CMS QUALITY CONFERENCE 2021 SUMMARY

Discern Health staff attended the virtual 2021 CMS Quality Conference from March 2-3. This document provides staff's summary notes from select conference sessions.

About the Event

The CMS Quality Conference convenes leaders across the health care spectrum, to explore how patients, advocates, providers, researchers, and champions in health care quality improvement can develop and spread solutions to address America's more pervasive health system challenges.

This year, themes included COVID response, addressing health inequities, identifying high value quality measures, lessons from value-based programs, reducing administrative burden, quality improvement innovation methods, and using data for actionable insights and impact.

Under the Biden administration, healthcare quality is still a key aspect of CMS' activities, which can be seen in CMS':

- Quality Action Plan: An ongoing, multi-year strategy that aims to advance the CMS vision for the future of quality and to change the healthcare system to meet the needs that are being faced
- Quality Vision: Using impactful quality measures to improve health outcomes and deliver value by empowering patients to make informed care decisions while reducing burden to clinicians
- Quality Strategy:
    - Using **Meaningful Measures** to streamline and align quality measurement
    - Leveraging **measures** to drive **improvement** through public reporting and payment programs
    - Improving quality measures efficiency by a transition to **digital measures** and use of **advanced data analytics**
    - Empowering consumers to make best healthcare choices through patient-directed **quality measures** and **public transparency**
    - Leveraging **quality measures** to promote **equity** and close gaps in care

As CMS' Medicare and Medicaid quality related policies have relevance for patients, providers, payers, and other healthcare stakeholders, Discern is happy to share our expertise on these core quality, measurement, and value-based care topics.

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March 2, 2021

Under Construction: Road to 2024

***Speakers**: Virginia (Gigi) Raney, LCSW (Center for Medicaid and CHIP Services), William Golden, MD (Arkansas Medicaid/Arkansas Office of Health Information Technology), Anne Santifer (Arkansas Medicaid/Arkansas Office of Health Information Technology)*

- Adult and child Medicaid quality measurement has only been developed over the last decade
  - Partnering with state Medicaid and CHIP programs, CMS is preparing for portions of the program to become mandatory in 2024
  - 2024 reporting will be mandatory for national Child QMP and Adult Behavioral Health measures
  - The number of measures reported by states has increased since 2010
  - States use data to make informed decisions and work to improve care and lives of beneficiaries
- There has been a national core measure set for children and adults that are reviewed and revised on a regular basis for effectiveness
  - CMS wants a national set to compare states
  - There is a variation in the number of measures states report
  - 16 states reported at least 22 Child Core Set measures for FY 2019
  - There was concern about states being ready to report mandatory core set measures in 2024
- Arkansas has been working on measures for quite some time and has a large administrative claim set with a good data partner
  - Also use surrogate measures that are calculated by the CDC across all states, given to CMS, and used in lieu of Arkansas calculating the measures themselves
  - Chart review is expensive and time-consuming that is a burdensome way to calculate measures
  - Health Information Exchanges are a new way to extract and create new datasets
- Local environments are different and cause a diversity in reporting, such as:
  - Fee-for-service vs. managed care organizations
  - Formularies vs. PBMs
  - Local coding requirements
  - Global billing
  - Analytic capacities
  - Identified vs. de-identified data
  - Health Information Exchanges (HIEs)
- Measures should have the following traits:
  - Value to provider community and are actionable
  - Have face validity
  - Minimize burden

- Arkansas has had a fee-for-service PCCM service for decades and have a large, sophisticated data warehouse
    - State was an early implementation site for CMMI for alternative payment models
    - CPC+ and CPC classic state
    - Statewide voluntary patient centered medical home (PCMH)
- Arkansas HIE
    - State agency within the health department that was created through an act during the legislative session around 2012
    - Inclusion as part of a government office makes it more sustainable
    - Access to federal funds through Medicaid
        - Charges fee to users to make federal match back
        - No cost to the state
    - Special agreements with Arkansas Department of Health
        - Opened up HIE data to epidemiologists to better forecast and manage COVID-19 during pandemic
    - Try to keep costs low to encourage participation
    - Provide services to providers
        - Daily admission, discharge, and transfer report
        - Daily COVID reports
        - Public health reporting
        - Bi-directional immunization registry query
        - 30-day readmission report
    - About 75% of hospitals are part of HIE in Arkansas
    - Around 1,200 providers send and receive data via the HIE and another 1,000 just retrieve data
    - Part of eHealthExchange to connect with Veterans Affair and Department of Defense data
    - Partnership with most private health plans
    - Working on a master data agreement with other state agencies to reduce the data silo
    - Arkansas is an “opt-out” state which means everyone is included in HIE unless they choose to opt-out
        - Worked with Centers of Health Literacy to craft informational flyers on what it means to participate in the HIE that is displayed in provider waiting rooms
- Arkansas uses financial incentives for measurement
    - Performance bonuses for metrics tied to excellent performance
    - Tollbooth incentives require providers to pass an average performance to qualify for excellent performance measure incentives
    - Minimal performance can jeopardize funding for medical home program or PMPM
        - Improved rate of infant wellness visits for PCMHs in a two-year span
- HIE has become a clearinghouse to reconcile data duplications and coding problems and ensure one record for one patient
- Lessons learned about big data
    - Analytics are essential, but maintenance and accuracy can be demanding

- HIEs can reduce the lag time of data and produce real time reports
- Big data can help to provide the patient journey and what happens outside of a health system
- Sometimes there has to be workarounds to make missing or clunky data useful

- The future of data
  - Providing data that drives performance in timely feeds
  - FHIR data extraction at scale with greater granularity
  - New data partnerships
    - Medicaid is partnering with HIE
    - HIE partnering with other payers

COVID-19 Response and Recovery: Identifying and Addressing Health Inequities

Speakers: *CAPT Wanda Finch (Deputy Director, CMS Office of Minority Health); Kevin Hodges (Deputy Director, Information Products and Analytics Group, Office of Enterprise Data and Analytics CMS), Christa-Marie Singleton Associate Director for Science, Chief Health Equity Officer Unit, CDC COVID-19 Response), Laura Benzel (Qlarant, IPRO QIN-QIO Project Manager and Health Equity Subject Matter Expert)*

Kevin Hodges (CMS)

- Office of Enterprise Data and Analytics (OEDA) within CMS produces numerous information products on provider payment, utilization, opioid prescribing, etc.
- Spring 2020: in response to COVID, OEDA developed a new information product to highlight the impact of COVID on Medicare population
  - Released first version of snapshot in June
    - https://www.cms.gov/research-statistics-data-systems/preliminary-medicare-covid-19-data-snapshot
    - Focus on Medicare beneficiaries with COVID: cases and hospitalization
    - Shows geography, dual eligible, reason for entitlement, age, race/ethnicity
    - Through Nov, 2020 we see 1.9 M cases and 500K hospitalizations in the Medicare population
    - Includes discharge status and length of stay
    - For FFS population, we also have data on chronic condition prevalence and Medicare spending
    - Based on admin claims for diagnosis
    - Before April there was no COVID code; so was using a coronavirus unspecified code
    - Allowing for 1 month of claims run out
    - Have brought together FFS payment information with MA encounter data; which we don't usually do.
    - Snapshot available that shows hospitalization rates by state
    - Can look at the hospitalizations by demographic characteristics such as age, race/ethnicity, dual eligibility status, rural/urban
    - Disparities seen across demographic characteristics

