**Background**

**Serious Illness**

- **What is serious illness?**
  - “...a health condition that carries a high risk of mortality AND either negatively impacts a person’s daily function or quality of life, OR excessively strains their caregivers.”

- **Who is included in the serious illness population?**
  - Cancer (poor prognosis, metastatic, or hematologic)
  - Advanced liver disease or cirrhosis
  - Other conditions + markers of advanced state
    - COPD + using home oxygen or hospitalized for the condition

- **What care does this population require?**
  - Identifies a population of patients and caregivers who need primary or specialty palliative care services.

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1. NQF Serious Illness Initiative
2. Quality Measurement Committee
3. Presentation for the C-TAC Summit
4. October 3, 2018
5. This project is funded by the Gordon and Betty Moore Foundation.
Background
Serious Illness and Accountability

▪ A growing number of programs and models are designed to target palliative services to individuals with serious illness. To name just a few...

<table>
<thead>
<tr>
<th>Programs</th>
<th>Models</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna Compassionate Care Program</td>
<td>Patient &amp; Caregiver Support for Serious Illness Model (AAHPM)</td>
</tr>
<tr>
<td>Mass General Hospital’s ELEOS Program</td>
<td>Advanced Care Model (C-TAC)</td>
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</table>

▪ Tools for assessing the quality of care delivered to the this population and a comprehensive approach to accountability for programs and providers caring for the seriously ill are lacking.

NQF Serious Illness Initiative
Goals

▪ The Initiative seeks to advance the quality of care delivered to the seriously ill by:

  ▪ *Advancing serious illness-related quality measurement and advance use of serious illness-related quality measures in public reporting and value-based payment programs*

  ▪ *Preparing providers to use serious illness-related quality measures*

  ▪ *Engaging and activating stakeholder groups to accelerate the alignment of incentives and quality measures within serious illness care*
NQF Serious Illness Initiative
Goals and Timeline

1. Advance Measurement
   • **Serious Illness Quality Alignment Hub**
   • Convene a Quality Measurement Committee
   • Host a series of Measurement Strategy Sessions

2. Prepare Providers
   • Develop a Serious Illness Playbook for providers

3. Engage and Activate Various Stakeholder Groups
   • Host Annual Stakeholder Summits

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**Introduction to the Serious Illness Quality Alignment Hub**
What do we mean by “serious Illness?”

Serious illness is a health condition that carries a high risk of mortality and either negatively impacts a person’s daily function or quality of life or excessively strains caregivers.

Conditions include:
- Cancer
- Renal failure
- Dementia
- Advanced liver disease
- Diabetes w/complications
- ALS
- AIDS
- Hip fracture
- COPD w/oxygen
- CHF w/hospitalization
- Advanced frailty

What do we mean by “high quality care?”

- Proactive identification and comprehensive assessment of the target population
- Patient and family goals-of-care clarified over time and communicated to full care team over time
- Informed and engaged patients and families, understanding what “high quality care” entails and demanding it
- Palliative care programs adherence to national guidelines
- Access to specialty palliative care teams for the most complex patients
What are the accountability systems?

<table>
<thead>
<tr>
<th>Accountability Systems</th>
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</thead>
<tbody>
<tr>
<td>CMS oversight of Medicare Advantage (MA) plans</td>
</tr>
<tr>
<td>CMS requirements and incentives for health care providers</td>
</tr>
<tr>
<td>Center for Medicare and Medicaid Innovation (CMMI) model requirements and measures</td>
</tr>
<tr>
<td>Accreditation and certification program standards and measures</td>
</tr>
<tr>
<td>Health Plan network credentialing and financial incentives</td>
</tr>
<tr>
<td>Accountable Care Organization (ACO) infrastructure and network management</td>
</tr>
<tr>
<td>State regulation of health plans and providers</td>
</tr>
<tr>
<td>Purchaser demands on health plans, ACOs and vendors</td>
</tr>
<tr>
<td>Public opinion/public awareness</td>
</tr>
<tr>
<td>Provider quality improvement/quality assurance structures</td>
</tr>
</tbody>
</table>

