

## Care Coordination Measures Roadmap Ad Hoc Work Group – For Discussion, July 26, 2017

### Framework: What is Care Coordination?

Much of the following material is drawn directly from the “*Care Coordination Measures Atlas*” prepared by the U.S. Agency for Healthcare Research and Quality (AHRQ) and published in June 2014. (<https://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html>)

The *Atlas* offers a useful framework for understanding care coordination and care coordination measurement, and includes a list of *some* of the existing measures of care coordination organized along different dimensions. The *Atlas* is a lengthy document (378 pgs) and the material included here is offered as the most pertinent to our discussion on measurement of care coordination in Washington State.

### Care Coordination Defined

Authors of the *Atlas* acknowledge that there are dozens of definitions of care coordination found in the literature and that the following definition is intentionally broad and seeks to combine common elements from many definitions to develop one working definition. From the *Atlas*:

Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery of health care services [to meet the patient’s needs and preferences in the delivery of high quality, high value care]. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care.

Points of transition are particularly vulnerable to failures of care coordination. Care transitions occur when a patient moves between two or more health care entities OR when the patient is managed over time. The level of care coordination need increases with greater system fragmentation, greater clinical complexity, and/or decreased patient capacity for coordinating their own care.

#### Transition between health care entities:

- Among members of one care team
- Between care teams
- Between patients/informal caregivers and professional caregivers
- Across settings (primary care, specialty care, inpatient, ER)
- Between health care organizations

#### Transitions over time:

- Between episodes of care
- Across lifespan and different needs associated with different life periods (pediatric, adult, geriatric)
- Across trajectory of illness and changing levels of coordination need

The *Atlas* views care coordination from three different perspectives, summarized below. These perspectives are further used to create a framework by which to view potential measures of care coordination and the types of data needed.

<b>Perspective:</b>	<b>Care Coordination includes activities that:</b>	<b>Health care entities Include:</b>	<b>Types of Measures Associated with this Perspective</b>
1. Patient/ Family	Help ensure the patient’s needs and preferences are met across people, functions and sites	Individual health care providers with whom the patient and family interact	Patient or family experience/patient report of care coordination  Patient report of unnecessary care (e.g., tests, procedures, ER visits)  <i>Typical Data Source: Survey</i>
2. Health Care Professional	Support clinical coordination, i.e., where is the patient sent, what information is necessary to transfer among health care entities, hand-offs between sites of care, and how responsibility is managed among different health care professionals	Individual members of a work group (e.g., nurse, physician, support staff) OR a provider group (e.g., primary care practice, specialty practice, or urgent care)	Provider/Nurse report of effectiveness of care coordination  <i>Typical Data Source: Surveys, Practice Assessment Tools</i>
3. System	<i>Deliberately integrate</i> personnel, information and other resources needed to effectively carry-out patient care between and among care participants	Groups of providers acting together as a unit either formally or informally (e.g., units in a hospital, clinics within an integrated delivery system, clinics with separate affiliations)	Quality of care (process, outcomes)  Health care utilization  Cost  <i>Typical Data Sources: EMR, administrative data)</i>

## Mechanisms for Achieving Care Coordination

The Atlas describes two domains that may also be useful when categorizing and considering potential measures of care coordination. Some categories lend themselves to systematic measurement more than others and this is reflected in the number of care coordination measures currently associated with each. To date, the ones that seem to lend themselves best to measures of care coordination are highlighted in yellow.

1. **Broad Approaches** –The *Atlas* describes these as “aimed at improving the delivery of health care, including improving or facilitating coordination, incorporate a number of coordination activities . . . and are often complex in intent and design.” Five broad approaches are outlined.

Broad Approach	Summary
Teamwork Focused on Coordination	Integration among health care entities participating in a specific patient’s care
Health Care Home	Source of usual care selected by the patient that functions as the central point for coordinating care around the patient’s needs and preferences
Care Management	Process designed to assist patients and their support systems in managing their medical/social/mental health conditions; includes case management (individual focused) and disease management (population focused)
Medication Management	Systematic review of patient’s complete medication regimen, particularly at transitions, to avoid adverse drug events.
Health IT enabled coordination	Using electronic tools (e.g., EMR, databases) to communicate information about patients and their care between health care entities

2. **Coordination Activities** – these are specific actions deployed between providers and between providers and patients to support care coordination. Nine coordination activities are outlined.