Laura Benzel (Qlarant-QIO)

- QIO covering 11 states in the northeast
- Focus areas: behavioral health & opioid, patient safety, chronic disease self-management, care transitions, nursing home quality
- 4 cross cutting priorities: HIT, vulnerable populations and disparities, patient engagement, rural health
- Recruit providers to achieve 5 areas over 5 years
- Focus on medically underserved areas, rural communities, disparities
- For nursing homes, focus on rural and vulnerable
- QIN QIO work shifted to focus on COVID
- Dashboard used to understand the nursing home, its demographics, performance on measures, etc.
- Support for nursing homes (no cost to them)
    - Infection control and prevention
    - COVID targeted response QI initiatives
    - Nursing healthcare safety network
    - AHRQ ECHO national nursing home COVID 19 Action network
    - Pharmacy partnership for long terms care program
    - Vaccine tools and resources for staff residents and families
    - Opioid and pain mgmt. best practices
- Best practices
    - Disseminate tools related to challenges such as vaccine hesitancy: Language that works to improve vaccine acceptance
    - Bi-weekly seminars
    - Health equity resources
    - SWEEPs: Strategic Web-Based Education and Engagement Plan
        - In progress:
            - Behavioral health integration in primary care
            - Opioid and pain management best practices

Christa-Marie Singleton (CDC)

- Addressing health equity
    - COVID-19 and health equity strategy
    - Enhancing data collection
    - Vaccine challenges and opportunities
    - The road ahead
- Racial and ethnic minority population health equity considerations
    - Discrimination, including racism
    - Healthcare access and utilization
    - Occupation
    - Educational, income, and wealth gaps
    - Housing
- Influential factors to medical care
    - Barriers to care

        - Health insurance coverage
        - Unreliable transportation
        - Stigmatization language in medical practices and materials
        - Access to medical resources
- Chief health equity office
    - Charge
        - Develop a CDC COVID-19 response health equity strategy to address the increasing health disparities and inequities that the pandemic exacerbated
        - Coordinate efforts with HHS and redouble CDC's commitment to diversity, equity, and inclusion to help CD achieve its public health mission
- CDC; why a health equity strategy
    - COVID may contribute to exacerbating already existing health and social inequities
    - Data highlights groups at risk of COVID 19
- Response health equity strategy
    - 1: Expand the evidence base with data to inform the impact and factors that influence the burden of COVID on disproportionally affected populations
    - 2: Expand programs and practices to reach populations that have been put at increased risk
    - 3: Expand program and practice activities to support essential and frontline workers to prevent transmission of COVID-19
    - 4. Expand inclusive workforce equipped to assess and address the needs of an increasingly diverse US population
- CMS/CDC opportunities for race/ethnicity data collection
- CMS opportunities for race/ethnicity data collection
    - Collects and publishes info by race and ethnicity for MA plans
    - Targets QI activities and monitors health and drug plan performance
    - Advances culturally and linguistically appropriate interventions and strategies
- CDC opportunities
    - Encourages the collection of data to understand the impact and factors influencing the disproportionate burden of COVID on populations
    - Supports data collection on testing, incidence, vaccination, and sever outcomes by race/ethnicity, considering age and sex differences
- Defining vaccine confidence
    - Trust that patients, parent, or providers have in
        - The vaccines
        - Providers
        - Process/policies that lead to development, licensure, manufacturing, and recommendations for us
    - Data from Kaiser Family Foundation COVID-19 Vaccine Monitor; Dec 2020
        - Asked; which are the trusted advisors? This was the order of response from most to least
            - Personal provider

        - CDC
        - Local health dept
        - FDA
        - Fauci
        - State govt officials
        - Biden
        - Pharma
        - Trump
- What is CDC is doing
    - Assist public health agencies
    - Facilitating partnerships
    - Assisting impacted communities
    - Supporting essential workers
    - Developing culturally tailored guidance
    - Building inclusive workforce
    - Tracking disparity data
- FACT: The COVID-19 Facilitating Acceptance with Community-Based Trusted Messengers (FACT) Alliance
    - Strengthening intersectoral partnerships to support COVD-19 and influenza vaccine confidence in communities
    - Listening sessions
        - Goal: collect data to ensure minority groups and rural populations receive accurate, timely, and culturally responsive COVID-19 messages
        - Engage communities to build trust and partnerships for effective implementation
        - Understand challenges, barriers, and opportunities to successfully address health needs
        - Identify efficiently address myths and misinformation
        - Connect with trusted individuals in the community when developing outreach or media materials
        - Ensure COVID-19 vaccine information for beneficiaries are clear, effective, and appropriate
    - Working together to prevent spread and promote equity
        - Community and faith-based organizations
        - Employers
        - Health delivery systems
        - Public health agencies
        - State, tribal, local, and territorial governments

Optimizing Telehealth for Kidney Transplant

- 108,321 people currently on organ transplant waitlists (91,582 Kidney)
- University of Cincinnati transplant program
  - April 2020 survey
    - Living donor transplants decreased by ~90%
  - UC transplant coordinated role conceptualized in 2011, hired in 2018
    - In the pandemic, goal was to screen referrals w/o delays and continue patient outreach using telehealth tools
    - Setting up MyChart was a challenge before 2020, became a requirement during pandemic
    - Needed to learn new EPIC visit codes
    - Needed to establish patient consent verbally
  - Benefits of transplant outreach telehealth
    - Safe care, minimal physical exposure, least intrusive means of evaluation
    - Patient and families more open to communication
    - Reduced commitment burden of visiting transplant center
    - Provided easy access to health care (nearly 0 no-show rate compared to usual 20-30%)
    - Center was able to filter more referrals
  - Jan - Jun 2019 vs. Jan - Jun 2020
    - 16% increase in evaluation referrals
    - 8% increase in kidney transplant listing
    - 7% increase in living donor evaluations
  - Telehealth barriers for patients
    - Tech knowledge, tech access, staff ability to educate
  - Telehealth barriers for patients for provider/system
    - Steep learning curve, missed "personal rapport," lack of physical exam, state licensure issues across state lines
  - Challenges going forward
    - Time consuming process, reimbursement concerns
- Mass General transplant program
  - Spring 2020
    - Immediately transitioned to all virtual, intensive manual process (only 1 patient a day from previous 8 patients a day)
    - Connection/meeting ID issues, lack of resources
  - Summer 2020
    - Epic/zoom integration with new telehealth features and appointment documentation (up to 5 patients a day)
    - Still struggled with signing patients up with electronic tools
    - Staff trainings to explain new tools and epic/zoom updates
    - Lacked enough electronic devices for staff

