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Advancing towards Value-Based Care: Overview of History of Dementia Care Elements and Quality Measures

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Disclosures

- Hebrew SeniorLife
- Beth Israel Deaconess Medical Center
- Brown University
- NIMH
- NHLBI
- NSF
- Dementia Caregiving Network
  - John A. Hartford Foundation
  - Gerontological Society of America
- 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
- Butler Hospital

Consensus-Building and a Selected History of Quality Measures

- 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
- CMS: Meaningful Measures
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- ASPE & RTI: Examining Models of Dementia Care

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

Sample Measure – Dementia: Cognitive Assessment NQF 2872e

Description: Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12 month period.

Numerator: Patients for whom an assessment of cognition is performed and the results reviewed at least once within a 12 month period

Denominator: All patients, regardless of age, with a diagnosis of dementia

Denominator Exclusions: Documentation of patient reason(s) for not assessing cognition

Steward: PCPI

Process measure, e-measure, Neurology

Types of Measures

Structural

- Focus on a feature of the healthcare organization or clinician related to the capacity to provide high quality care (e.g. Assessment of Patient Experience of Care)

Process

- Focus on a health care related activity performed for or on behalf of a patient (e.g., Tobacco Use Screening).
- Most common type of quality measure

Outcome (Patient Reported Outcome, Outcome, Intermediate Outcome)

- Focus on a health state of a patient resulting from health care (e.g., 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)

Data Sources for Quality Measures

- Administrative Data – Derived from insurance claims and enrollment files.
- Medical Records – Provide details about the care being received (e.g. patient's history, condition, complications).
- Patient Surveys –Measures patient experience with care (e.g. CAHPS).
- Electronic Health Records – EHR Incentive Program and Meaningful Use; Hybrid data sources
- Assessment Instruments – Additional to clinical services

Reliability and Validity

- Validity testing
  - Indicates the ability of a measure to record or quantify what it purports to measure
- Reliability testing
  - Demonstrates that measure results are repeatable and the measurement error is acceptable, producing the same results a high proportion of the time

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/Blueprint-130.pdf

Assessing Care of Vulnerable Elders (ACOVE) RAND Corp.

- Cognitive and Functional Screening
- Medication Review
- Laboratory Testing
- Neuroimaging
- Cholinesterase Inhibitors
- Caregiver Support and Patient Safety
- Screening for Depression
- Depression Treatment
- Driving Privileges
- Restraints (in hospital)
- Memory Loss (without previous diagnosis of dementia)

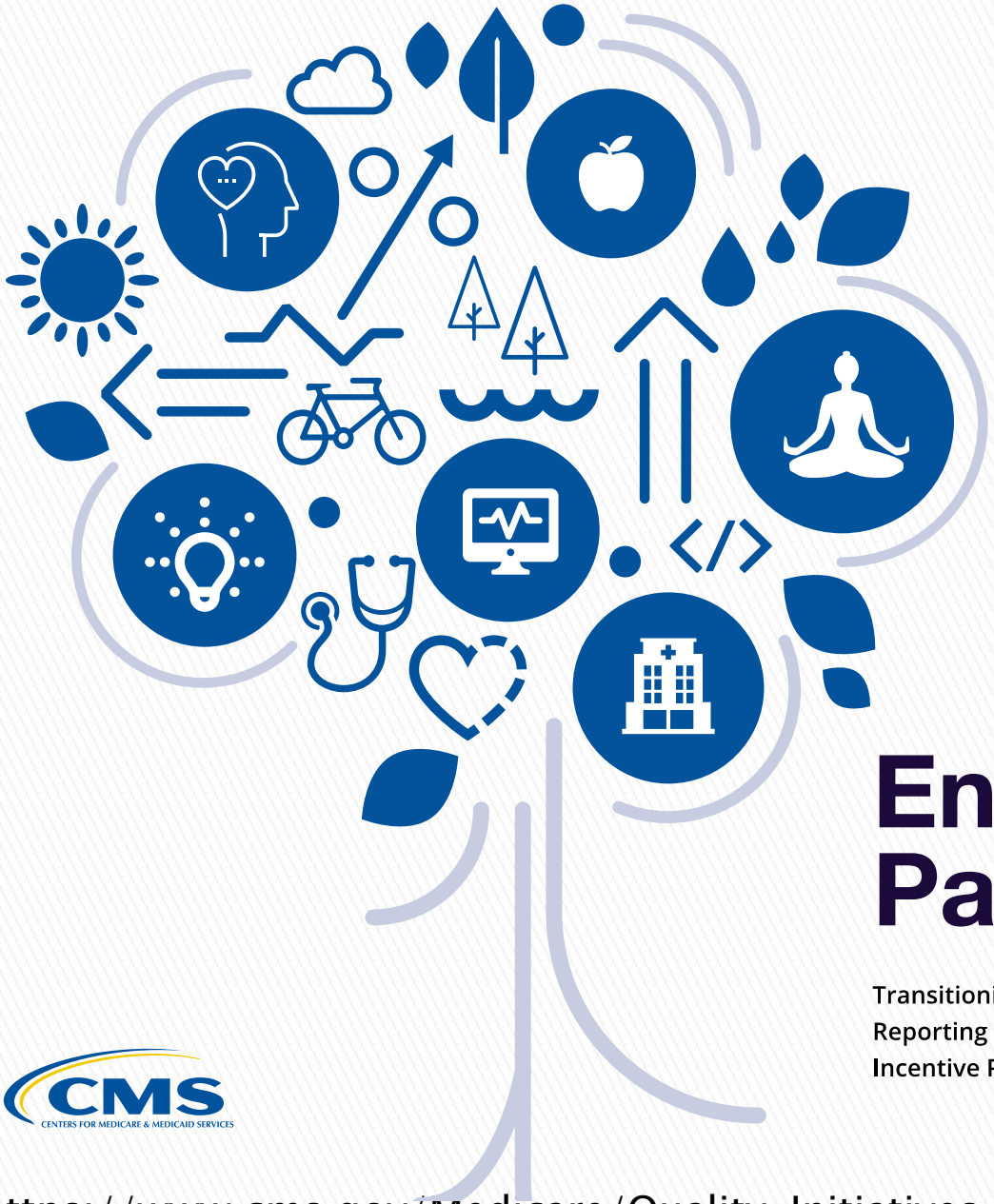
2001 RAND
https://www.rand.org/pubs/reprints/RP1130.html

