• <i>Member (patient) activation</i></li> <li>• <i>Mental health assessment for children in DHS custody</i></li> </ul> |  |   |   |
| <p><b>Initiation and engagement of addictions and mental health treatment</b></p>  | <p>Claims/<br/>                 encounter data</p>                 | <p>(Partial – for alcohol and drug only: HEDIS, Medicaid Adult, Meaningful Use)</p> |   |
| <p><b>Penetration rate</b></p>   |  |   |   |
| <p><b>Admission rate</b></p> <ul style="list-style-type: none"> <li>• Acute psychiatric care</li> <li>• Residential care</li> </ul>  |  |   |   |
| <p><b>Screening for adverse childhood events</b></p>   |  |   |   |

| Service Area: Addictions   |   |                                   |   |
|--|---|-----------------------------------|---|
| <b>Service retention</b><br>% individuals retained in services for at least 90 days  | Admin data                                | National Outcome Measure (SAMHSA) |   |
| <b>Improvement in housing status</b><br>% service recipients in need of housing upon entry to who had stable housing at discharge  | Admin data;<br>Patient or enrollee survey | National Outcome Measure (SAMHSA) | <ul style="list-style-type: none"> <li>• Too much outside of CCO control (although some debate on this)</li> <li>• Would need to be “appropriate” housing, if used</li> </ul> |
| <b>Improvement in employment status</b><br>% service recipients seeking employment upon entry to treatment who had employment at discharge   | Admin data;<br>Patient or enrollee survey | National Outcome Measure (SAMHSA) | <ul style="list-style-type: none"> <li>• Too much outside of CCO control (although some debate on this)</li> </ul>  |
| <b>Family stability</b><br>% parents who regain custody of their children after treatment  | Admin data                                | Unknown                           | <ul style="list-style-type: none"> <li>• Too much outside of CCO control (although some debate on this)</li> </ul>  |
| <p><i>Note: September meeting also included discussion of some addictions-related indicators, namely:</i></p> <ul style="list-style-type: none"> <li>• Preventive health screening for individuals with behavioral health diagnosis</li> <li>• Patient experience of care (several elements)</li> <li>• Member (patient) activation</li> </ul> |   |                                   |   |
| <b>% Receiving drug and alcohol treatment who are clean and sober X years later</b><br>(perhaps as a future measure)   |   |                                   |   |
| <b>Utilization of peer wellness specialists among people receiving chemical dependency services</b>  |   |                                   |   |
| <b>% of births where infant was born with addiction</b>  |   |                                   |   |
| <b>Use of lower-cost treatment options when available</b>  |   |                                   |   |

|   |                                   |   |  |
|---|-----------------------------------|---|--|
| <b>Improvement in penetration rate for addictions services</b>  |                                   |   |  |
| <b>Screening for alcohol misuse in primary care (e.g. SBIRT)</b>  |                                   | OR PCPCH  |  |
| Service Area: Oral health   |                                   |   |  |
| <b>ED visits for dental conditions</b><br>Rate of ED visits for dental conditions (per 1,000 or other)  | Claims or encounter data          | Unknown   | <ul style="list-style-type: none"> <li>• Good in combination with measure below</li> <li>• An indirect measure of poor access</li> </ul> |
| <b>Dental visits</b><br>% of members aged 2-21 who had any dental visit in the past year  | Claims or encounter data          | HEDIS   | <ul style="list-style-type: none"> <li>• Should be all ages</li> <li>• Good in combination with measure above</li> </ul>                 |
| <i>Note: September meeting also included discussion of some oral health-related indicators, namely:</i>   |                                   |   |  |
| <ul style="list-style-type: none"> <li>• Access to/utilization of <b>preventive</b> dental services</li> <li>• Children's oral health screening and follow-up</li> </ul>  |                                   |   |  |
| <b>Dental service utilization during pregnancy</b><br>(e.g. third trimester visit)  |                                   |   |  |
| <b>Wait time for dental appointment</b>   |                                   |   |  |
| <b>Prevalence of dental decay in young children (baby bottle tooth decay)</b>   |                                   |   |  |
| Service Area: Hospital care   |                                   |   |  |
| <b>Hospital processes of care<sup>^</sup></b> (CMS/TJC core measures)<br>CCO <b>choice of 3</b> among measures that meet Chassin's accountability criteria <sup>#</sup> e.g.: <ul style="list-style-type: none"> <li>• AMI 8a: Primary PCI received within 90 minutes of hospital arrival</li> <li>• HF-3: ACEI or ARB for LVSD on discharge</li> <li>• PN-7 Influenza vaccination</li> </ul> | Largely clinical / medical record | CMS/TJC inpatient hospital quality reporting; Medicare Hospital VBP |  |