Coordination Activities	Summary
1. Establish accountability	Specify who is primarily responsible for key care and coordination activities

Coordination Activities	Summary
2. Communication	Sharing knowledge among participants in a patient’s care through: <ul style="list-style-type: none"> <li>• Interpersonal communication (face-to-face, phone, email, letters)</li> <li>• Information transfer (medical records, clinical notes and recommendations, diagnostic images and results)</li> </ul>
3. Facilitate transitions	Transfer of information for aspects of a patient’s care between two or more health care entities (across settings or as coordination needs change)
4. Assess needs and goals	Determine the patient’s needs for care and coordination
5. Create a proactive plan of care	Establish and maintain a plan of care, jointly created and managed by the patient/family and health care team
6. Monitor, follow-up and respond to change	Assess progress toward care and coordination goals and refine the care plan as needed
7. Support self-management goals	Tailor education and support to align with patient’s capacity for and preferences about involvement in their own care
8. Link to community resources	Provide information about and coordinate services with additional resources in the community that may help support the patient’s specific needs
9. Align resources with patient and population needs	Within the health care setting, assess the needs of patients and populations and allocate health care resources according to those needs

## TYPICAL DATA SOURCES FOR MEASURES ON CARE COORDINATION

### 1. Administrative (Claims) Data, including enrollment, encounter and cost data

This data source is the most well-established both nationally and in the state of Washington. The Washington Health Alliance has a claims data warehouse in place with data on approximately four million insured lives in Washington (Medicaid, commercial) and data going back to 2004. In addition, Washington state has recently implemented a new state-mandated All Payer Claims Database that is currently under construction.

### 2. Electronic Health Records

Based on the measure mapping included in the *Atlas*, the Care Coordination domains and activities most often measured using EHR-based measures include:

- Communication
- Facilitate Transitions
- Medication Management
- Health IT-enabled Coordination

There is strong interest in the *potential* to use EHR-derived data for quality measurement, but there are still a number of barriers and challenges that will need to be overcome before this is a reliable source for measurement *with the intent to publicly report results* (differentiated from private measurement for the purpose of quality improvement within a health care entity). Some of these barriers and challenges are noted below:

#### Generally:

- a. The concept of care coordination is still ambiguous and there is insufficient agreement in the clinical sphere about what constitutes care coordination. This ambiguity limits documentation of coordination activities in any sort of standardized fashion.
- b. Variability in documenting care coordination activity is a challenge; specifically, heavy reliance on narrative documentation, rather than use of structured data fields, limits use of information within EHRs for measurement and reporting.
- c. The development of standardized, nationally vetted EHR-based measures of care coordination is underway but slow to gain traction nationally for use in measures sets used for public reporting.
- d. More work and testing is needed to evaluate the reliability, accuracy and completeness of EHR information for the purpose of public reporting.

#### In Washington:

- a. The Washington State Health Care Authority is leading an effort to build a Clinical Data Repository (CDR), also known as "Link4Health." The primary purpose of the CDR, focusing initially on EHR data for Medicaid-insured patients, is to aggregate

clinical data from providers around the state and to support clinical data exchange *for clinical decision-making and care coordination*. The CDR leverages standards already incorporated into certified EHRs to enable sharing clinical summaries, thereby supporting clinical data exchange for organizations that do not share similar platforms.

- b. This is a very large initiative and is intended to be implemented over multiple years. It will take several years to build critical mass, including longitudinal data on millions of Washington residents (beyond Medicaid).
- c. Although it is envisioned that the CDR will provide mainstream reporting and analytics capabilities (e.g., HEDIS) for practices and MCOs (reducing the need for chart reviews associated with quality reporting), it is unclear when the CDR will be available to enable quality measurement *for the purpose of public reporting* on provider performance.

### 3. Surveys

Surveys targeting input from either patients or providers constitute another source of data on the effectiveness of care coordination. The *Atlas* includes a list of 80 care coordination measures; of these 80 measures, more than 60 are associated with some form of a survey.