How the Hub Operates

National Serious Illness Projects
- Information sharing
- Collaboration
- Resource sharing

National Strategic Plan

Quality Measurement Committee
- Measures identification
- Recommendations to fill measurement gaps and overcome challenges

Operations and Opportunity Investigations
- Fact finding
- Interviews
- Field Input

Accountability Committee
- Review Opportunities for:
  - Feasibility
  - Impact
National Serious Illness Projects

<table>
<thead>
<tr>
<th>Project</th>
<th>Organization</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Consensus Project Clinical Practice Guidelines</td>
<td>National Coalition for Hospice and Palliative Care</td>
<td>Develop 4th Edition, spanning settings and including evidence review</td>
</tr>
<tr>
<td>Serious Illness Care Measures</td>
<td>National Committee for Quality Assurance</td>
<td>Develop structure, assessment, and patient-reported measures</td>
</tr>
<tr>
<td>Purchaser Toolkit for High-Quality Serious Illness Care</td>
<td>Catalyst for Payment Reform and CAPC</td>
<td>Develop tools for employers/others to specify competencies needed in their health plans and provider networks</td>
</tr>
<tr>
<td>Measures of Care Experience for Seriously Ill Individuals</td>
<td>RAND Corporation</td>
<td>Develop and test new survey questions specific to the experience of care for those with serious illness, family, and caregivers</td>
</tr>
<tr>
<td>CMMI Advanced Alternative Payment Model</td>
<td>AAHPM and CTAC</td>
<td>Advance the development of an APM for the concurrent care of Medicare beneficiaries with serious illness</td>
</tr>
<tr>
<td>Denominator Definition</td>
<td>Icahn School of Medicine at Mount Sinai</td>
<td>Develop a methodology to proactively identify appropriate populations using claims data</td>
</tr>
<tr>
<td>Mapping Community-based Palliative Care</td>
<td>CAPC</td>
<td>Identifying palliative care programs in home, office, and nursing home settings</td>
</tr>
<tr>
<td>Advancing Quality &amp; Transparency</td>
<td>NOF</td>
<td>Convene stakeholders to define best measures and next steps in quality measurement</td>
</tr>
<tr>
<td>Policy Recommendations</td>
<td>Bipartisan Policy Center</td>
<td>Convene stakeholders to define policy barriers to access and quality, as well as recommendations to overcome</td>
</tr>
<tr>
<td>Palliative Care Quality Collaborative</td>
<td>AAHPM</td>
<td>Create single quality registry for palliative programs, for benchmarking and quality improvement</td>
</tr>
<tr>
<td>Resource Hub for State Policymakers</td>
<td>National Academy for State Health Policy</td>
<td>Collect and disseminate options and examples for state health policymakers to improve access and quality</td>
</tr>
<tr>
<td>Legislative Strategy Options</td>
<td>The Sheridan Group</td>
<td>Define “hooks” and opportunities to advance federal policy supportive of access and quality</td>
</tr>
</tbody>
</table>

Hub Member Organizations

- AARP
- Accountable Care Learning Collaborative (ACLC)
- American Academy of Hospice and Palliative Medicine (AAHPM)
- Blue Cross Blue Shield Massachusetts
- Blue Shield California
- Catalyst for Payment Reform (CPR)
- Center to Advance Palliative Care (CAPC)
- Centers for Medicare & Medicaid Services (CMS)
- Cerner
- Coalition to Transform Advanced Care (CTAC)
- Discern Health
- Duke-Margolis Center for Health Policy
- Epic
- John D. Stoeckle Center for Primary Care Innovation
- Johns Hopkins University School of Medicine
Hub Member Organizations (cont.)

➔ Mount Sinai School of Medicine
➔ National Academy for State Health Policy (NASHP)
➔ National Coalition for Hospice & Palliative Care
➔ National Hospice & Palliative Care Organization (NHPCO)
➔ National Patient Advocate Foundation (NPAF)
➔ National Committee for Quality Assurance (NCQA)
➔ National Partnership for Women and Families
➔ National Quality Forum (NQF)
➔ Network for Regional HC Imp (NRHI)
➔ Optum Supportive Care
➔ Oregon Health & Science University (OHSU)
➔ Peterson Center on Healthcare
➔ RAND Corporation
➔ The Joint Commission (TJC)
➔ UCSF

Quality Measurement Committee

Looking Back....