|   |   |  |   |
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| <p><b>Hospital acquired infections<sup>^</sup></b><br/>         3 infection rates:</p> <ul style="list-style-type: none"> <li>• CLABSI</li> <li>• SSI for colon surgery</li> <li>• SSI for abdominal hysterectomy</li> </ul>  | <p>Clinical data via Oregon HAI program</p> | <p>(Partial) Medicare ACOs, Medicare hospital VBP</p>                      |   |
| <p><b>Skin injuries<sup>^</sup></b><br/>         Stage 3 or 4 pressure ulcers acquired after admission to a health care facility</p>  | <p>Claims/ encounter data</p>               | <p>Medicare hospital VBP</p>   |   |
| <p><b>Falls &amp; Trauma<sup>^</sup></b><br/>         Patient death or serious physical injury associated with a fall while being cared for in a healthcare facility</p>  | <p>Claims/ encounter data</p>               | <p>Medicare hospital VBP</p>   | <ul style="list-style-type: none"> <li>• Not very actionable – difficult indicator to budge</li> </ul>  |
| <p><i>Note: September meeting also included discussion of some hospital-related indicators, namely:</i></p> <ul style="list-style-type: none"> <li>• Readmission rates</li> <li>• Care transition measure (CTM-3)</li> <li>• Follow up after hospitalization</li> <li>• Patient experience of care (several elements)</li> <li>• (Preventable) admissions</li> <li>• (Avoidable) ED use</li> <li>• Cesarean rate</li> </ul> |   |  |   |
| <p><b>Influenza vaccination</b><br/>         Pneumonia patients 50+ discharged during flu season who received flu vaccine, if not already vaccinated</p>  | <p>Claims/ encounter data</p>               | <p>CMS/TJC inpatient hospital quality reporting; Medicare hospital VBP</p> |   |
| <p><b>Medication errors</b></p>   |   |  | <ul style="list-style-type: none"> <li>• Perhaps as future measure</li> </ul>   |
| <p>Service Area: Primary care (including prevention)</p>  |   |  |   |
| <p><b>Tobacco Assessment &amp; Cessation</b><br/>         % of enrollees age 13 and above w/visit in reporting period who were assessed for tobacco use</p>   | <p>Medical record or hybrid</p>             | <p>Medicaid adult; Medicare ACOs, Meaningful Use,</p>                      | <ul style="list-style-type: none"> <li>• Hold CCOs responsible for outcome as well (i.e. rate of tobacco use among enrollees)</li> <li>• Follow-up or treatment is as important as</li> </ul> |