Physician Quality Reporting System (PQRS)

2015 PQRS MEASURES IN DEMENTIA MEASURES GROUP:

- #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



Enhancing Patient Care

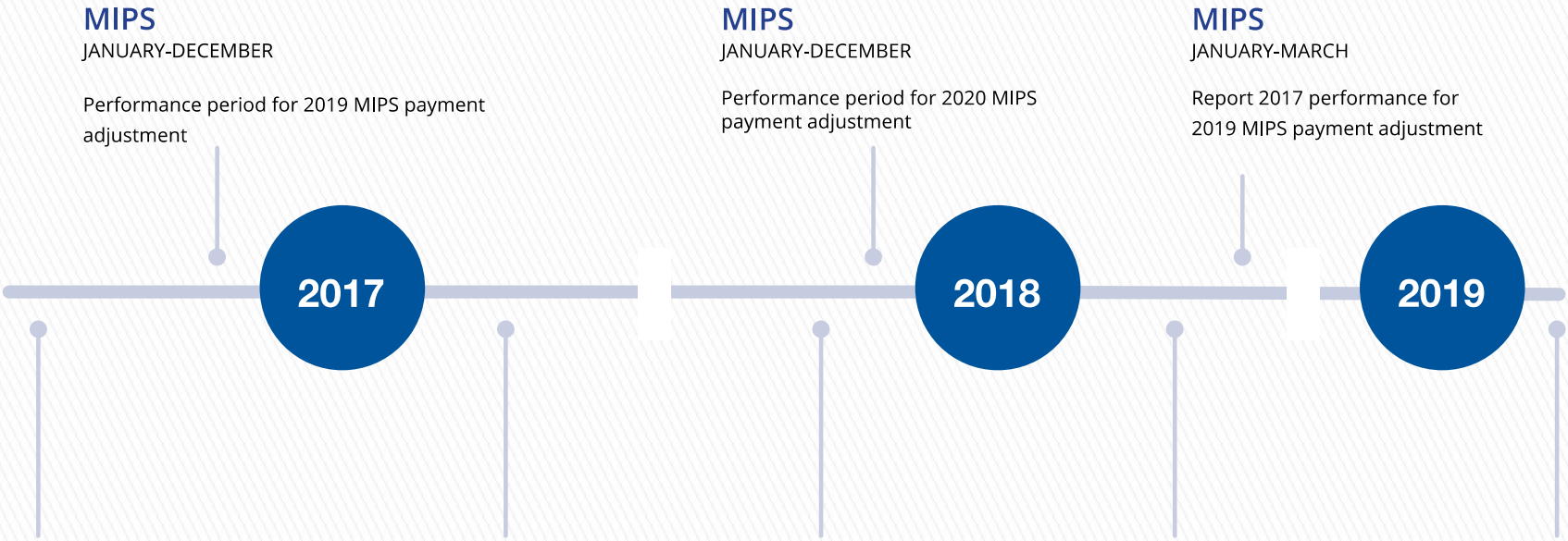
Transitioning from the Physician Quality Reporting System (PQRS) to the Merit-based Incentive Payment System (MIPS)

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/TransitionResources_Landscape.pdf

Transition Timeline

The last data submission timeframe for reporting 2016 PQRS quality data to avoid the 2018 PQRS downward payment adjustment was January through March 2017. The first MIPS performance period is January through December 2017.