- Fall 2020
  - Began utilizing a zoom waiting room, more patients and providers were comfortable with virtual platform. Added support persons and interpreter services
  - Struggled with check-in process, scheduling, working through referral backlog
- Provider benefits
  - See patients in home environment, more scheduling flexibility, fewer no shows, increased family engagement
- Patient benefits
  - No city commutes
  - Ability to include family/friends
  - Easy access to prescription medications during appointment
  - More scheduling flexibility
- Provider challenges
  - Consent forms, physical exam, frailty/mobility test
- Patient challenges
  - Had to complete lab work individually

The Path to Alignment: Identifying High Value Measures

***Speakers**: Michelle Schreiber, Nidhi Singh Shah, Danielle A. Lloyd, Karen Matsuoka, Pierre Yong*

- Introduction
  - Goal: Use impactful quality measures to improve health outcomes and deliver value by empowering people to make informed care decisions while reducing burden to clinicians.
  - The role of quality measures
    - Provides information to beneficiaries to make informed healthcare choice
    - Creates level of accountability through transparency and payment
  - Stakeholders have expressed concerns
    - Issues of too many and issues of too few
    - Measures lack alignment in purpose, definition
    - Process vs. outcomes
    - Burden to providers
    - Not well understood by patients/consumers
- Identification of high-value measures
  - Meaningful Measures 2.0
    - Utilize only quality measures of highest value and impact focused on key domains
      - Person-centered care, safety, chronic conditions, coordinated care, equity, affordability & efficiency, wellness & prevention, behavioral health
    - Align measures across value-based programs and partners, including CMS, federal, and private entities
    - Prioritize outcome and patient reported measures

        - Transform measure to fully digital by 2025 and incorporate all-payer data
        - Develop and implement measures that reflect social and economic determinants
    - Quality Measure Action Plan
        - Use Meaningful Measures to streamline and align
        - Leverage measures exposure through public reporting and in payment programs
        - Improve measure efficiency by through digital measures and using advanced data analytics
        - Empower patient decision making with patient-directed measures and public transparency
        - Leverage measures to improve equity and close care gaps
- Identification of measure impact
    - Quality Measure Index (QMI)
        - Tool that provides an objective and standard methodology to rapidly assess the relative value of quality measures in achieving CMS strategic objectives
        - Addresses GAO recommendations for alignment
        - Streamlines and standardizes required measure information
        - Helps CMS prioritize measures
        - Enhances measure selection process
        - Adaptable over measure lifecycle and measure settings
    - Classification Variables – data used to stratify and group measures for evaluation
        - Meaningful Measures Classification
        - Measure Type
        - Composite Measure
        - Measure Submission Method
        - NQF Endorsement Status
        - Development Phase
        - Digital Measure
    - Scoring variables – range 0-100 with high, medium, low impact thresholds
        - Importance
            - Evidence based, high priority, measure performance, variation in performance
        - Feasibility and usability
            - Patient burden, physician burden, feasibility, shared accountability
        - Scientific acceptability
            - Reliability, validity, risk adjustment
    - Proposed Impact variables – data to assess clinical significance
        - Meaningful to patients
        - Meaningful to clinicians
        - Estimated impact of measures
        - Estimated cost avoided by measure
        - Reach of measure
- Alignment

- Core Quality Measures Collaborative (CQMC)
  - Goals
    - Align measures across public and private payers
    - Identify high-value, high impact, evidence-based measures
    - Improve health outcomes
    - Reduce measure burden
    - Provide patients/consumers with actionable information
  - CQMC core measure sets
    - ACO/PCMH/PC, HIV & Hep C, orthopedics, ob/gyn, cardiology, gastroenterology, medical oncology, pediatrics, behavioral health, neurology
  - Major areas of work
    - Maintenance, standard operations
    - Measurement model alignment
    - Digital measurement
    - Cross-cutting issue
    - Measure gaps and prospective alignment
- Medicaid and CHIP
  - Alignment is more about the signal and the consistency vs. "same" measures
  - Medicaid and CHIP have very different populations than Medicare
  - Medicaid has biggest enrollment by annual enrollment numbers
  - Adult and child core set measure reporting is voluntary in some states
    - Reporting by states improved greatly
    - Overlaying with CDC data when data incomplete
      - Streamlines
      - No additional reporting needed by providers
      - Provides more holistic picture
  - Multilevel measurement drives quality improvement
    - Macro (e.g., core sets)
    - Meso (Managed care quality at MAC level)
    - Micro (clinician level)

- CMMI
  - Three critical domains
    - Impact
    - Alignment
    - Burden
  - Aligned with Meaningful Measures 2.0
  - Focus on use of outcome measures, patient-reported outcomes or patient experience, digital measures, and evaluable measure

Future of the Quality Payment Program: MIPS Value Pathways and APM Performance Pathway

***Speakers**: Molly MacHarris (Program Lead, MIPS, CMS, Center for Clinical Standards and Quality), Brittany LaCoutoure (Health Insurance Specialist, CMS, CCSQ), Sophia Sugumar (Health Insurance Specialist, CMS, CCSQ)*

- Focusing on the future of the quality payment program, as they shift focus toward MIPS Value Pathways (MVPs) and Alternative Payment Models (APM) Pathway (APP)
    - Brief QPP Overview
        - Authorized by Medicare Access and CHIP Reauthorization Act (MACRA) in 2015
        - Repealed the SGR methodology, which would have resulted in significant cuts for Medicare clinicians
        - Authorizes two tracks of QPP (MIPS and Advanced APMs)
        - Advanced APM is a means by which eligible clinicians can avoid participation in MIPS by achieving qualifying participant status in an APM
        - Reward Medicare providers for transforming care; three types of APMs (APMs, MIPS APMs, Advanced APMs)
        - MIPS is made up of four performance categories, and each are weighted differentially (quality = 40%; cost = 20%; IA = 15%; PI = 25%); Categories scores are added together to define MIPS score, and compared to performance threshold in order to determine the payment adjustment
            - Cost and Quality will eventually be 30% each
- MIPS MVP Overview
    - What we've heard from clinicians
        - Current structure and reporting requirements are confusing
        - In some cases, too much choice and complexity
        - Not all measures/activities are relevant to a clinician's specialty
        - Hard to compare performance across clinicians
    - CMS response to feedback
        - Have been incremental changes each year, additional long-term improvements are needed to align w/ CMS' goal to develop a meaningful program
        - Committed to transformation through MVPs
    - MVPs
        - New framework to remove barriers to APM participation
        - Move away from siloed activities with more aligned measure options relevant to scope of practice
        - Promote value by focusing on quality and cost measures and IAs built on foundation of population health measures (claims-based) and PI concepts
        - Seeking to reduce reporting burden and keep patients at the center of this work
        - Anticipate clinicians will report on fewer measures and activities that are more meaningful to their specialty/sub-specialty