|  |                                  |   |   |
|--|----------------------------------|---|---|
|  |                                  | OR PCPCH, QCorp   | screening   |
| <p><b>Weight screening and follow-up</b><br/>% patients with BMI documented AND, if BMI is outside parameters, a follow-up plan documented</p>   | Medical record or hybrid         | Medicaid adult; Medicare ACOs, Meaningful Use, HEDIS, QCorp, (OR PCPCH partial) | <ul style="list-style-type: none"> <li>• Hold CCOs responsible for outcome as well (i.e. obesity rate among enrollees)</li> <li>• Follow-up or treatment is as important as screening</li> </ul>      |
| <p><b>Well child care</b><br/>% patients with all recommended well child visits during measurement year.</p> <ul style="list-style-type: none"> <li>• 0-15 months</li> <li>• 3-6 years</li> <li>• 12-21 years</li> </ul> | Medical record or hybrid         | CHIPRA, OR PCPCH, HEDIS, HKC, QCorp   | <ul style="list-style-type: none"> <li>• Well-suited to OHP population</li> <li>• Hold CCOs responsible for outcome as well</li> <li>• Follow-up or treatment is as important as screening</li> </ul> |
| <p><b>Developmental screening</b><br/>% of children screened for risk of developmental, behavioral and social delays using a standardized screening tool (ASQ, MCHAT, etc) in the first three years of life</p>          | Admin data or medical record     | CHIPRA, OR PCPCH  | <ul style="list-style-type: none"> <li>• Well-suited to OHP population</li> <li>• Specify that tools should be evidence-based</li> </ul>  |
| <p><b>Childhood Immunization Status</b><br/>% kids up to date at 2 years (4 DtaP/DT; 3 IPV; 1 MMR; 3 influenza type B; 3 Hep B; 1 chicken pox; 4 pneumococcal conjugates).</p>   | Medical record or state registry | Meaningful Use, CHIPRA, OR PCPCH, HEDIS, HKC                                    | <ul style="list-style-type: none"> <li>• Get feedback from state immunization advisory committee – some provider and community resistance exists</li> <li>• Well-suited to OHP population</li> </ul>  |
| <p><b>Chlamydia screening in women</b><br/>% eligible, sexually active women age with at least one Chlamydia test in past year</p>   | Claims / encounter data          | Meaningful Use, CHIPRA, OR PCPCH, HEDIS, HKC, QCorp                             | <ul style="list-style-type: none"> <li>• Specify alignment with USPSTF guidelines</li> </ul>  |
| <p><b>Breast cancer screening</b><br/>% eligible women 40-69 who receive a mammogram in a two year period</p>  | Claims / encounter data          | Medicaid adult, Medicare ACOs, Meaningful Use, OR PCPCH, HEDIS, QCorp           | <ul style="list-style-type: none"> <li>• Specify alignment with USPSTF guidelines</li> </ul>  |

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| <p><b>Cervical cancer screening</b><br/>% women 18-64 years of age who received one or more Pap tests during last 3 years</p>   | <p>Claims / encounter data</p>                 | <p>Medicaid adult, Meaningful Use, OR PCPCH, HEDIS, QCorp</p>         | <ul style="list-style-type: none"> <li>Specify alignment with USPSTF guidelines</li> </ul>  |
| <p><b>Colorectal cancer screening</b><br/>% enrollees age 50-80 who have received appropriate colorectal cancer screening</p>   | <p>Claims / encounter data</p>                 | <p>Medicare ACOs, Meaningful Use, OR PCPCH, HEDIS</p>                 | <ul style="list-style-type: none"> <li>Specify alignment with USPSTF guidelines</li> <li>Not well targeted to OHP population; negative cost impact</li> <li>However, screening rates are low</li> </ul>   |
| <p><b>HIV testing</b><br/>% of members age 13-65 screened at least once for HIV, regardless of risk</p>   | <p>Medical record or claims/encounter data</p> | <p>CDC</p>  | <ul style="list-style-type: none"> <li>Not beneficial or cost-effective at CCO level</li> </ul>   |
| <p><b>Controlling High Blood Pressure</b><br/>% hypertensives age 18–85 years with BP controlled (&lt;140/90)</p>   | <p>Medical record</p>                          | <p>Medicaid adult, Medicare ACOs, Meaningful Use, OR PCPCH, HEDIS</p> | <ul style="list-style-type: none"> <li>This is still an intermediate measure – ultimate measure is prevention of complications associated with this condition.</li> </ul>   |
| <p><b>Controlling Cholesterol</b><br/>% individuals with coronary artery disease with lipids controlled (&lt;100 ml/dl)</p>   | <p>Medical record</p>                          | <p>Medicare ACOs, QCorp, (OR PCPCH partial)</p>                       | <ul style="list-style-type: none"> <li>This is still an intermediate measure – ultimate measure is prevention of complications associated with this condition.</li> </ul>   |
| <p><b>Controlling Blood Sugar</b><br/>% diabetics (type 1 and 2) age 18 - 75 years with HbA1c under control (&lt;8.0%)</p>  | <p>Medical record</p>                          | <p>Medicare ACOs, Meaningful Use, OR PCPCH</p>                        | <ul style="list-style-type: none"> <li>One group suggested a different standard for controlled glucose.</li> <li>This is still an intermediate measure – ultimate measure is prevention of complications associated with this condition.</li> </ul>   |
| <p><b>Preventable Hospital Admissions (AHRQ PQIs)</b><br/>Perhaps a subset of the 16 measures? E.g.<br/>01: Diabetes short-term complications<br/>05: Chronic Obstructive Pulmonary Disease (COPD)<br/>07: CHF (Chronic Heart Failure)<br/>11: Bacterial pneumonia<br/>12: UTI (Urinary tract infection)<br/>15: Adult asthma</p> | <p>Claims / encounter data</p>                 | <p>Medicaid adult, Medicare ACOs</p>                                  | <ul style="list-style-type: none"> <li>CCOs should have sufficient enrollment to produce valid rates.</li> <li>One group considered this a particularly good Primary Care measure</li> <li>One group member commented that total hospital admissions may adequately capture this</li> </ul> |