Have Questions?

For more information, and to learn more about the Quality Payment Program, please view the following resources.

CMS Quality Payment Program website | CMS PQRS website | CMS Twitter account

March 2018 / version 1

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

Select Measures

SEARCH BY KEYWORD

All | dementia | SEARCH

FILTER BY:

High Priority Measure | Data Submission M

Showing **6** Measures

Add All Measures

- Dementia: Caregiver Education and Support — ADD
- Dementia: Cognitive Assessment — ADD
- Dementia: Counseling Regarding Safety Concerns — ADD
- Dementia: Functional Status Assessment — ADD
- Dementia: Management of Neuropsychiatric Symptoms — ADD
- Dementia: Neuropsychiatric Symptom Assessment — ADD

Priority Setting for Healthcare Performance Measurement: Addressing Performance Measure Gaps for Dementia, including Alzheimer's Disease

FINAL REPORT

OCTOBER 15, 2014

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

Administration for Community Living

NADRC
National Alzheimer's and Dementia Resource Center

Dementia Capability Assessment Tool

(Note: If your organization is an ADI-SSS or ADSSP grantee or project partner, please contact Sari Shuman at sshuman@rti.org prior to completing this tool.)

Instructions

This assessment tool is designed to measure the dementia capability of the long-term services and supports in various organizations. The information resulting from this assessment will assist in measuring changes in dementia capability over time.

Any organization can complete an individual assessment of its dementia capability. Questions 1 through 5 are used to identify the responding organization and its focus areas. Questions 6 through 9 are used to measure various aspects of dementia capability. The goal of the assessment is to demonstrate dementia capability throughout the organization. Due to organizational changes over time, periodic re-evaluation of dementia capability is strongly recommended.

- https://nadrc.acl.gov/node/117

8. Providing specialized services to people with a cognitive impairment or dementia and their caregivers

Does your organization: (Circle the letters of ALL that apply.)

a. Conduct a formal assessment to determine the specific needs of people with cognitive impairment or dementia?
    i. If so, what assessment tool is used? _____
b. Conduct an assessment of caregivers of people with cognitive impairment or dementia to determine their service needs?
c. Have a standard procedure for providing referrals to people with dementia?
d. Have a standard procedure for providing referrals to caregivers?
e. Have a list of dementia-capable providers and organizations to which people with dementia and their caregivers are referred?
f. Track referrals to determine if the person with dementia or their caregivers contact the organization they are referred to?

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

- CAHPS Home and Community Based Services Survey:

Overview

The CAHPS Home and Community-Based Services Survey (HCBS CAHPS) is the first cross-disability survey of home and community-based service beneficiary's experience receiving long-term services and supports. It is designed to facilitate comparisons across the hundreds of state Medicaid HCBS programs throughout the country that target different adults with disabilities, e.g., including frail elderly, individuals with physical disabilities, persons with developmental or intellectual disabilities, those with acquired brain injury and persons with severe mental illness. The HCBS CAHPS Survey is available for voluntary use in HCBS programs as part of quality assurance and improvement activities and public reporting.

https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/cahps-hcbs-survey/index.html