<table>
<thead>
<tr>
<th>Year 1 Activities and Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Committee Meeting Results</td>
</tr>
<tr>
<td>Identified Priority Areas Year 1: Denominator Problem &amp; Patient &amp; Caregiver Experience</td>
</tr>
<tr>
<td>Developed draft Guiding Principles to address the lack of guidance on approaches to identifying individuals with serious illness</td>
</tr>
<tr>
<td>Shared Committee Member work related to Priority Areas: RAND’s Development of an Experience Survey for Individuals with Serious Illness</td>
</tr>
<tr>
<td>Provided feedback on the Guiding Principles for Identifying Individuals with Serious Illness</td>
</tr>
<tr>
<td>Engaged in prioritization of quality measures and measures concepts</td>
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</tbody>
</table>

Measurement Strategy Session Results

Developed draft Guiding Principles to address the lack of guidance on approaches to identifying individuals with serious illness
Quality Measurement Committee

Looking Ahead..

<table>
<thead>
<tr>
<th>Year 2 Activities and Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Committee Goals</strong></td>
</tr>
<tr>
<td>Finalize recommendations for prioritized quality measures and measures concepts</td>
</tr>
<tr>
<td>Continue to share updates on Committee Members related work</td>
</tr>
<tr>
<td>Develop recommendations for integrating the work of the Accountability and Quality Measurement Committees</td>
</tr>
<tr>
<td><strong>Measurement Strategy Session Results</strong></td>
</tr>
<tr>
<td>Develop recommendations for advancing the development of the prioritized measures concepts</td>
</tr>
</tbody>
</table>

References

PTAC Serious Illness Patient Eligibility Criteria

<table>
<thead>
<tr>
<th>Program Purpose</th>
<th>Criteria for Identifying the Seriously Ill</th>
<th>Data Sources</th>
<th>Challenges to Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced Care Model (C-TAC)</td>
<td>Acute care utilization: Performance status (PPS)</td>
<td>Claims</td>
<td>• Performance status and functional and nutritional decline not captured in claims/admin data if no SNF (MDS) or home health (OASIS) stay or DME claim</td>
</tr>
<tr>
<td></td>
<td>Functional decline (ADLs)</td>
<td>EHR &amp; admin data*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nutritional decline (wt. loss)</td>
<td>EHR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prognosis (surprise question)</td>
<td>EHR</td>
<td></td>
</tr>
<tr>
<td>Patient And Caregiver Support for Serious Illness (AAHPM)</td>
<td>Acute care utilization: Performance status (PPS, ADL or DME)</td>
<td>Claims</td>
<td>• Cannot identify a comparison group using only claims/admin data</td>
</tr>
<tr>
<td></td>
<td>Diagnosis or multiple chronic conditions (criteria different for cancer vs. non-cancer)</td>
<td>EHR &amp; admin data*</td>
<td>• Limited accuracy of clinician prognosis estimates</td>
</tr>
</tbody>
</table>

- **Claims**: EHR & admin data
- **Claims**: EHR
- **Claims**: *If admin data includes OASIS, MDS, or DME

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**Severities of Illness**

- Healthy or Reversible Disease
- Chronic Early Disease
- Progressive To Frequent
- Death

**Chronic Disease Management**

- Anticipatory Care
- Palliative Care
- Hospice
- Family Bereavement

**Health Progression**

- Identification of chronic disease
- Disease progression with increased interference with quality of life. Anticipate use of the hospice for disease exacerbations in the future
- Potential non-elective hospice transition due to chronic disease exacerbations, continued decline in performance status
- Prognosis 6 months

**Advance Care Planning**

- Entry to Sharp AV
- Initiate Care Coordination
- Transition to Palliative Care or CCP
- Hospice