MEETING MATERIALS - ATTACHMENT 4

DATE: **October 2, 2017**

TO: **Performance Measures Coordinating Committee**

FROM: **Susie Dade, Deputy Director, Washington Health Alliance**

RE: **Recommendations from the Care Coordination Measures Roadmap Work Group**

Introduction:

At the April 2017 meeting of the Performance Measures Coordinating Committee (PMCC), a decision was made to form a small, ad hoc work group to:

1. Review the status of measuring care coordination/care transitions, i.e., what is going on elsewhere in the country, what measures are in common use, and what data is necessary to support measurement.
2. Formulate advice and/or specific recommendations to the PMCC regarding:
   a. What topic(s) are the most important to address with measurement of care coordination/care transitions?
   b. Are there specific measures that we should consider adding to the Common Measure Set at this time?
   c. What data will we need to have access to in Washington to implement the measures and does a data source exist in Washington?

After consulting with PMCC co-chairs Dorothy Teeter and Nancy Giunto, and with input from Dr. Dan Lessler, it was agreed that the following individuals would be asked to participate in this work group (all agreed to participate):

- Sue Bergmann, Washington State Hospital Association
- Susie Dade, Washington Health Alliance
- Julie Lindberg, Molina Healthcare
- Leah Hole-Marshall, WA State Labor & Industries
- Elya Moore, Olympic Community of Health
- Laura Pennington, WA State Health Care Authority
- Britt Reddick, WA State Health Care Authority
- Jonathan Sugarman, Qualis Health
- Emily Transue, WA State Health Care Authority

The Washington Health Alliance was asked to lead/facilitate the work group.

The work group met three times to complete their work: June 27, July 26 and August 9.

Detail on the final recommendations of the work group to the PMCC can be found on pages 11-14 of this report. There are six recommendations, summarized here:

1. **The PMCC should adopt the AHRQ Atlas definition and overall framework for care coordination as the context and structure for its current and future deliberations related to care coordination measurement.**
2. **The PMCC should maintain seven measures that indirectly measure a process or outcome related to care coordination and that are currently approved for the Common Measure Set.**
3. **The PMCC should not add any additional claims-based measures related to care coordination to the Common Measure Set at this time.**
4. **The PMCC should not add any measures requiring clinical data (from EHR) to the Common Measure Set at this time.**
5. **The PMCC should periodically monitor the following over the next several years:**
    a. **EHR data availability within Washington state to support statewide measurement and public reporting.**
    b. **EHR-based care coordination measure development occurring nationally with an emphasis on five focus areas.**
6. **The PMCC should discuss and consider adding the following measure from the Clinician-Group CAHPS survey to the Common Measure Set: "*How Well Providers Use Information to Coordinate Care*."**

Discussion: What is Care Coordination?

The first task of the work group was to gain consensus regarding the definition of care coordination. This was particularly important given the diversity of perspectives regarding the meaning of the term. The work group sought to identify a definition that was, to the extent possible, authoritative and widely accepted at a national, multi-stakeholder level. In developing its recommendations, the work group largely relied upon material drawn from the "*Care Coordination Measures Atlas,*" prepared by the U.S. Agency for Healthcare Research and Quality (AHRQ) and published in June 2014[1].

The *AHRQ Atlas* offers a useful framework for understanding care coordination and care coordination measurement. The AHRQ Atlas provides a reasonable working definition of care

---

[1] https://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html

coordination and it fits with the PMCC's goal of focusing on nationally vetted tools, measures, etc., whenever possible. We did not identify any other *nationally agreed-upon* definition of care coordination.

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 noted as being 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 *AHRQ Atlas* views care coordination from three different perspectives, noted below.

1. Patient/Family
   Care coordination includes activities that help to ensure the patient's needs and preferences are being met across individual providers and different sites of care.

2. Health Care Professionals
   Care coordination includes activities that support clinical "connectedness", i.e., knowledge about where the patient is being seen and by whom, 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.

3. Health Care Systems
   Care coordination includes activities that *deliberately integrate* personnel, information and other resources needed to effectively carry-out patient care between and among care participants.