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

NICE National Institute for Health and Care Excellence

NICE Pathways

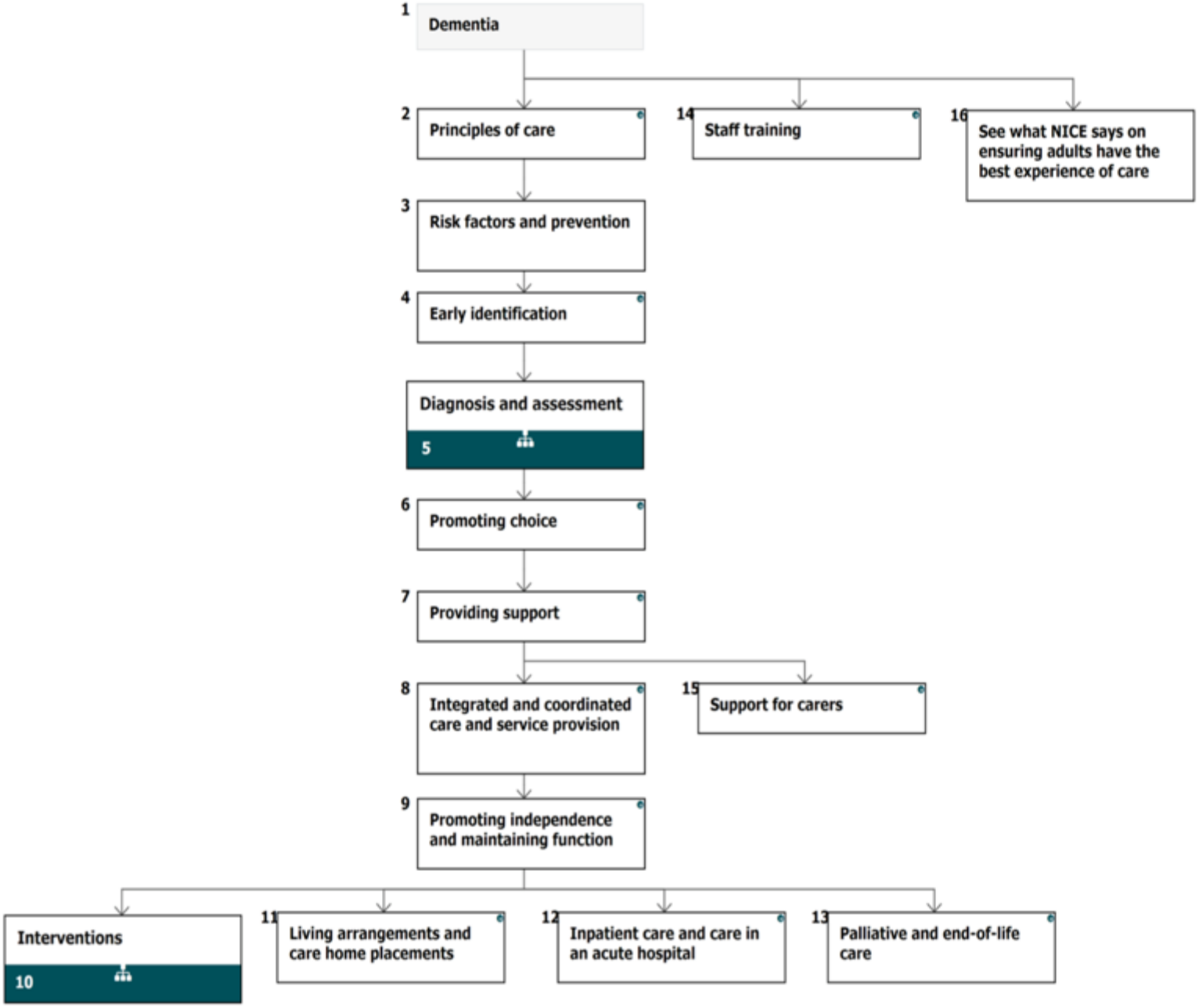
Dementia overview

NICE Pathways bring together everything NICE says on a topic in an interactive flowchart. NICE Pathways are interactive and designed to be used online.

They are updated regularly as new NICE guidance is published. To view the latest version of this NICE Pathway see:

http://pathways.nice.org.uk/pathways/dementia
NICE Pathway last updated: 27 March 2018

This document contains a single flowchart and uses numbering to link the boxes to the associated recommendations.

