Person-Driven Outcomes

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Problem

What is the challenge?

State Medicaid & IDD agencies are approaching IDD quality of care in **silos**, resulting in **non-standardized** accountability structures.

This **fragmentation** will continue to **exacerbate** as more states integrate IDD in managed care and aging population grows.

National interest - especially from multistate IDD providers –to eliminate this fragmentation!

Long-Term Services and Supports (LTSS) quality framework

Structure

NCQA Evaluation Products

- *LTSS Distinction*
- *Case Management LTSS Accreditation*

Process

HEDIS Managed LTSS Measures

- *Comprehensive Assessment*
- *Comprehensive Care Plan*
- *Shared Care Plan*
- *Reassessment and Care Plan Update after Inpatient Discharge*

Outcome

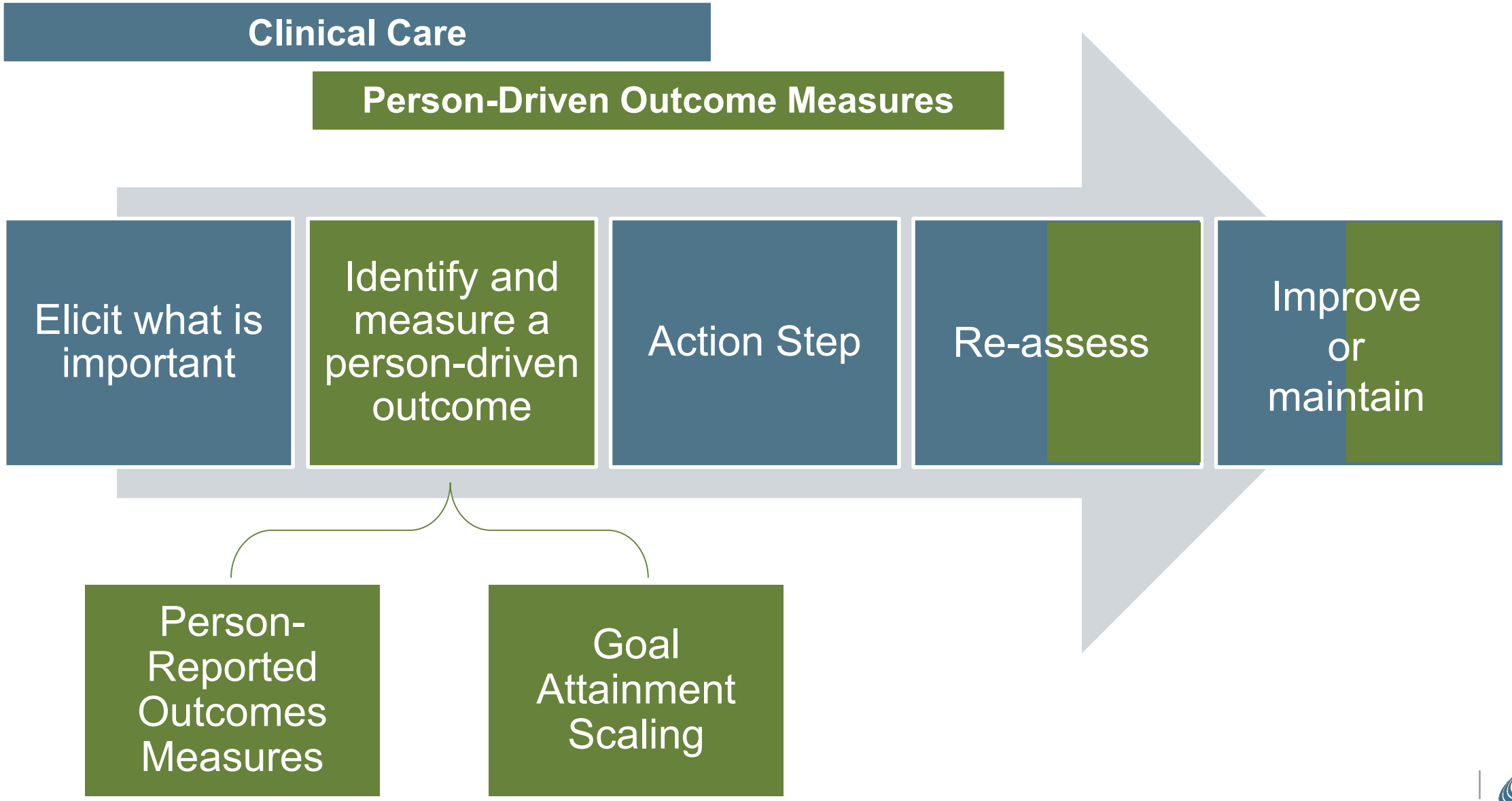
Person-Driven Outcome Measures

- *Assessment of a Person-Driven Outcome Measure*
- *Follow-Up on a Person-Driven Outcome Measure*
- *Achievement of a Person-Driven Outcome Measure*

Person-driven outcomes measure “What Matters Most”

Person-Driven Outcomes
Outcomes identified by the individual (or caregiver) as important that can be used for care planning and quality measurement

Person-driven outcome measures integrate clinical care and measurement



Proposed Person-Driven Outcome Measures

	Numerator	Denominator
Assessment of a Person-Driven Outcome	Documented person-driven outcome, using goal attainment scaling or person-reported outcome measure, AND a documented plan for achieving their individualized outcome	Individuals with an identified complex care need
Follow-up on a Person-Driven Outcome	Documented follow-up on the person-driven outcome within 180 days from the start of the measurement period	Individuals with an identified complex care need who had a documented person-driven outcome
Achievement of a Person-Driven Outcome	Documented achievement of the person-driven outcome (which can be maintaining or improving) within 180 days from the start of the measurement period.	Individuals with an identified complex care need who had a documented person-driven outcome and follow-up.

Summary of Project Participants

Pilot (2015-2017), Functional Disability Project (2018-2020), Serious Illness Project (2018-2020)

Medicaid Case Management	Case Management	Geriatric and Serious Illness Programs
•Case Management in MMP •Case Management in D-SNP •Case management in Medicaid plan with a health home program	•Case management in Medicare Advantage plan •Case management in an integrated delivery system •Case management in accountable care organization	•Geriatric Primary Care Practice (3) •Hospice system •Serious Illness Programs (3)
25 Clinicians, 142 Patients	**33 Clinicians, 373 Patients**	**45 Clinicians, 794 Patients**

Testing Results: Variability among sites in measure performance

Measure	Four Functional Disability Sites (n=384)	Four Serious Illness Sites (n=679)
Follow-up on a Person-Driven Outcome	62% Range: 24% to 83%	77% Range: 41% to 87%
Achievement of a Person-Driven Outcome	66% Range: 40% to 82%	61% Range: 54% to 67%

- Variation noted in follow up and goal achievement by different sites
- For the functional disability sites, using claims data, we compared the number of patients in intervention and control groups with at least one visit to the hospital or ED 6 months before and after the intervention was implemented. Intervention group experienced a significant decrease in hospitalization rates 6 months after the intervention, and a non-significant decrease in ED visits.

Key Takeaways

- Novel approach to measuring what matters most to individuals
- Pushes practice delivery change towards care that matters
- Can be used for care planning and quality measurement
- Working towards implementing these measures in digital environment

Thank you

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