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| <p><i>Note: September meeting also included discussion of some primary care indicators, namely:</i></p> <ul style="list-style-type: none"> <li>• <i>Use of patient-centered medical homes</i></li> <li>• <i>Preventive health screening for individuals with behavioral health diagnosis / mental health screening for individuals with chronic disease</i></li> <li>• <i>Patient experience of care (several elements)</i></li> <li>• <i>(Preventable) admissions</i></li> <li>• <i>(Avoidable) ED use</i></li> <li>• <i>Follow up after hospitalization</i></li> <li>• <i>Medication reconciliation</i></li> </ul> |  |                     |  |
| <p><b>Depression screening in primary care</b></p>   |  |                     |  |
| <p><b>Primary care access</b><br/>% members seeking primary care services</p>  |  |                     |  |
| <p><b>Healthy eating</b></p>   |  |                     |  |
| <p><b>Rate of exercise or physical activity</b></p>  |  |                     |  |
| <p><b>Breastfeeding rates</b><br/>(listed also under overall outcomes)</p>   |  |                     |  |
| <p><b>Measure of investment in primary care</b><br/>(e.g. increase in % of medical spend on primary care over time)</p>  |  | <p>Rhode Island</p> |  |
| <p>Service Area: End of Life Care</p>  |  |                     |  |

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|---|---|--|---|
| <p><b>POLST forms</b><br/>% members who have a POLST form completed in the registry</p>                       | <p>Admin data</p>                                       |  | <ul style="list-style-type: none"> <li>• Restrict to dual eligibles or some other relevant age or condition-specific group</li> <li>• Add “at the time of death” to achieve more specification</li> </ul> |
| <p><b>Advanced Directives</b><br/>% members who have an advanced directive</p>                                | <p>Admin data</p>                                       |  | <ul style="list-style-type: none"> <li>• Would need a rational age cut-off for this – it’s not relevant for all adults</li> <li>• Add “at the time of death” to achieve more specification</li> </ul>     |
| <p><b>Location at death</b><br/>% of deaths occurring at home/residence, in nursing home, and in hospital</p> | <p>Clinical data or vital records</p>                   |  | <ul style="list-style-type: none"> <li>• Too many assumptions – probably not appropriate as a performance measure</li> </ul>  |
| <p><b>Use of palliative care</b><br/>% of members who receive palliative care at the end of life</p>          | <p>Claims/<br/>encounter data<br/>or medical record</p> |  | <ul style="list-style-type: none"> <li>• Would need a good definition of palliative in this case, which should include hospice</li> <li>• Goal would not be 100% - perhaps improvement?</li> </ul>        |
| <p><b>% of members for whom end-of-life care complies with POLST</b></p>                                      |   |  |   |
|   |   |  |   |
|   |   |  |   |

**DRAFT**

**Medicare – Medicaid Integration of Care and Services Work Group  
October 19, 2011 Meeting Summary**

**Discussion Topics**

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**Medicare-Medicaid Plans Workgroup**

Co-Chair Judy Mohr Peterson updated the group on the meeting of a workgroup of Medicare and Medicaid plans. The meeting focused on better aligning the Medicare and Medicaid requirements for plans, and the group identified four key areas for focus: consolidating and improving written materials; enrollment and disenrollment issues and processes; Special Needs Plans (SNP) model of care requirements; and alignment of reporting on performance metrics.

