



## Care Coordination Measurement Roadmap - Ad Hoc Work Group

Wednesday, July 26, 2017

9:00 – 10:30 am

Meeting Summary

### In Attendance:

Susie Dade, Washington Health Alliance

Julie Lindberg, Molina

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

Guest: Jennifer Harvell, WA State Health Care Authority

Guest: Dylan Oxford, WA State Health Care Authority

### Absent:

Leah Hole-Marshall, Labor & Industries

Elya Moore, Olympic Community of Health

1. The workgroup reviewed and discussed elements of the *Care Coordination Measures Atlas* (AHRQ, 2014) which has been proposed as a useful framework for understanding care coordination and care coordination measurement. The workgroup spent approximately one hour discussing the key concepts of the framework, including the elements summarized below (please see meeting materials, distributed in advance, for more detail):
  - a) A definition of care coordination
  - b) Who benefits from care coordination
  - c) Perspectives about care coordination (patient and family/caregiver, health care professionals, systems)
  - d) Domains for categorizing potential measures of care coordination (broad systems, specific coordination activities)
  - e) Data sources for care coordination measures
  
2. The work group tentatively agreed that the broad topic we are trying to address with measurement of care coordination is as follows:

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?

3. The workgroup discussed and tentatively approved the following recommendations:

- a) The PMCC should adopt the AHRQ Atlas definition and framework for care coordination as the context and structure for its roadmap related to care coordination measurement. The Atlas definition of care coordination is as follows:

*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.*

Rationale for recommendation: The AHRQ Atlas fits with our goal of focusing on nationally vetted tools, measures, etc. and it provides a reasonable working definition of care coordination that combines common elements from many definitions. There is no other nationally agreed-upon definition of care coordination that we were able to find.

- b) The PMCC should maintain the following seven measures that are *related to* care coordination.

- i. Follow-up After Hospitalization for Mental Illness (NCQA-FUH)
- ii. 30-day Psychiatric Inpatient Readmissions (DSHS RDA)
- iii. Follow-up Care for Children Prescribed ADHD Medication (NCQA-ADD)
- iv. Potentially Avoidable Use of the Emergency Room (Alliance)
- v. Plan All-Cause Hospital Readmissions (NCQA-PCR)
- vi. Follow-up After Discharge from ER for Mental Illness (NCQA-FUM) (*approved for implementation in 2018*)
- vii. Follow-up After Discharge from ER for Alcohol or Other Drug Dependence (NCQA-FUA) (*approved for implementation in 2018*)

Rationale: It was agreed that these measures indirectly measure a process or outcome related to care coordination but do not necessarily directly measure specific care coordination activity. Arguably, it is likely that performance on these measures will be better in systems that coordinate care in a deliberate and reliable manner.

- c) It was agreed that the work group would review additional claims-based measures to determine whether there are any that should be recommended for inclusion in the Common Measure Set in 2018 or 2019.

Rationale: Administrative (claims) data is one of the only readily available data sources in Washington today to support robust, statewide reporting in the near term.

4. The workgroup had a lengthy discussion regarding the current status of the state's clinical data repository (CDR) and the availability of data from the CDR to support measurement and public reporting. A number of questions were posed and additional information will be collected prior to the next meeting of the work group so that recommendations can be developed and agreed upon.
5. The work group also began a discussion about the availability of surveys to measure care coordination. CAHPS surveys appear to be our best path forward for using surveys as a data source on care coordination. Additional information will be collected about the feasibility of using CAHPS surveys prior to the next meeting.
6. The meeting adjourned at 10:35 am.