    - Future state – fully implement pathways and improve the type of performance feedback to better deliver care to patients
- What will MVPs Do?
    - Provide enhanced data to clinicians
    - Analyze existing Medicare information to provide clinicians and patients with more information to improve health outcomes
    - Reduce reporting burden by limiting the number of required specialty or condition-specific measures
- Future of MIPS with MVPs
    - Recognize concerns with timeline; will implement incremental process that will not immediately eliminate the current MIPS framework
    - CMS committed to working with stakeholders on implementing MVPs
- MVP updates
    - Did not propose MVPs for 2021; earliest date is possibly in 2022 performance period; anticipate working closely with stakeholders regarding this process
    - Finalized guiding principles for MVPs to recognize patient voice and promoting digital performance measure data submission
        - Previously finalized in 2020 rule; updated principles in 2021 to align with evolving vision of MVPs
    - Also finalized criteria to be considered when creating MVP candidates for 2022 performance period
        - Highly encourage inclusion of the patient voice as part of the MVP development process; measures and activities that reflect the patient voice (PROs, shared decision making, patient experience and patient safety)
        - Want to ensure quality measures align with existing MIPS inclusion criteria; would need to go through existing MIPS call for measures process
        - Want to be mindful as not to increase burden with fewer collection methods for measurement
        - QCDR measures must be fully tested at time of submission to be considered
        - Cost measures must be related to the other measures included in the MVP, or utilize broadly applicable cost measures and consider what future cost measures are needed
    - Process for MVP submission; in December held a webinar and outline criteria, timeline, and submission process for MVPs
        - Stakeholders will formally submit using the template document; CMS will review against criteria; once feasible candidates are identified, reach out to submitter to discuss feedback on the candidate; anticipate iterative dialogue process about possible changes to ensure candidates align with criteria
            - Won't be able to communicate about whether candidates are moving forward; will be using rulemaking vehicle to propose future MVPs
- APM APP Overview

- QP determination thresholds are frozen for the next two years
- APP framework is complementary to MVPs and is intended to create maximum flexibility for MIPS APM participants
- Optional reporting pathway made of fixed set of quality measures designed to be applicable to as many MIPS APM participants as possible
    - MSSP requires reporting of the APP for participation in that program; MSSP participants may choose to report outside the APP for the purposes of MIPS scoring if they believe it is appropriate to do so
- Any MIPS APM participants can report via the APP, but it is only available to participants in MIPS APMs
    - Because of this, CMS waived the cost reporting requirements for any APP reporting participants (because they are participating in APMs with cost incentives); PI is reweighted to 30%; IA is reweighted to 20%
        - APP reporters automatically receive the full IA score based on their APM participation
        - PI is reported at the individual or group level, or rolled up to the APM level
- Delayed sunsetting of CMS Web Interface until 2022 due to COVID health emergency; included Web Interface as a reporting option for MSSP ACOs required to report the APP

- Help and Support
    - CMS held a virtual town hall on Jan 7 to share policy considerations for MVPs
    - CMS is using the feedback to evaluate policies on MVP framework
    - Materials from town hall are on the CMS QPP website (webinar library and dedicated MVP website)
    - New website for APM APP on QPP website
- Q&A
    - Announced last week, CMS is applying extreme and uncontrollable circumstances to all individual MIPS ECs for 2020 – all performance categories will be reweighted to zero percent
        - Reopened for groups, virtual groups, and APMs
    - Will MVPs be mandatory or will clinicians have the option to remain in traditional MIPS?
        - For first few years of MVPs, anticipate MVPs to be voluntary, and allowing for the continuation of traditional MIPS as they implement them in the program
        - Haven't decided whether traditional MIPS will be sunsetted
    - As PHE affects quality and cost categories, and will do so for most of 2021, will CMS consider a reset of these categories?
        - Issued additional flexibilities for 2020 and re-opened application for non-individual MIPS participants
        - Have already announced they will offer the extreme and uncontrollable application for 2021; anticipate this will happen after submissions close
        - More information will be announced
        - Can't completely reset categories or lower those weights (determined by statute); performance has already begun for 2021

- What is the advantage of being a partial QP?
  - Partial QP status does give clinicians the exemption from MIPS (does not qualify you for the 5% bonus payment), not subject to downward MIPS adjustment
- How will MVPs work with multi-specialty groups in one TIN? Will we have to submit multiple measures?
  - Cognizant of large specialty groups made up of multiple specialties; should be meaningful to the providers, but data should be meaningful to patients
    - Not always the case with multi-specialty group reporting
    - Sub-group reporting is supposed to address this issue – larger group providers will focus in on MVPs aligned with their clinician groups
    - Haven't addressed yet whether sub-group reporting will be mandatory; have heard several comments through town hall and are taking this into consideration
- How will patients be educated on provider scores?
  - Agency recently re-released the new public reporting experience last year (Care Compare) – consolidated several different Compare sites
  - Patients can look for physician / hospital / group data
  - Provider data catalogue is also published through CMS websites
  - One of the key goals of MVPs is to provide patients with more granular data as they select their physicians
  - More information on the specifics will be provided
- Do we have to report for all payers and all populations for APP?
  - APP is intended to get physicians to report to MIPS in a way that's comparable to all MIPS – so yes, this is required
- APP Web Interface reporting availability?
  - Within the APP, Web Interface reporting is limited to ACOs; not available to groups; can report outside of the APP

March 3, 2021

Medicaid Administrative Data: Availability, Quality and Use

***Speakers**: Kimberly Proctor, PhD (Center for Medicaid and CHIP Services), Shondelle Wilson-Frederick, PhD, (Center for Medicaid and CHIP Services), Karen Llanos, MBA, (Center for Medicaid and CHIP Services), Kate McEvoy, JD, (Connecticut Medicaid)*

- T-MSIS Resources and the T-MSIS Analytic File (TAF)
  - A research-ready version of the T-MSIS data
  - Replaces MAX data as the next generation of Medicaid and CHIP data
  - Includes data on:
    - Beneficiary eligibility and enrollment
    - Fee-for-service claims and managed care service use and spending data
    - Managed care plan and provider information (upcoming)
- T-MSIS (many relational) – feeds to TAF (streamlined for analytic use)—feeds to RIF* (public version of TAF) *RIF (Research Identifiable Files)
- TAF basics:
  - Time period all T-MSIS submissions
  - Calendar year format not fiscal year
  - Date of service not paid date
  - Final action claims
- TAF file types
  - Claims
  - Beneficiaries
  - Managed Care plans
  - Providers
- TAF RIF availability
  - Available
    - 2014-2018
    - Prelim 2019
  - Planned
    - Final 2019
    - Managed Care plan and Provider 2021
    - 2017 & 2018 v2 (corrections, additions)
- What is DQ Atlas
  - Web-based tool that allows users to explore the quality and usability of TAF
  - Helps users understand what topics are usable for which states, territories, and years
  - DQ Assessments, state and topic snapshots, and detailed methodology information are all available
  - Mapped to the TAF RIF releases

