NATIONAL QUALITY FORUM

3667 Days at Home for Patients with Complex, Chronic Conditions

- **Measure Steward:** Centers for Medicare & Medicaid Services / Yale Center for Outcomes Research and Evaluation (CORE)
  - New measure
- **Brief Description of Measure:**
  - This is a provider group-level measure of days at home or in community settings (that is, not in acute care such as inpatient hospital or emergent care settings or post-acute settings such as Skilled Nursing Facilities (SNFs)) among adult (age 18 years or older) Medicare FFS beneficiaries with complex, chronic conditions who are aligned to participating provider groups. The measure includes risk adjustment for differences in patient mix across provider groups, with an adjustment based on patients' risk of death. An additional adjustment that accounts for patients' risk of transitioning to a long-term nursing home is also applied to encourage home- and community-based care in alignment with CMS's policy goals. A higher risk-adjusted score indicates better performance.

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3667 Related Measures

Category	3667 Days at Home for Patients with Complex, Chronic Conditions	2888 Risk-Standardized Acute Admission Rates for Patients with Multiple Chronic Conditions
Steward/ Developer	Centers for Medicare & Medicaid Services /Yale New Haven Health Services Corporation – Center for Outcomes Research and Evaluation (CORE)	Centers for Medicare & Medicaid Services/Yale New Haven Health Services Corporation – Center for Outcomes Research and Evaluation (CORE)
Description	This is a provider group-level measure of days at home or in community settings (that is, not in acute care such as inpatient hospital or emergent care settings or post-acute settings such as Skilled Nursing Facilities (SNFs)) among adult (age 18 years or older) Medicare FFS beneficiaries with complex, chronic conditions who are aligned to participating provider groups.	Rate of risk-standardized acute, unplanned hospital admissions among Medicare fee-for-service (FFS) beneficiaries 65 years and older with multiple chronic conditions (MCCs) who are assigned to an Accountable Care Organization (ACO).
Numerator	The outcome measured for each eligible beneficiary is days spent "at home," adjusted for clinical and social risk factors, risk of death, and risk of transitioning to a long-term nursing home.	The number of acute unplanned hospital admissions per 100 person-years at risk for admission during the measurement period.
Denominator	Eligible beneficiaries aligned to participating provider groups.	The cohort, or group of patients included in the measure, is comprised of patients whose combinations of chronic conditions put them at high risk of admission and whose admission rates could be lowered through better care.
Target Population	Adults age >=18	• Patient age = 65 years at the start of the year prior to the measurement period. • Chronic Condition • Medicare FFS beneficiary • Attributed to a Medicare Shared Savings Program ACO.
Care Setting	Inpatient/hospital, post-acute care	Outpatient Services
Level of Analysis	Accountable Care Organization	Other

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Activities and Timeline –Fall 2021 Cycle

***All times ET**

Meeting	Date, Time
Measure Evaluation Follow-up Web Meeting	February 17th 10am-12pm
Draft Report Comment Period	March 25 – April 25
Committee Post-Comment Web Meeting	May 25th 2pm-5pm
CSAC Review	Late July
Appeals Period (30 days)	July 21 – August 19