CAHPS (Consumer Assessment of Healthcare plans and Systems) patient experience surveys (AHRQ developed and NQF-endorsed) do include questions regarding care coordination. Health plans are required to implement the health plan CAHPS survey for NCQA accreditation. In addition, the Washington Health Alliance implements the Clinician/Group-CAHPS survey for patient experience with primary care practices on a biannual basis. Examples of care coordination-related questions in CG-CAHPS include:

- How often did this provider seem to know the important information about your medical history?
- How often did this provider seem informed and up-to-date about the care you got from specialists?

There are many other types of survey instruments that focus on the patient/family perspective of care coordination, such as:

- Ambulatory Care Experiences Survey (ACES)
- Patient Assessment of Care for Chronic Conditions (PACIC)
- Patient Perceptions of Care (PPOC)
- Client Perception of Coordination Questionnaire (CPCQ)

There is no readily available information suggesting that these other types of survey instruments (non-CAHPS) are currently being used on a statewide basis in Washington state.

Surveys tend to be very expensive to implement, particularly with the goal of producing statistically reliable and valid statewide results for public reporting.

#### 4. Practice Assessment Tools

Within the context of care coordination, practice assessment tools are used to evaluate how effectively a health care entity is implementing care coordination activities. These tools may be used for accreditation (e.g., The Joint Commission's Patient-Centered Medical Home Self-Assessment Survey, or the NCQA PCMH Tool). They may also be used to identify quality improvement opportunities within or between health care entities (e.g., Safe Transitions Community Physician Office Best Practice Measure)

At the present time, they are rarely used to support measurement *with the intent of public reporting*.

## RECOMMENDATIONS FOR WORK GROUP DISCUSSION/CONSIDERATION:

1. Adopt the AHRQ *Atlas* definition and framework for care coordination as context and a structure for the group's work.
2. Recommend that the PMCC maintain the following eight care coordination-related measures already approved for the WA State Common Measure Set:
  - a. Follow-up After Hospitalization for Mental Illness (NCQA-FUH)
  - b. 30-day Psychiatric Inpatient Readmissions (DSHS RDA)
  - c. COPD or Asthma in Older Adult Hospital Admissions (AHRQ PQI)
  - d. Follow-up Care for Children Prescribed ADHD Medication (NCQA-ADD)
  - e. Potentially Avoidable Use of the Emergency Room (Alliance)
  - f. Plan All-Cause Hospital Readmissions (NCQA-PCR)
  - g. Follow-up After Discharge from ER for Mental Illness (NCQA-FUM) (*approved for implementation in 2018*)
  - h. Follow-up After Discharge from ER for Alcohol or Other Drug Dependence (NCQA-FUA) (*approved for implementation in 2018*)
3. Work group review additional readily-available claims-based measures to determine whether there are any that should be recommended for inclusion in the WA State Common Measure Set (see attachment) for 2018. Continue to take into account measure selection criteria established by the PMCC, the most important of these being:
  - a. Preference given to nationally-vetted measures (e.g., NQF-endorsed) and other measures currently used by public agencies within WA.
  - b. Each measure should be valid and reliable, and produce sufficient numerator and denominator size to support credible public reporting.
  - c. Measures target issues where we believe there is significant potential to improve health system performance in a way that will positively impact health outcomes and reduce costs.
  - d. If the unit of analysis includes health care providers, the measure should be amenable to influence of providers.



4. Formally acknowledge that, at the present time and for the foreseeable future, Washington state does not yet have a fully functioning clinical data repository that is robust enough and capability-ready to enable quality measurement *for the purpose of public reporting* on provider performance on care coordination.
5. Given the current status of access to EHR-based information for the purpose of measurement and public reporting in Washington, do not recommend any EHR-based care coordination measures for the Common Measure Set at this time.