        - Currently available for years 2016-2018 and preliminary 2019
        - Supports multiple versions of data years when data are updated (e.g., 2016 Release 1 and 2016 Release 2)
    - DQ Assessment values = low concern, medium concern, high concern, unusable, unclassified
- Uses
    - MACBIS landing page, search by topic, see data by state, can get state snapshots helpful to see priorities and areas of concern
    - TAF & Medicaid & CHIP analytics combine to provide data picture
- Using data to improve quality in Medicaid and CHIP
    - Beneficiary profile
        - Released in March 2020, the Beneficiary Profile provides a comprehensive overview of the characteristics, health status, access, utilization, expenditures, and experience of care of beneficiaries
        - Highlights two special populations
            - People dually eligible for Medicare and Medicaid
            - Children with special health care needs are profiled in depth
            - 2021 update is coming soon!
        - Infographics created to give big picture
            - Selected information from the Beneficiary Profile in a two-page format including:
                - Medicaid expenditures by beneficiary category
                - Self-reported health conditions for adult and children
                - CAHPS information on beneficiary experiences in getting needed care
- Medicaid and CHIP Scorecard
    - Provide greater public transparency about Medicaid & CHIP program administration and outcomes
    - Improve care for Medicaid & CHIP beneficiaries
    - Drive improvements in areas such as state and federal alignment and program administration
    - CMS updates the Scorecard annually with new data and enhancements to the website (3rd release was in October 2020)
    - In an effort to align with existing reporting efforts, many of the measures highlighted in the Scorecard have been included in other public report
    - Example – Antibiotic prophylaxis among Medicaid and CHIP beneficiaries ag 15 months to age 4 with sickle cell disease (SCD)
    - SCD scorecard and infographic
        - National and state-level estimates for SCD among adults and children enrolled in Medicaid and CHIP, who are 75 years old or younger
        - Demographic, health, and healthcare utilization characteristics
- Data included on scorecard
    - T-MSIS derived measures
        - Per capita expenditures

        - Share of Medicaid & CHIP Population by Age
        - Production and Currency Status
    - Medicaid Performance Indicators
        - Medicaid & CHIP Child Enrollment by State
        - Medicaid MAGI and CHIP Application Processing Times
    - Subset of Child & Adult Core Sets
    - Data collected by CMS
        - Managed Care Capitation Rate Review
        - State Use of Experience of Care Survey for Beneficiaries using Long-term Services & Supports
        - State Plan Amendment and 1915 Waiver Processing
- Stakeholder feedback taken in to determine what goes on the scorecard
    - NAMD's Advisory Group: Partners with CMS to identify changes to Scorecard measures and provide other feedback on the future direction of the Scorecard
    - CMS Child/Adult Core Set Stakeholder Committee: Multi-stakeholder committee provides feedback on potential changes to Pillar 1
    - Public Listening Sessions: CMS holds annual public listening sessions to gather non-state stakeholder feedback
    - User Experience Feedback Sessions: CMS holds user feedback sessions to gather feedback on changes and enhancement
- How Scorecard helps states
    - Over 50 data points and measures that are updated annually
    - Centralized place where users can go to see how CMS is leveraging a wide range of state reported and CMS generated data
    - Data are displayed in various ways
        - National context: national and state-specific data on Medicaid & CHIP topics
        - Pillar 1: state-specific quality measures displayed alongside other states for latest reporting year
        - Pillar 2 & 3: national or state-specific rates for different administrative data points and measures
        - State profiles: state-specific quality measures for the latest reporting year
- State perspective
    - Connecticut found scorecard very helpful
    - Medicaid/CHIP and CMS partners very willing to work with states to aid in reporting and new data to inform their quality improvement efforts

Advancing Digital Strategies for Quality Measurement and Improved Care

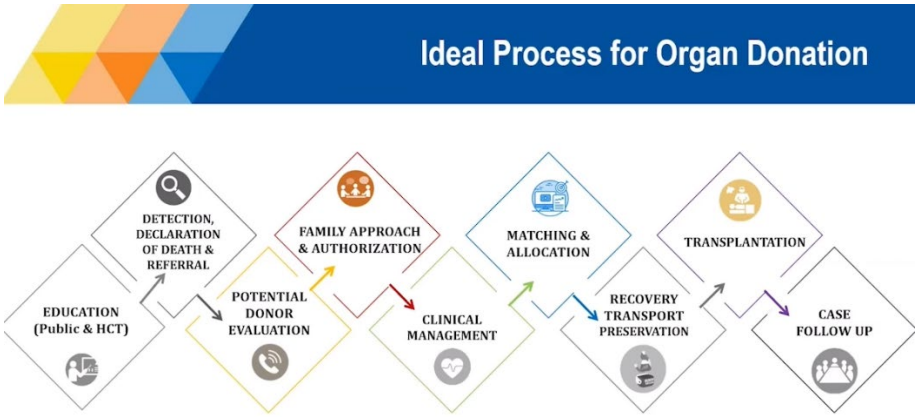
***Speakers**: Lorraine Wickiser, RN, BSN (Lead Technical Advisor, Quality Measurement & Value-Based Incentives Group, CMS), Elizabeth Holland, MPA (Lead Technical Advisor, Quality Measurement, CMS), Michelle Schreiber, MD (Deputy Director of the Center for Clinical Standards and Quality), Joel Andress, PhD (Tech Lead, CMS)*

- Background
  - The COVID-19 pandemic highlighted the need for rapid exchange and sharing of patient care information across the continuum of care and across multiple locations.
  - CMS rapidly supported the expansion of digital strategies to provide access to highest quality and safe care.
  - Digital strategies will also become the foundation of quality measurement to further promote seamless and rapid communication, and the creation of learning systems through rapid and robust data.
- CMS Electronic Blueprint
  - In 2020, CMS committed to converting to digital quality measurement (dQM) by 2030 for the following purposes:
    - Enabling a future where care quality is only measured electronically
    - Reducing burden of EHR data transfer
    - Provide usable, timely data to support delivery of high-quality, patient-centered care
    - Produce reliable and valid measurement results common across multiple payers
  - CMS' strategy for advancing dQM is centered around: 1) improving data quality, 2) advancing technology, 3) optimizing data aggregation, and 4) enabling measure alignment
  - CMS can leverage US Core Data and Interoperability (USCDI) to scale availability of high-quality data
  - CMS can leverage Fast Healthcare Interoperability Resources (FHIR) application programming interfaces (APIs) to implement low-burden measurement approach that facilitates learning
    - FHIR APIs are already mandated for interoperability
  - An efficient and streamlined healthcare digital ecosystem advances technology in all 5 data lifecycle phases: capture, standardize, share, analyze, interpret and apply
- Digital Strategies for Post-Acute Care (PAC)
  - Barriers to Quality Measurement in PAC: poor communication across care providers, reliance on patient recall, and increased cost and provider burden
  - Barriers to Interoperability and Digital Strategies in PAC: lack of business case, limited understanding of interoperability and its value, lack of formalized workflows between providers, and lack of standards or consistent use of standards
  - dQM in PAC requires policy and economic incentives for interoperability
  - Four strategies for improving PAC's Digital Strength:
    - Utilize PAC Assessment Content and the Data Element Library for interoperable exchange and quality measurement
    - Integrate use of FHIR in PAC to enable interoperable exchange and communication
    - Re-envision iQIES
    - Plan for transition to cross-setting digital quality measures