**Fact Sheet on Medicare and Medicaid Services for Individuals who are Dually Eligible**

Susan Otter presented an updated fact sheet related to the population of individuals in Oregon who are dually eligible for Medicare and Medicaid services. The fact sheet included new information on the age distribution of this group, rates of chronic conditions and behavioral health conditions, and long term care expenditures associated with this population. Workgroup members provided feedback on data presentation and suggestions for additional data that would be useful to analyze.

**Introduction to CCO Criteria**

Co-Chair Judy Mohr Peterson reviewed a summary of the key criteria for CCOs that were included in House Bill 3650. She noted that language relevant to care coordination is woven throughout the bill. She discussed how in thinking about how to develop the criteria for CCOs it is important to find a balance between being prescriptive and allowing for innovation. She suggested that the final criteria need to establish some parameters or sideboards, but that within those parameters it may be preferable to provide a range of possible options or ask CCOs how they will meet the requirement.

**Breakout Groups**

The work group was divided into three smaller discussion groups to address the following questions and to identify the key points to go forward to the Oregon Health Policy Board:

- What would effective care coordination look like from the perspective of a beneficiary, a care giver or family member, and a provider? What key elements in a CCO proposal would demonstrate that it can effectively coordinate care?
- What would effective transitions of care look like from the perspective of a beneficiary, a care giver or family member, and a provider? What key elements in a CCO proposal would demonstrate that it has an effective strategy for transitions of care?

## Key Points for Oregon Health Policy Board – Care Coordination and Transitions of Care

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### Care Coordination

#### Areas of Agreement:

- Need for a patient-centered, culturally appropriate care team that incorporates patient and caregivers.
- Inclusion/use of non-**traditional providers, such as peer navigators/workers, in care coordination team.**
- **Providing** adequate workforce development, training and livable wages, particularly for non-traditional providers.
- Utilization of a strength-based assessment, taking into account social factors (such as social determinants of health, caregiver and family supports, home environment, etc).
- Development of an individualized care plan that follows the patient and is updated over time.
- Need for holistic, system-wide communication and information sharing, including IT systems and information exchange.

#### Areas of Tension/Anticipated Challenges:

- Need to ensure care coordination model can work in rural areas, where there may not be as many providers to make up a team – may need to look different in different areas.
- Alignment with the Patient Centered Primary Care Home (PCPCH) model and ensuring that efforts are not duplicated.
- Payment alignment to support care coordination and ensure that providers are reimbursed appropriately to support these efforts.
- Revisited importance of metrics and ensuring accountability at CCO level.
- Theme of patient inclusion and personal responsibility
- Providers not used to coordination with government agencies.
- Need for regulatory consistency, including a single governance process

#### Surprises:

- None.

### Transitions of Care

#### Areas of Agreement:

- Elements of effective care coordination will contribute to effective transitions of care.
- Need a specific assessment and plan for transitions, including who is responsible for follow-up care.
- Determining the appropriate setting is a key part of transition planning.
- Medication reconciliation and information handoff are also key elements.

Areas of Tension/Anticipated Challenges:

- How to ensure effective hand off of baton.

Surprises:

- Focus on end-of-life care and palliative care as part of transitions of care.

### **Small Group Discussion**

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#### ***What would effective care coordination look like/what are key elements?***

Breakout group members discussed the key elements of effective care coordination. There was substantial agreement both within the groups and between the groups as to what these key elements were.

The groups agreed that a key element of care coordination was an interdisciplinary/multidisciplinary care team (IDT/MDT).

- Care teams need to provide person-centered, culturally specific care, with patients engaged in the process.
- Care teams may need to extend beyond traditional medical practitioners to include other key members from social services, caregivers, home care workers, and peer navigators/workers.
- A care coordinator was identified as a key member of the team who would take the lead on day-to-day coordination activities; one team also identified the need for a more advanced care manager to handle clinical tasks such as medication reconciliation and drug/treatment interactions across specialists.
- Adequate training, standards and pay are important, particularly for non-traditional providers and for the new role of care coordinator.
- Concept of care team should be flexible, who is on the team/how many members may vary depending on intensity of client needs, and availability of providers (eg, care team may be more limited in rural areas).