Discussion: Measuring Care Coordination

The three perspectives of care coordination, noted above, are further used within the *AHRQ Atlas* to create a framework by which to view potential measures of care coordination and the types of data needed to complete measurement.

Perspective	Types of Measures	Source of Data for Measurement	"Unit(s) of Analysis"
Patient/Family	• Patient or family report of care coordination • Patient report of unnecessary care (e.g., tests, procedures, ER visits)	• Patient/Family Surveys	Individual health care providers with whom the patient and family interact
Health Care Professionals	• Provider/Nurse report of effectiveness of care coordination	• Provider/Nurse Surveys • Practice Assessment Tools	Individual members of a work group (e.g., nurse, physician, support staff) OR a provider group (e.g., primary care practice or specialty practice)
Health Care Systems	• Quality of care (process, outcome) • Health care utilization • Cost of care	• Patient/Family Surveys • Administrative claims data • Clinical data from EHR	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)

Discussion: 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**

Generally speaking, there is strong interest in using 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 the barriers and challenges are noted below:

Generally:

a. The activities, services or other elements that reflect care coordination are not yet adequately specified; there is insufficient agreement in the clinical sphere about what constitutes care coordination. This ambiguity limits documentation of coordination activities in a 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, significantly limits use of EHRs for measuring and reporting on care coordination.

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 extracting information from summary of care records submitted to a clinical data repository for the purpose of public reporting on quality results.

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 CDR leverages standards already incorporated into certified EHRs to enable real-time sharing of summary of care records, thereby supporting clinical data exchange particularly for organizations that do not share a common medical record or similar EHR platforms. 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.*

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. In addition, the system will need to incorporate capabilities needed to enable quality *measurement for the purpose of statewide public reporting on provider performance*.

c. The Health Care Authority is estimating that this will be a reliable data source <u>for the Medicaid-insured population</u> in approximately three years. It may be ready for use as a data source for public reporting by that time. It is not known at this time when the CDR may be ready as a longitudinal clinical data source for all or most Washington residents (beyond Medicaid, i.e., all payer plus the uninsured).

d. When considering readiness, we should consider two variables:

- Is data from the CDR robust?

  "Robust" data means that it is sufficiently "complete" to publicly report statistically valid and reliable results from the CDR for (1) the Medicaid population and subsequently (2) for the WA state population (all payer and uninsured). "Complete" refers to both the percentage of the total encounters during a measurement period AND longitudinal data (because measures often have a multi-year look back period).

- Is the CDR capability-ready to enable measurement for public reporting?

  This means that work is complete, tested and implemented to reliably extract information from summary of care records submitted to the CDR to accurately report aggregate numeric results for clinical measures (process and outcome), for (1) the Medicaid population and subsequently (2) for the WA state population (all payer and uninsured). NOTE: For results to be reported at a clinic/medical group level, the CDR will need to be able to accurately map providers to clinics and clinics to medical groups.

3. **Survey Data**

Surveys targeting input from patients (and/or their families) or providers constitute the most common source of data for measures on the effectiveness of care coordination. The *AHRQ Atlas* makes note of approximately 80 care coordination measures; of these, more than 60 are associated with some form of a survey as the data source.

Some CAHPS (Consumer Assessment of Healthcare plans and Systems) patient experience surveys (AHRQ developed and NQF-endorsed) do include questions related to care coordination. While health plans are required to implement the health plan CAHPS survey for NCQA accreditation, the Health plan CAHPS survey does not focus specifically on care coordination. The Washington Health Alliance implements the Clinician/Group-CAHPS survey (CG-CAHPS) for patient experience with primary care practices on a biannual basis. Examples of care coordination-related questions in the CG-CAHPS survey 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 noted in the *AHRQ Atlas* 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, nor are they widely used across the country for measurement *and public reporting*.

Surveys are very expensive to implement, particularly with the goal of producing statistically reliable and valid statewide results for public reporting. For example, this year's implementation of the CG-CAHPS survey with results for primary care groups of four or more statewide is expected to cost approximately $550,000.