Performing Kidney Transplants During the Coronavirus Pandemic

***Speakers**: Howard Nathan (CEO, Gift of Life Donor Program), Giselle Guerra, MD (Medical Director, Miami Transplant Institute)*

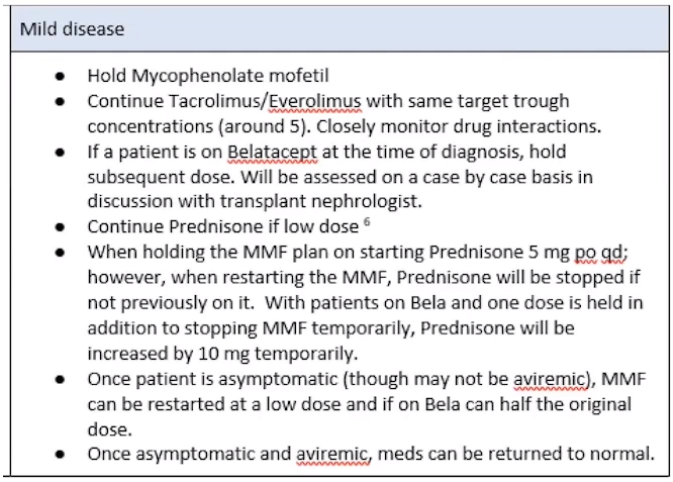
- Howard Nathan - CEO, Gift of Life Donor Program (Philadelphia, PA)
  - 58 OPOs, 267 transplants centers, linked by UNOS
  - Deceased organ donation increased by about 50% 2019 – 2020
  - Living organ donation decreased 2019 – 2020
  - ~108,000 total people on national waiting list for all organs



  - Weekly transplants decreased by about 50% March-April 2020
  - No major change in potential organ donor outcomes, although raw donation numbers decreased 2019 - 2020
  - Lessons learned
    - Communication critical intra-OPO and with donor hospitals and transplant centers
    - Tele-work possible for OPOS
- Giselle Guerra, MD - Medical Director, Miami Transplant Institute
  - COVID-related changes
    - Created COVID task force to deal with inpatient/outpatient issues
    - Screening/testing of transplant patients (phone screening and point of entry screening)
    - COVID Triage Clinic (isolated entry and negative pressure room for testing)
    - COVID Transplant Clinic in separate building for evaluation, testing, and infusions
    - Telehealth clinic visits for pre/post-transplant patients
    - Zoom multi-disciplinary rounds
  - Communication with OPOs critical, establish close communications
  - Testing of donors to assure safety of organs to recipients is key
  - Optimizing kidney allograft/utilization of perfusion machine
  - Donor Desk
    - In house team 24/7 dedicated to organ placement and preservation
    - Central hub to coordinate communication and logistics

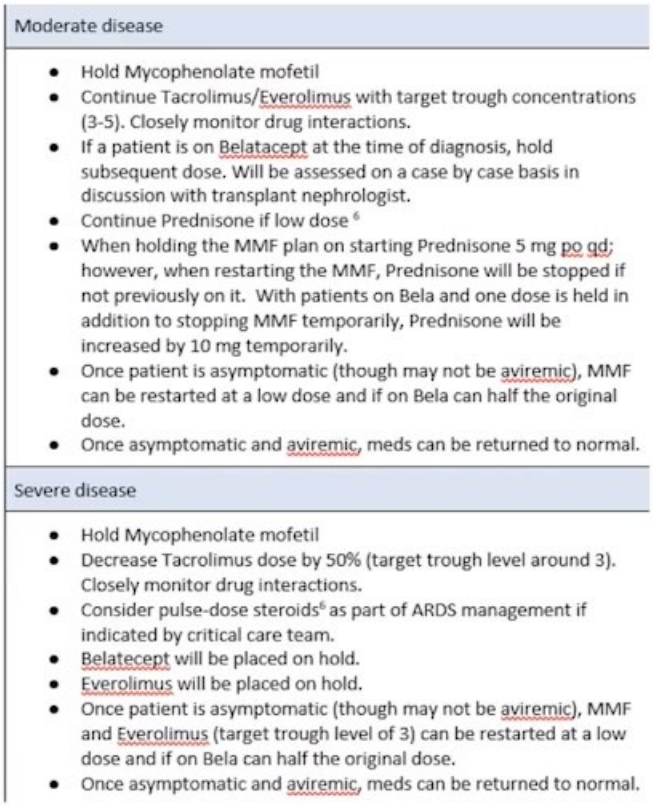
- Moved team to working from home

- 67 patients transplanted from March - April 2020. Followed patients until end of May 2020. At time of transplant, all donors and recipients tested negatives. 42 patients tested positive, 12 patients were symptomatic, no mortality
- Minority groups elsewhere are majority groups in Miami (~1/3 Hispanic, ~1/3 Haitian, ~1/3 Caucasian)
- 137 COVID positive transplant patients (105 kidney)
- 15 Mortalities (11% over 6-month period)
- Changed immunosuppression protocol



Mild disease

- Hold Mycophenolate mofetil
- Continue Tacrolimus/Everolimus with same target trough concentrations (around 5). Closely monitor drug interactions.
- If a patient is on Belatacept at the time of diagnosis, hold subsequent dose. Will be assessed on a case by case basis in discussion with transplant nephrologist.
- Continue Prednisone if low dose [6]
- When holding the MMF plan on starting Prednisone 5 mg po qd; however, when restarting the MMF, Prednisone will be stopped if not previously on it. With patients on Bela and one dose is held in addition to stopping MMF temporarily, Prednisone will be increased by 10 mg temporarily.
- Once patient is asymptomatic (though may not be aviremic), MMF can be restarted at a low dose and if on Bela can half the original dose.
- Once asymptomatic and aviremic, meds can be returned to normal.



Moderate disease

- Hold Mycophenolate mofetil
- Continue Tacrolimus/Everolimus with target trough concentrations (3-5). Closely monitor drug interactions.
- If a patient is on Belatacept at the time of diagnosis, hold subsequent dose. Will be assessed on a case by case basis in discussion with transplant nephrologist.
- Continue Prednisone if low dose [6]
- When holding the MMF plan on starting Prednisone 5 mg po qd; however, when restarting the MMF, Prednisone will be stopped if not previously on it. With patients on Bela and one dose is held in addition to stopping MMF temporarily, Prednisone will be increased by 10 mg temporarily.
- Once patient is asymptomatic (though may not be aviremic), MMF can be restarted at a low dose and if on Bela can half the original dose.
- Once asymptomatic and aviremic, meds can be returned to normal.