Instead, recommend:

- a. PMCC continue to periodically monitor EHR data availability to support statewide measurement with public reporting in Washington; and
- b. PMCC continue to periodically monitor EHR-based care coordination measure development occurring nationally with a focus primarily (but not exclusively) on measures that reflect a “System” perspective with an emphasis on the following care coordination domains and activities:
  - i. Communication
  - ii. Facilitation of Transitions
  - iii. Medication Management
  - iv. Health IT-enabled Coordination
6. Given the resource-intensity associated with implementation of statewide surveys, recommend that the PMCC focus on survey-based measures associated with surveys currently being implemented in Washington state and/or statewide surveys that could be implemented in the near term with a clear owner and funding source identified. At the present time, this would include questions included in Health Plan CAHPS, Hospital CAHPS and CG-CAHPS.
  - c. Maintain the following survey-based care coordination-related measures already approved for the WA State Common Measure Set:
    - i. Patient experience with primary care: How Well Providers Communicate with Patients (CG-CAHPS, Alliance data source)
    - ii. Patient experience with hospital care: Information at the Time of Discharge
    - iii. Patient experience with hospital care: Communication about Medicines
  - d. Consider adding the following survey-based care coordination-related measure to the Common Measure Set:
    - i. Patient experience with primary care: How Well Providers Use Information to Coordinate Care (CG-CAHPS, Alliance data source)

Attachment – Potential Claims-Based Measures for Consideration, Need to Confirm Data Source in Washington

1. Heart Attack 30-day Readmit (CMS, NQF-endorsed #0505)
2. Pneumonia 30-day Readmit (CMS, NQF-endorsed #0506)
3. Vascular Procedures 30-day Readmit (CMS, NQF-endorsed #2513)
4. Chronic Obstructive Pulmonary Disease 30-day Readmit (CMS, NQF-endorsed #1891)
5. Heart Failure 30-day Readmit (CMS, NQF-endorsed #0330)
6. Coronary Artery Bypass Graft 30-day Readmit (CMS, NQF-endorsed #2515)
7. Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty 30-day Readmit (CMS, NQF-endorsed #1551)
8. Medication Reconciliation Post Discharge (for Medicare-aged adults) (NCQA, NQF-endorsed #0554)  
(Claims version of measure relies on routine use of CPT and CPT II Codes (99495, 99496, 1111F))
9. Acute Care Hospitalization During the First 60 Days of Home Health (Medicare) (CMS, NQF-endorsed #171)
10. Emergency Department Use Without Hospitalization During the First 30 Days of Home Health (CMS, NQF-endorsed #173)
11. Proportion of Patients with a Chronic Condition that Have a Potentially Avoidable Complication During the Calendar Year (Altarum Institute, NQF-endorsed 709)
12. Fragmentation of Care Index  
The FCI is calculated using an equation that utilizes data on: (1) the total number of visits, (2) the total number of clinics visited, and (3) the total number of visits to a specific clinic being examined. The FCI can range from 0 (all visits were made to the same clinic) to 1 (all visits took place at a different clinic).
13. Patients with a Transient Ischemic Event ER Visit That Had a Follow Up Office Visit  
Percent of patients with an emergency department visit for a transient ischemic event who had a follow-up outpatient encounter within 14 days
14. Advance Care Plan (Medicare) (NCQA, NQF-endorsed #0326)

**Just for Information:** NCQA has announced two new HEDIS measures for implementation beginning in 2018. Both are focused on the Medicare population. The detailed technical specifications will not be released until later this year. Per NCQA policy, first year measures are never publicly reported; therefore, health plan results on these measures will not be available earlier than 2020 (for CY 2019).

1. **Transitions of Care.** The measure assesses percentage of inpatient discharges for Medicare members 18 years and older who had each of the following during the measurement year:
  - Notification of Inpatient Admission
  - Receipt of Discharge Information
  - Patient Engagement After Inpatient Discharge
  - Medication Reconciliation Post-Discharge

**Intent:** This measure aims to improve care coordination during care transitions for at-risk populations including older individuals and those with complex health needs. It is likely that clinical data is required in addition to claims data to implement this measure.

2. **Follow-Up After Emergency Department Visit for People With High-Risk Multiple Chronic Conditions.** This measure assesses the percentage of ED visits for Medicare members 18 years and older with high-risk multiple chronic conditions and follow-up care within 7 days of the ED visit.

**Intent:** The purpose of this new measure is to improve the coordination of care for Medicare beneficiaries with multiple chronic conditions who are sent home from the ED. This follow-up should ensure better coordination of diagnoses, medications and follow-up needs.