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 and other 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, practice assessment tools are rarely used to support measurement *with the intent of public reporting*.

Discussion: Mechanisms for Achieving Care Coordination

The *AHRQ Atlas* describes two domains of activities (or interventions) that may be useful when categorizing and considering measures of care coordination. It is important to note that some categories better lend themselves to systematic measurement than others. These areas are highlighted in blue in the two tables included on page 8.

1. **Broad Approaches** –The *AHRQ Atlas* describes five activities as "aimed at systematically improving the delivery of health care, including improving or facilitating coordination; they incorporate a number of coordination activities . . . and are often complex in intent and design."

System 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 nine specific actions deployed between providers and between providers and patients to support care coordination.

Coordination Activities	Summary
1. Establish accountability	Specify who is primarily responsible for care and coordination activities
2. Communication	Sharing knowledge among participants in a patient's care through: • Interpersonal communication (face-to-face, phone, email, letters) • Information transfer (medical records, clinical notes and recommendations, diagnostic images and results)
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

Discussion: Use and Availability of Care Coordination Measures Today

For our work, a national scan was completed to better understand what is going on elsewhere in the country. Alliance staff reviewed measures characterized by the National Quality Forum as related to care coordination, including the measure specifications and the data needed to complete measurement. Alliance staff reviewed care coordination measures included in the "Buying Value" tool developed by Bailit Health and funded by the Robert Wood Johnson Foundation. Alliance staff also reached out to the Network for Regional Health Improvement (NHRI) to find out whether and how other states or communities are measuring care coordination. [2]

Bottom line: Care coordination and care transitions measures are not easy to come by. Of those that do exist, most are not in wide use so they couldn't be described as "nationally vetted" or standardized and there is little experience to draw upon in terms of learning how they are used for public reporting. Some are specific to a smaller subset of the population (e.g., by clinical diagnosis) that is likely to have an accompanying small "N" problem. And, as was noted earlier, a majority of the measures that are out there depend upon (1) survey data that is expensive to produce, or (2) clinical data from the medical record that is hard to access at the present time in Washington state.

There are seven claims-based measures that are *currently approved* for the WA State Common Measure Set that are included in national lists of measures that pertain to care coordination. These include:

1. Follow-up After Hospitalization for Mental Illness (NCQA-FUH)
2. 30-day Psychiatric Inpatient Readmissions (DSHS RDA)
3. Follow-up Care for Children Prescribed ADHD Medication (NCQA-ADD)
4. Potentially Avoidable Use of the Emergency Room (Alliance)
5. Plan All-Cause Hospital Readmissions (NCQA-PCR)
6. Follow-up After Discharge from ER for Mental Illness (NCQA-FUM) *(approved for implementation in 2018)*
7. Follow-up After Discharge from ER for Alcohol or Other Drug Dependence (NCQA-FUA) *(approved for implementation in 2018)*

The work group concluded that these seven are worthwhile measures that indirectly measure a process or outcome related to care coordination, but they do not necessarily directly measure specific care coordination activity. Arguably it is likely that performance on these measures will be better in health care systems that coordinate care in a deliberate and reliable manner. The work group also noted that they all pertain to care transitions and follow-up care, rather than the existence and effectiveness of care coordination "upstream" (i.e., coordination of care to optimize outpatient and community-based care and avoid hospitalization, ER use, etc.).

---

[2] NHRI represents more than 30 regional health improvement collaboratives and state-affiliated partners, many of whom engage in measurement and public reporting on health care quality and cost.