Severe disease

- Hold Mycophenolate mofetil
- Decrease Tacrolimus dose by 50% (target trough level around 3). Closely monitor drug interactions.
- Consider pulse-dose steroids[6] as part of ARDS management if indicated by critical care team.
- Belatecept will be placed on hold.
- Everolimus will be placed on hold.
- Once patient is asymptomatic (though may not be aviremic), MMF and Everolimus (target trough level of 3) can be restarted at a low dose and if on Bela can half the original dose.
- Once asymptomatic and aviremic, meds can be returned to normal.

Medicaid State Directed Payments: A Pathway Towards Quality Improvement and Value-Based Payments in Managed Care

***Speakers**: Allison Lynn Weaver (State Directed Payments Quality Lead, Division of Quality and Health Outcomes, Centers for Medicaid and CHIP Services), Mike Levine (CFO and Chief Strategy Officer, MassHealth), Linda Shaughnessy (Director of MassHealthQuality Office), Moderator: Alex Loizias (Health Insurance Specialist, Division of Managed Care Policy, Center for Medicaid and CHIP Services)*

- Demonstrate relationship between state directed payments (SDPs) and the goals and objectives articulated in a state's quality strategy

- State Directed Payments - The foundation of a state directed payment (SDP) arrangement is the utilization and delivery of services to Medicaid beneficiaries covered under a state's managed care (MC) plan contract. Directed payment arrangements can assist states in promoting VBP initiatives. They are categorized into two broad categories:
  - Value-based purchasing/Delivery system reform (VBP/DSR) directed payment arrangements requiring providers to participate in specified VBP/DSR initiatives, such as pay for-performance incentives or shared-savings arrangements for accountable care organizations (ACOs); and
  - State-directed fee schedules with minimum and maximum amounts for particular services, or uniform dollar or percentage increase in payment above negotiated capitated rates
- Statutory State Directed Quality Payment regulations
  - Under 42 CFR 438.6(c), for contract arrangements in managed care, the state must demonstrate that the arrangement is based on utilization and delivery of services and directs expenditures equally, using the same terms of performances, for a class of providers under the contract.
  - The specific quality requirements for states to receive CMS approval for their SDP are identified in 42 CFR 438.6(c). The state must demonstrate that the arrangement:
    - Is expected to advance at least one of the goals and objectives in the quality strategy in §438.340
    - Has an evaluation plan that measures the degree to which the arrangement advances at least one of the goals and objectives in the quality strategy in §438.340
- Align an SDP with a quality strategy, states must consider not only how the SDP design furthers the quality strategy goal(s), but also how the state will measure progress towards those goal

- Demonstrate how states can set up their evaluations to drive their SDP toward improved quality of care and outcomes for Medicaid beneficiaries
  - SDP Evaluations
    - 1) The measure(s) the state will use to track the effects of the payment arrangement
    - 2) The baseline year(s) and baseline statistic(s) the state will use to evaluate whether the payment arrangement led to improved performance
    - 3) The performance targets the state expects the payment arrangement to achieve
    - Evaluation measures track the state's progress toward achieving the goals of the payment arrangement, which are linked to the quality strategy. Evaluation measures may be the same or different than the provider performance measures for VBP/DSR SDPs
    - Provider performance measures are for VBP/DSR SDPs and link provider payments to the goals of the payment arrangement
    - Performance targets are the measure targets set by the state that are meant to achieve the goals of payment arrangement. Progress toward achieving the targets should be included in the evaluation

- When setting performance targets, states can review past performance as reported in:
  - Quality Assurance & Performance Improvement (QAPI) programs
  - Adult and Child Core Set measure reporting
  - External Quality Review (EQR) technical reports
  - States' quality strategy
- For each measure included in the evaluation plan, the state must also include a baseline statistic to measure performance targets against. The baseline year should be at least one year before the start of the payment arrangement
- SDP strategies
  - States may conduct the evaluations by comparing performance before and after the SDP implementation.
  - States may also leverage existing contracts to conduct SDP specific evaluations by:
    - Amending 1115 waiver contracts
    - Amending External Quality Review Organization contracts
  - Evaluations must be specific to the SDP

- State Example - Massachusetts' SDP to improve inpatient hospital clinical quality
- With the launch of its current 1115 waiver in 2017, MassHealth (Massachusetts Medicaid) undertook a substantial shift toward risk-based alternative payment models focused on accountability for quality, integration and total cost of care
  - Shifted ~80% of eligible lives to provider-based ACOs with TCOC and quality accountability
  - Thirteen ACOs are capitated partnerships between health plan and primary care provider
  - Significant membership in both managed care and managed fee-for-service; as MassHealth drives policy priorities (e.g., access to behavioral health services, quality performance, etc.) across both delivery systems, state directed payments are required under 42 CFR 438.6(c), with accompanying documentation in preprints, rate certifications, and managed care contracts
  - MassHealth has taken a complementary approach to enhanced payments to providers, applying cost and quality accountability across performance-based payments
  - As part of its restructuring, MassHealth reviewed historical hospital funding streams and took steps to directly tie payments to quality performance
  - Authorities
    - Memorialized in Attachment Q of Massachusetts's 1115 Waiver through FY22
    - Subject to annual review and approval under 42 CFR 438.6(c)(1)(ii)
  - Common characteristics of MA's four performance-based quality improvement programs
    - Significant financial accountability: up to 100% of payment at risk for performance
    - Mix of national and "homegrown" measures
    - Linked to state quality strategy
    - Tied to performance during the contract year
    - Determine an appropriate measurement strategy to assess progress against the quality goals to drive improvement in population health among MassHealth members
  - Mass Health Quality Strategy

    - Priority Areas
        - Promoting Maternal, Child and Family Health
        - Healthy Living and Chronic Disease Prevention and Control
        - Reducing Emergency Department and Hospital Utilization
        - Promoting Mental Health and Reducing Addiction by Prevention, Treatment and Care Integration
        - Promoting Person-centered Long-term Services and Supports
    - Quality Goals
        - Transform to a member-centered culture of care focused on engaging members in their health
        - Improve communication, coordination and care integration
        - Focus on preventative, patient-centered primary care, and community-based services and supports
        - Promote effective prevention and treatment to address chronic diseases or priority conditions
        - Engage communities through population health and best practices for healthy living
        - Identify and address health disparities to provide equitable care
- MassHealth decided on (4) areas
    - Disability access
    - Hospital quality
    - Integrated care
    - Behavioral health quality
- MassHealth participants – Essential MassHealth hospitals in network
- SDP type: Value based purchasing
    - Medicaid-Specific Delivery System Reform
    - Performance Improvement initiative
- Measure or Domain Focus:
    - Inpatient Care (30%)
    - Care Transitions (30%)
    - Avoidable Utilization (25%)
    - System Transformation Activity (15%) (e.g., Enhanced quality reporting through electronic medical record (EMR) reporting)
- Measures reflect priority areas and goals
    - Maternal/newborn health
    - Healthy living, mental health
    - Reducing ED/ hospital utilization (high-utilizers)
    - Improving patient safety/avoidable utilization
    - Improved care transitions and care coordination
    - In and out of high-intensity settings