A standardized needs assessment was also identified as a key element.

- The assessment should be strength/ability-based, to focus on how to build on a client's strengths, and should include a focus on prevention (e.g. fall prevention).
- The assessment should be done from the person's point of view and help to identify their goals.
- The assessment needs to look at social determinants of health, not just medical determinants.

The groups identified an individualized care plan as a key tool resulting from the assessment to be used by the care team.

- The care plan needs to move with the client between different settings of care, and document the transitions that have occurred.
- The care plan should be updated as the client's condition changes.
- The care plan should incorporate after-hours needs and should plan for urgent care to be delivered in a non-hospital setting.

- One group suggested that the client should sign off on the care plan to ensure that it reflects their needs and goals.
- The SNP model of care was mentioned as an existing model including this kind of individualized care plan.

The need for holistic system-wide communication emerged as a key element and a challenge.

- The need for health information technology (HIT)/health information exchange (HIE) systems was discussed in several groups.
- One group also raised serious doubts about whether the needed HIT/HIE solutions would be possible to implement given the divergent systems that had already been adopted.
- There were several examples raised of how this is a key element lacking today, such as a nursing facility that will send after hours faxes about urgent health issues.

Payment alignment and whether providers would be reimbursed for care coordination activities was raised as a significant concern.

- This was particularly a concern for providers, who felt that some of these care coordination activities do not take place now because they are not reimbursed.
- CCO proposals would need to account for how these new care coordination activities will be paid for.

Other discussion points included:

- At the heart, effective care coordination relies on a trusted relationship.
- Care coordination with governmental entities outside the CCO (such as local mental health authority) will pose particular challenges and needs to be specifically considered/addressed.
- The care coordination work needs to be closely aligned with the Patient Centered Primary Care Home (PCPCH) model, since many of the elements are similar and there is a potential for duplicative efforts.
- Need for metrics to assess this work, including patient satisfaction; should consider existing best-practices and metrics that have already been developed, such as by NCQA.
- Ensuring patient responsibility and how to serve difficult to serve clients are both challenges that need to be addressed.
- Particular ideas around pharmacy – system to track and analyze medication non-adherence, implementation of collaborative drug therapy program giving pharmacists a greater role.
- Ensure accountability of CCOs through regulatory alignment, including a single grievance process.

### ***What would effective transitions of care look like/what are key elements?***

Breakout group members discussed the key elements of effective transitions of care. There was again substantial agreement both within the groups and between the groups.

Effective care coordination elements previously identified were seen as integral to effective transitions of care, including:

- Systems to share necessary information, including test results and care plans among other information;
- A care plan that moves with the patient, gets updated at transitions and with changes in patient condition; and
- A care coordinator who ensures a smooth hand off.

The groups also discussed the need for a specific assessment and plan to be developed for the transition of care.

- The assessment should address risks, access to care, and need for DME specific to the new setting (such as a patient returning home after an acute stay).
- The plan needs to identify needed follow-up care, and who is responsible for delivering it.
- The assessment and resulting plan should again address social determinants of health and should be patient-centered.

One group discussed the concept that an important part of transitions of care is determining the appropriate setting for a patient.

- Determining the appropriate setting will depend on the patient's needs, desires and goals, and should consider social factors (for example, availability of social supports and caregivers) in addition to medical factors.
- Transitions of care should include both transitions from a higher level of care to a lower level of care/home, and early intervention to address the increasing needs of people as their illness progresses, requiring them to move to higher levels of care.
- As such, end-of life planning (such as POLST forms) and planning for palliative care is often a critical element of transitions of care and is best when discussed early.

Other elements that were noted as critical to transitions of care included:

- Medication reconciliation/medication management;
- Role of in-home care worker; and
- The need for a true hand off (or "passing the baton") where one care setting doesn't let go of the patient until the next has really received them and is addressing their needs.