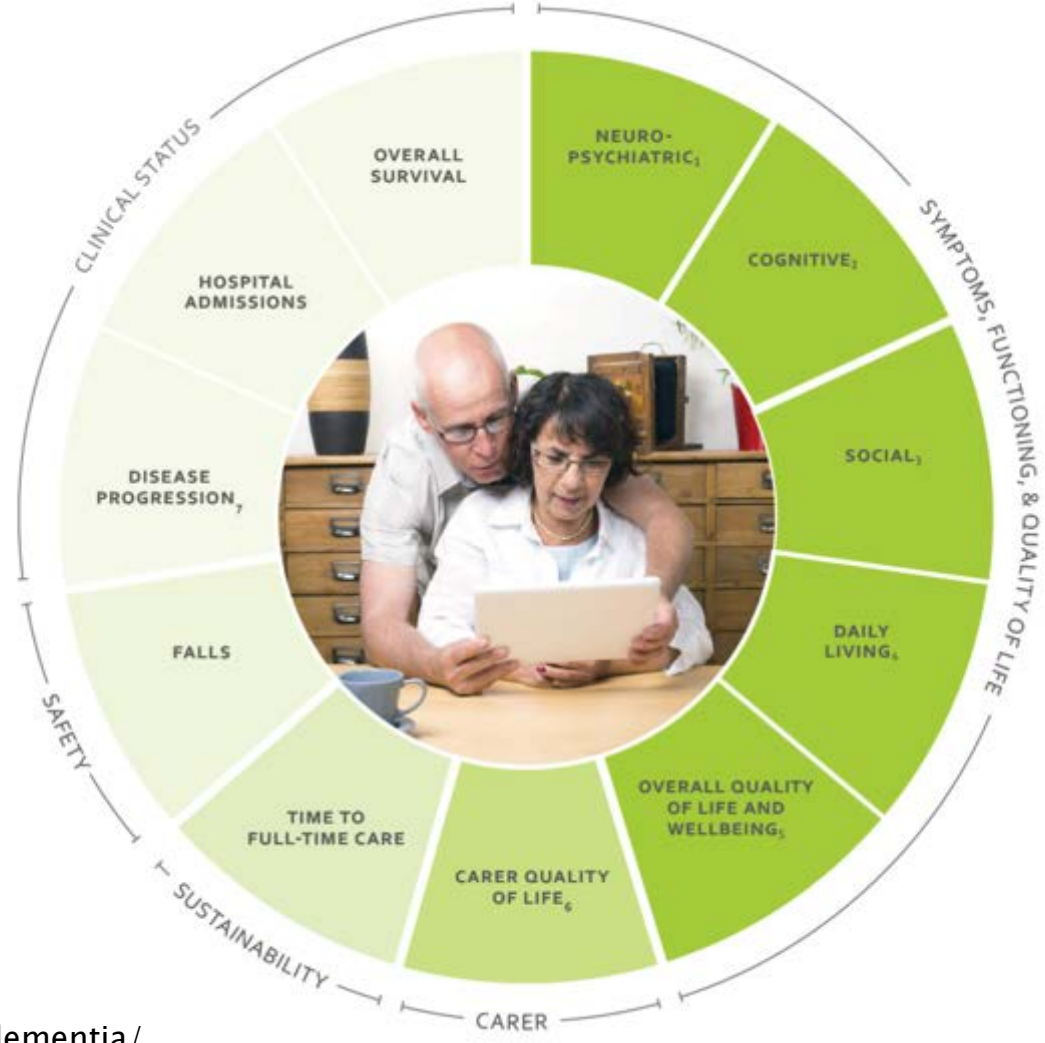

1 Dementia
2 Principles of care
14 Staff training
16 See what NICE says on ensuring adults have the best experience of care
3 Risk factors and prevention
4 Early identification
Diagnosis and assessment
5
6 Promoting choice
7 Providing support
8 Integrated and coordinated care and service provision
15 Support for carers
9 Promoting independence and maintaining function
Interventions
10
11 Living arrangements and care home placements
12 Inpatient care and care in an acute hospital
13 Palliative and end-of-life care

ICHOM

International Consortium for Health Outcomes Measurement

DEMENTIA

The ICHOM Standard Set for Dementia is the result of hard work by a group of leading physicians, measurement experts and patients. It is our recommendation of the outcomes that matter most to persons with Dementia. We urge all providers around the world to start measuring these outcomes to better understand how to improve the lives of their patients.



http://www.ichom.org/medical-conditions/dementia/

ICHOM: International Consortium on Health Outcome Measures – Dementia Care Categories

- Demographic Factors
- Baseline Clinical Status
- Associated Clinical History
- Medication Variables
- Symptoms, Functioning and Quality of Life
- Carer
- Sustainability
- Safety
- Clinical Status

ICHOM: International Consortium on Health Outcome Measures – Dementia Outcomes Assessment Measures

- Neuropsychiatric Inventory (NPI)
- Bristol Activities Daily Living Scale (BADLS)
- Quality of Life-AD (QOL-AD)
- Quality of Wellbeing Scale – Self Adm (QWB-SA)
- EuroQol-5D (EQ-5D)
- Clinical Dementia Rating (CDR)
- Montreal Cognitive Assessment (MoCA)

Meaningful Measures

Promote Effective Communication & Coordination of Care
Meaningful Measure Areas:
- Medication Management
- Admissions and Readmissions to Hospitals
- Transfer of Health Information and Interoperability

Promote Effective Prevention & Treatment of Chronic Disease
Meaningful Measure Areas:
- Preventive Care
- Management of Chronic Conditions
- Prevention, Treatment, and Management of Mental Health
- Prevention and Treatment of Opioid and Substance Use Disorders
- Risk Adjusted Mortality

Strengthen Person & Family Engagement as Partners in their Care
Meaningful Measure Areas:
- Care is Personalized and Aligned with Patient's Goals
- End of Life Care according to Preferences
- Patient's Experience of Care
- Patient Reported Functional Outcomes

Work with Communities to Promote Best Practices of Healthy Living
Meaningful Measure Areas:
- Equity of Care
- Community Engagement

Make Care Safer by Reducing Harm Caused in the Delivery of Care
Meaningful Measure Areas:
- Healthcare-Associated Infections
- Preventable Healthcare Harm

Make Care Affordable
Meaningful Measure Areas:
- Appropriate Use of Healthcare
- Patient-focused Episode of Care
- Risk Adjusted Total Cost of Care