        - Discharge management from ED, Inpatient, Skilled Nursing Facility (SNF), Home Health, Inpatient Rehab, Long-Term Acute Care Hospital
        - Care management
        - Promoting long-term services and supports
    - Measure Domain
        - Inpatient care
        - Care transitions
        - Avoidable utilization
        - System transformation
    - Considerations when designing the payment and selection of measures
        - Alignment with other at-risk payments, e.g., Medicaid Acute Hospital P4P program, psychiatric hospital program
        - ACO quality slate
        - Other CMS programs (MIPS)
        - Commercial payer
        - Link to state quality strategy priorities and goals
        - Unique needs and profile (e.g., Safety, Avoidable Utilization) of eligible providers
        - Tradeoff between measure proliferation and concentration of risk
        - Reporting / measurement burden
            - Use of standard measures, including those available only on a multi-payer basis (e.g., MIPS, The Joint Commission (TJC), Agency for Healthcare Research and Quality (AHRQ) measures)
            - Use of available data sources (e.g., CMS reported, CDC data)
        - Availability of MassHealth data
        - Unanticipated: COVID-19!

Healthy Equity as a "New Normal": CMS Efforts to Address the Causes of Health Disparities

***Speakers**: Meagan Khau, MHA (CMS Office of Minority Health), Jessica Maksut, PhD (CMS Office of Minority Health), Tenly Pau Biggs, MSW, LMSW (CMS Office of Minority Health), Brandon Wilson, DrPh, MHA (CMMI)*

- IMPACT Act of 2014
    - Mandated submission of standardized data in long term care hospitals, skilled nursing facilities, home health agencies, and inpatient rehabilitation facilities
    - Improves Medicare beneficiary outcomes through shared decision-making, care coordination, and enhanced discharge planning
    - Collects standardized data elements for use in the Post-Acute Care Prospective Payment System
    - Assess appropriate adjustments to quality measures, resource measures, and other measures to assess and implement appropriate adjustments to payment

    - CMS Office of Minority Health (OMH) proposed demographic and social determinants of health standards patient assessment data elements
- Post-Acute Care Instruments
    - Core set of data elements completed at regular intervals for all post-acute care patients
    - Forms foundation of a comprehensive assessment used by providers to assess patients' needs and develop individualized plan of care
    - The assessment tools are:
        - Minimum Data Set for skilled nursing facilities
        - LTCH Continuity Assessment Record and Evaluation (CARE) Data Set (LCDS) for long term care hospitals
        - Outcomes and Assessment Information Set (OASIS) for home health agencies
        - IRF-Patient Assessment Instrument (IRF-PAI) for inpatient rehabilitation facilities
- CMS solicited expert feedback on data elements to prioritize
    - Told to explore standardizing data collection of demographic and social determinants of health (SDOH) data given disparities and barriers to care coordination
    - Should prioritize language preference, race, ethnicity, sexual orientation, gender identity, health literacy, social isolation, transportation barriers, food insecurity, and housing insecurity
    - Suggested data elements only be asked at admission
    - Encouraged expansion beyond post-acute care
- Health Equity Technical Assistance Program
    - Receive personalized coaching and resources
    - Guidance on data collection and analysis
    - Assistance in developing language access plan
    - Obtaining resources on culturally and linguistically competent care and communication
- Health Equity Summary Score (HESS)
    - Upstream causes of health affect health outcomes and disparities
    - HESS is a stratification/group differences measurement tool developed to increase visibility of disparities for quality improvement and provide a mechanism for targeting incentives to achieve equity across groups
    - Using Medicare Advantage (MA) contract data, CMS applied the methodology as a proof-of-concept exercise for grouping race and ethnicity and dual eligible/LIS status
        - Positive correlation between plans' overall HESS and MA summary ratings
        - Demonstrated moderately high stability over time
        - HESS can identify plans that provide equitable care across race/ethnicity and dual/LIS status strata
        - Highest scoring plans had a sizable enrollment of persons of color and dual/LIS population
    - Feedback from stakeholders
        - Plans expressed HESS would be a good tool for evaluation
        - Participants actively engaged in health equity work within organizations and felt they could act on information from HESS

        - Plans are eager to understand drivers of disparities
    - CMS OMH working on dashboard to provide confidential HESS data to MA contracts in the future
- Accountable Health Communities (AHC) Model
    - Many drivers of healthcare costs are outside clinical environment
    - SDOH significantly drive utilization and costs
    - Emerging evidence that addressing Health Related Social Needs (HRSN) through community linkages can improve outcomes and impact costs
    - AHC model seeks to address current gaps between delivery and community services
        - Systematic screening of all Medicare and Medicaid beneficiaries to identify unmet needs
        - Tests effectiveness of referrals and community services navigation on total cost of care
        - Partner alignment at the community level and implementation of community-wide quality improvement
    - Two interventions
        - Assistance track tests universal screening and provision of navigation assistance
        - Alignment track tests universal screening, referral, and navigation combined with engaging key stakeholders in community-level continuous quality improvement
    - AHC focuses on five core HRSNs:
        - Housing instability
        - Food insecurity
        - Transportation problems
        - Utility difficulties
        - Interpersonal violence
    - AHC implemented in 29 communities in 21 states
    - Model structure
        - Consortium must meet minimum standards
        - Organization must have established relationship with state Medicaid agency, clinical delivery sites, and community social services providers
        - Organizations will screen in at least one hospital, primary care provider, and provider of behavioral health services using questions provided by CMS
        - Make tool available to all beneficiaries regardless of language, literacy, or disability status
        - Beneficiaries must not be institutionalized, be a Medicare or Medicaid beneficiary, score positive on HRSN, and have two or more self-reported ED visits in 12 months before screening
        - Organization must maintain community resource inventory and provide beneficiary with tailored community referral summary that includes contact information and hours of operation
        - Organizations must have a health resource equity statement
    - AHC Model has been successful in identifying vulnerable populations

- Lower income beneficiaries who are racial and ethnic minorities and have less than a high school degree or equivalent were more likely to report HRSNs and two or more ED visits in 12 months before screening
- Food and housing were most prevalent needs
- Transportation needs more likely to meet the high ED use requirement for navigation

Closing Plenary

***Keynote**: Amy Edmondson, PhD*

- The presentation focused on the importance of building a work environment and culture that encourages others to feel supported and encouraged to share their thoughts and ideas.
- Leveraging the voices of scientists and other health experts is important for communicating with the public but effective management is necessary to ensure consistent messaging.
    - When consulting experts:
        - Invite them to stay within the bounds of their expertise
        - Remind them to speak up and own mistakes
        - Get out of their way
- Organizations should take the initiative to assess their internal cultures and should think about ways in which they are helping to mitigate interpersonal fears at work.
- Staff members should feel safe reporting issues and/or concerns without repercussion or backlash. This will help the organization succeed by uncovering and addressing problems early before cascading into more serious issues.
- Psychological safety allows for quality improvement and allows individuals to take healthy risks to better themselves and the organization as a whole.