The work group also reviewed 13 additional NQF-endorsed measures (not currently on the Common Measure Set) that utilize administrative (claims) data. These measures were selected for review because administrative (claims) data is one of the only readily available data sources in Washington today to support robust, statewide reporting in the near term. These measures include the following:

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. Acute Care Hospitalization During the First 60 Days of Home Health (Medicare) (CMS, NQF-endorsed #171)
9. Emergency Department Use Without Hospitalization During the First 30 Days of Home Health (CMS, NQF-endorsed #173)
10. Patients with a Transient Ischemic Event ER Visit That Had a Follow Up Office Visit (Optum, NQF-endorsed #0644)
11. Proportion of Patients with a Chronic Condition that Have a Potentially Avoidable Complication During the Calendar Year (Altarum Institute, NQF-endorsed #709)
12. 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)
13. Advance Care Plan (Medicare) (NCQA, NQF-endorsed #0326)

The work group is not recommending any of these measures at this time for immediate inclusion (2018 implementation) in the Common Measure Set. It was felt that measures #1 – 10 do not add additional elements as they all generally pertain to care transitions and follow-up care (already somewhat covered in the Common Measure Set); they also focus on clinical subsets of the population. Measures #11-13 are being suggested for a “watch list” (see Recommendation #3).

Work Group Recommendations to the PMCC:

Recommendation #1

The PMCC should adopt the AHRQ Atlas definition and overall framework for care coordination as the context and structure for its current and future deliberations related to care coordination measurement. (Definition included on page 2 of this document.)

Rationale: The AHRQ Atlas provides a reasonable working definition of care coordination and it fits with the PMCC's goal of focusing on nationally vetted tools, measures, etc., whenever possible. It also helps us to establish a key question that we are trying to address through measurement: *Is there deliberate, reliable and effective organization of patient care activities that facilitate appropriate delivery of health care services to meet patients' needs and preferences?*

Recommendation #2

The PMCC should <u>maintain</u> the following seven measures that are currently approved for the Common Measure Set:

1. Follow-up After Hospitalization for Mental Illness (NCQA-FUH)
2. 30-day Psychiatric Inpatient Readmissions (DSHS RDA)
3. Follow-up Care for Children Prescribed ADHD Medication (NCQA-ADD)
4. Potentially Avoidable Use of the Emergency Room (Alliance)
5. Plan All-Cause Hospital Readmissions (NCQA-PCR)
6. Follow-up After Discharge from ER for Mental Illness (NCQA-FUM) *(approved for implementation in 2018)*
7. Follow-up After Discharge from ER for Alcohol or Other Drug Dependence (NCQA-FUA) *(approved for implementation in 2018)*

Rationale: These seven measures are worthwhile nationally-vetted measures that indirectly measure a process or outcome related to care coordination. Arguably it is likely that performance on these measures will be better in health care systems that coordinate care in a deliberate and reliable manner.

Recommendation #3

The PMCC should not add any additional <u>claims-based</u> measures related to care coordination to the Common Measure Set at this time. However, the work group does recommend that the PMCC include the following NQF-endorsed measures on a "watch list" for potential *future* consideration when resources and/or access to data (needed for implementation) become available.

1. **Medication Reconciliation Post Discharge (Steward: NCQA, NQF 0554)**
   <u>Data Required</u>: May be completed with claims data or electronic medical record data
   <u>Summary of Measure</u>: The percentage of discharges during the first 11 months of the

measurement year for patients 66 years of age and older for whom medications were reconciled on or within 30 days of discharge.
Barriers for Immediate Implementation: Requires access to Medicare data and, if implemented with claims data, requires robust provider use of CPT codes that document medication reconciliation.

2. **Proportion of patients with a chronic condition that have a potentially avoidable complication during a calendar year (Steward: Altarum Institute, NQF 0709)**
   Data Required: Administrative Claims
   Summary of Measure: Percent of adult population (18 and older) who were identified as having as least one of six chronic conditions (Asthma, COPD, Coronary Artery Disease, Heart Failure, Hypertension, or Diabetes), were followed for at least one-year, and had one or more potentially avoidable complications (PACs) during the most recent 12 months. (detailed definitions of PACs provided).
   Barriers for Immediate Implementation: Measure is still relatively untested (not widely used). It is complex to program and validate; resources would need to be identified to support implementation.

3. **Advance Care Plan (Steward: NCQA, NQF 0326)**
   Data Required: Electronic Health Record data
   Summary of Measure: The percentage of patients aged 65 years and older who have an advance care plan or surrogate decision-maker surrogate documented in the medical record OR documentation in the medical record that an advance care plan was discussed but the patient did not wish one or was not able to name a surrogate decision-maker or provide an advance care plan.
   Barriers for Immediate Implementation: Requires access to Electronic Health Record data.