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/11_30_17-Meaningful-Measures-Final_508v2.pdf

CMS – Meaningful Measures

- Promote Effective Prevention & Treatment of Chronic Disease
- Work with Communities to Promote Best Practices of Healthy Living
- Make Care Affordable
- Make Care Safer by Reducing Harm Caused in the Delivery of Care
- Strengthen Person & Family Engagement as Partners in their Care
- Promote Effective Communication & Coordination of Care

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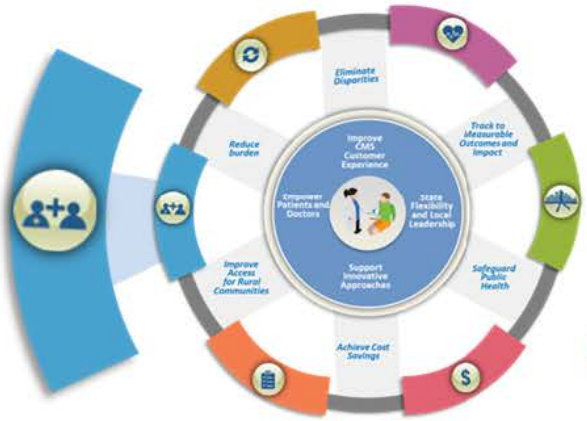


Person- and Family-Centered Care

Care is Personalized and Aligned with Patient's Goals

End of Life Care according to Preferences

Patient's Experience and Functional Outcomes

Meaningful Measure Areas

The Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function IRF QRP, LTCH QRP, SNF QRP, HH QRP

Care plan QPP

Hospice Visits while Death is Imminent HQRP

CAHPS® Hospice Survey: Getting Emotional and Religious Support HQRP

CAHPS In-Center Hemodialysis Survey ESRD QIP

Home and Community Based Services CAHPS Medicaid & CHIP

Functional Status Assessment for Total Hip Replacement QPP

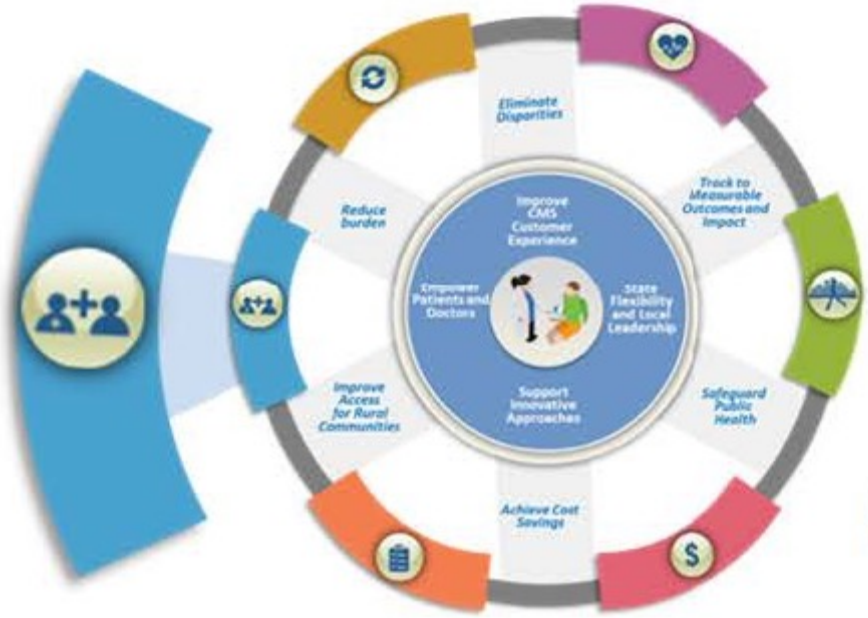
Measures

Programs Using Illustrative Measures

Quality Payment Program (QPP)
Hospice Quality Reporting Program (HQRP)
End-Stage Renal Disease Quality Incentive Program (ESRD QIP)
Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)
Skilled Nursing Facility Quality Reporting Program (SNF QRP)
Long-Term Care Hospital Quality Reporting Program (LTCH QRP)
Medicaid and CHIP (Medicaid & CHIP)
Home Health Quality Reporting Program (HH QRP)

The Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function

IRF QRP, LTCH QRP, SNF QRP, HH QRP



Person- and Family-Centered Care

Care is Personalized and Aligned with Patient's Goals

End of Life Care according to Preferences

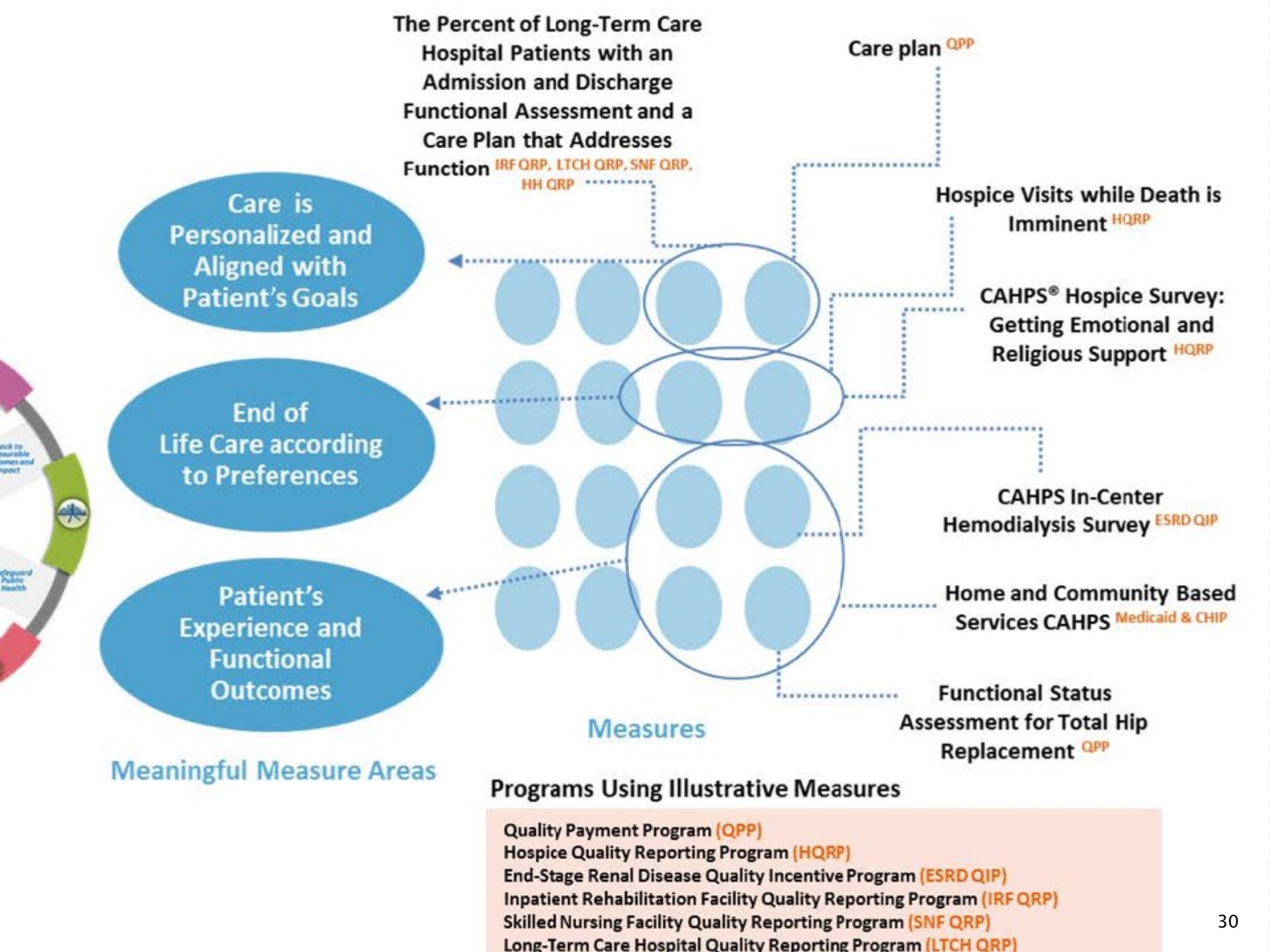
Patient's Experience and Functional Outcomes

Meaningful Measure Areas

Measures

Programs Using Illus

Quality Payment Program
Hospice Quality Reporting


The Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function IRF QRP, LTCH QRP, SNF QRP, HH QRP
Care plan QPP
Hospice Visits while Death is Imminent HQRP
CAHPS® Hospice Survey: Getting Emotional and Religious Support HQRP
CAHPS In-Center Hemodialysis Survey ESRD QIP
Home and Community Based Services CAHPS Medicaid & CHIP
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Skilled Nursing Facility Quality Reporting Program (SNF QRP)
Long-Term Care Hospital Quality Reporting Program (LTCH QRP)

C.M.Callahan; Health Affairs 2014

Redesigning Systems of Care for Older Adults with AD

COMPONENTS OF BEST PRACTICE MODELS

1. Make a formal diagnosis using a standardized instrument and with input from a family member;
2. Evaluate the patient for treatable causes of cognitive impairment or excess disability;
3. Consider referral to a specialty memory care practice;
4. Educate the patient and family about the diagnosis and care options;
5. Accept the caregiver-care recipient dyad as the target of care
6. Refer the patient to relevant community support services;
7. Regularly assess patient for problem behaviors and train the caregiver in identifying and managing these behaviors
8. Discuss goals of care
9. Discuss driving and home safety
10. Consider cognitive enhancing drugs
11. Regularly reassess the psychoactive side effects of prescription and non-prescription medications and alcohol and other substance abuse
12. Facilitate regular cognitive, physical, and social activity
13. Detect and treat vascular risk factors
14. Manage the patients comorbid conditions in the context of dementia
15. Track patient outcomes and adjust goals of care as appropriate

ASPE & RTI: Examining Models of Dementia Care

1. Detection of Possible Dementia
2. Diagnosis
3. Assessment and Ongoing Reassessment
4. Care Planning
5. Medical Management
6. Information, Education, and Informed and Supported Decision-Making
7. Acknowledgement and Emotional Support for the Person with Dementia
8. Assistance for the Person with Dementia with Daily Functioning and Activities

ASPE & RTI: Examining Models of Dementia Care

9. Involvement, Emotional Support, and Assistance for Family Caregiver(s)
10. Prevention and Mitigation of Behavioral and Psychological Symptoms of Dementia
11. Safety for the Person with Dementia
12. Therapeutic Environment, Including Modifications to the Physical and Social Environment of the Person with Dementia
13. Care Transitions
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

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.

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.

ASPE & RTI: Examining Models of Dementia Care	ACOVE	PQRS & QPP	ACL: Dementia Capability	Alzheimer's Association: Dementia Care Practice Recommendations
1. Detection of possible dementia	Cognitive & Functional Screening; Memory Loss	**Cognitive Assessment**	Identification and Awareness of Dementia	Detection & Diagnosis
2. Diagnosis	Medication Review; Laboratory Testing; Neuroimaging	Staging of Dementia; **Functional Status Assessment**		
3. Assessment and ongoing reassessment			Measuring Functional Ability for Care Planning and Resource Allocation	Assessment & Care Planning
4. Care planning		Care Plan		
5. Medical management	Cholinesterase Inhibitor			Medical Management
6. Information, education, and informed and supported decision making			Understanding Decision-making Capacity for Care Planning & Resource Allocation	Information, Education and Support
7. Acknowledgement and emotional support for the person with dementia			Support Resources for Persons with ADRD	
8. Assistance for the person with dementia with daily functioning and activities			Support Resources for Persons with ADRD	Ongoing Care for BPSD and Support for ADLs
9. Involvement, emotional support, and assistance for family caregivers	Caregiver Support (and Patient Safety)	**Caregiver Education and Support**	Caregiver Support Resources	

ASPE & RTI: Examining Models of Dementia Care	ACOVE	PQRS & QPP	ACL: Dementia Capability	Alzheimer's Association: Dementia Care Practice Recommendations
9. Involvement, emotional support, and assistance for family caregivers	Caregiver Support (and Patient Safety)	**Caregiver Education and Support**	Caregiver Support Resources	
10. Prevention and mitigation of behavioral and psychological symptoms of dementia	Screening for Depression; Depression Treatment	**Neuropsychiatric Symptom Assessment**; **Management of Neuropsychiatric Symptoms**; Screening for Depressive Symptoms	Understanding Decision-making Capacity for Care Planning & Resource Allocation	Ongoing Care for BPSD and Support for ADLs
11. Safety for the person with dementia	(Caregiver Support) and Patient Safety; Driving Privileges; Restraints	**Counselling Regarding Safety Concerns**; Counselling Regarding Risks of Driving	Safety Resources	
12. Therapeutic environment, including modifications to the physical and social environment of the person with dementia				Supportive and Therapeutic Environment
13. Care transitions				Transition and Coordination of Services
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			Information, Referral, and Assistance Services Capable of Meeting the Unique Needs of Persons with Dementia and Caregivers	
			Options Counselling and Assistance	
			Resources for Diverse and Underserved Persons with Dementia and Caregivers	
			Self-directed Services	
			Workforce Training and Tools	Workforce
			Quality Assurance Systems	

Medicare's Cognitive Impairment Assessment and Care Planning Code: *Alzheimer's Association Expert Task Force Recommendations and Tools for Implementation*

alzheimer's association

alz.org/careplanning | 800.272.3900

Domain	Suggested measures
Cognition	Mini-Cog GPCOG Short MoCA
Function	FAQ (IADL), Katz (ADL), Lawton-Brody (IADL)
Stage of cognitive impairment	Mini-Cog + FAQ Dementia Severity Rating Scale
Decision-making	3-level rating: able to make own decisions, not able, uncertain/needs more evaluation
Neuropsychiatric symptoms **Depression**	NPI-Q BEHAVE 5+ PHQ-2
Medication review and reconciliation	Med list + name of person overseeing home meds
Safety	Safety Assessment Guide