In addition, it should be noted that NCQA has announced two new HEDIS measures related to care coordination for initial implementation in 2018. Both are focused on the Medicare population. The detailed specifications have not yet been released. Per NCQA policy, first-year measures are never publicly reported, therefore health plan results on these measures will not be available via NCQA Quality Compass earlier than 2020 (for CY 2019).

- **Transitions of Care**
  The measure will assess the percentage of inpatient discharges for Medicare members 18 years and older who had each of the following during the measurement year: (1) notification of inpatient admission, (2) receipt of discharge information, (3) patient engagement after inpatient discharge, and (4) medication reconciliation post discharge. It is likely that this will be a hybrid measure, inclusive of clinical data.

- **Follow-up After Emergency Department Visit for People with High-Risk Multiple Conditions**
  This measure will assess 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.

Recommendation #4

The PMCC should not add any measures requiring clinical data (from EHR) to the Common Measure Set at this time.

At the present time and for approximately the next three years, Washington State does not and will not have a fully functioning clinical data repository (CDR) that is robust enough and capability-ready to support quality measurement for the purpose of public reporting on care coordination. When the CDR does become available during this time frame, it will only be suitable for public reporting on the Medicaid-insured population. It is unknown at this time, when the CDR will be robust enough to support quality measurement for the rest of the Washington population (commercial, Medicare, uninsured).

Given this, the work group does not recommend any EHR-based care coordination measures for the Common Measure Set at this time. Three to four years from now, when the CDR will hopefully be able to support measurement for public reporting purposes, the landscape of nationally-vetted measures may be quite different than it is today. Therefore, the work group concluded that there is little point in recommending specific measures now that may change or be replaced over the coming years.

Recommendation #5

The PMCC should periodically monitor the following over the next several years:

1. EHR data availability within Washington state to support statewide measurement and public reporting. Measures that may be used to do this, include:
   - Summary of care records were submitted for X% of the Medicaid encounters during the measurement period (e.g., the previous six months)
   - Summary of care records were submitted for X# of non-Medicaid medical encounters during the measurement period

   The PMCC may also wish to ask for a report from the HCA on these measures as well as how often the CDR is being used, i.e., how often are clinicians utilizing the CDR to extract information to support clinical decision-making.

2. EHR-based care coordination measure development occurring nationally with an emphasis on the following five focus areas, four of which appear in the *AHRQ Atlas* as being the most common areas of interest *for measurement*:

- Communication between providers and between providers and patients
- Patients with chronic conditions who also have potentially avoidable complications
- Facilitation of transitions in care
- Medication management
- Health IT-enabled coordination

In addition to additional measures that focus on care transitions, the work group encourages continued attention to the development of measures that would add new a dimension to the Common Measures Set – in other words, measures that would help us evaluate the effectiveness of care coordination "upstream."

Recommendation #6

The PMCC should discuss and consider adding the following measure from the Clinician-Group CAHPS survey to the Common Measure Set: "*How Well Providers Use Information to Coordinate Care*." This is a composite measure that combines results for three survey questions, including:

- Provider knew important information about patient's medical history
- Someone from provider's office followed up with patient to give results of blood test, x-ray or other test
- Someone from provider's office talked about all prescription medications being taken

Rationale: The CG-CAHPS survey is the only available data source at this time to support statewide reporting of "Communication between providers and patients" related to care coordination. The CG-CAHPS survey is implemented by the Washington Health Alliance every other year. The survey is currently being implemented (survey in the field now) with results expected 1st Quarter 2018. Future implementation of the survey (2019-2020) will be dependent upon the availability of funding. The work group noted that there are pros and cons to including this measure, as follows:

PROS	CONS
• Measures a clearly related topic • Patient-reported (patient centric) • Robust results for primary care clinics with four or more providers statewide	• Doesn't include smaller practices (three or fewer providers) • Doesn't include results for specialty practices • Survey is expensive to implement and done every other year at the current time