Care Coordination Measurement Roadmap - Ad Hoc Work Group

Wednesday, August 9, 2017

9:00 – 10:30 am

Meeting Summary

In Attendance:

Sue Bergmann, Washington State Hospital Association
Susie Dade, Washington Health Alliance
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

Guest: Jennifer Harvell, WA State Health Care Authority
Laurie Kavanagh, Washington Health Alliance
Dawn Williams, WA State Department of Social and Health Services
Jim Jackson, WA State Department of Social and Health Services

Absent:

Julie Lindberg, Molina
Leah Hole-Marshall, Labor & Industries

1. The work group reviewed and reaffirmed decisions made at the July meeting.
    a) The work group will recommend that the PMCC adopt the *Care Coordination Measures Atlas* (AHRQ, 2014) definition and framework as the context and structure for its work related to care coordination measurement. The *Atlas* definition of care coordination is:
    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.

    b) The work group agreed that the broad topic that we are trying to address with measurement of care coordination is: *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?

c) The work group will recommend that the PMCC maintain the following seven measures that are *related to* care coordination. (note: these measures are already approved for inclusion in the Common Measure Set)
    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)*

2. The work group followed up on the topic of using data from the Health Care Authority's Clinical Data Repository (CDR) for the purpose of statewide public reporting on quality measures, including care coordination. The work group discussed that the CDR must be both robust and capability-ready to support the Common Measure Set implementation.

   Robust means:

   a) Data that is sufficiently "complete" to publicly report statistically valid and reliable results from the CDR
      i. for the Medicaid population
      ii. for the WA state population (all payer and uninsured)
   b) "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)

   Capability-ready means:

   a) Work is complete, <u>tested and implemented</u> 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)
      i. For the Medicaid population
      ii. For the WA state population (all payer and uninsured)

      NOTE: for results to be reported at a clinic/medical group level, the CDR needs to be able to accurately map providers to clinics and clinics to medical groups

   At the conclusion of its discussion, the work group agreed to recommend the following to the PMCC:

   a) 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 that is robust enough and capability-ready to enable quality measurement *for the purpose of public reporting* on provider performance on care coordination.
   b) Given this, the work group does <u>not</u> recommend any EHR-based care coordination measures for the Common Measure Set at this time.

c) The work group does recommend that the PMCC periodically monitor:
   – 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 how often the CDR is being used, i.e., how often are clinicians engaging with the CDR to extract information to support clinical decision-making
   – EHR-based care coordination measure development occurring nationally with an emphasis on the following focus areas that 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

3. The workgroup reviewed a list of 13 claims-based measures that are NQF-endorsed and appear to be loosely related to care coordination. The rationale for looking at additional claims-based measures at this time is that administrative (claims) data is one of the only readily available data sources in Washington today to support robust, statewide reporting in the near term. The measures included:
   a) Heart Attack 30-day Readmit (CMS, NQF-endorsed #0505)
   b) Pneumonia 30-day Readmit (CMS, NQF-endorsed #0506)
   c) Vascular Procedures 30-day Readmit (CMS, NQF-endorsed #2513)
   d) Chronic Obstructive Pulmonary Disease 30-day Readmit (CMS, NQF-endorsed #1891)
   e) Heart Failure 30-day Readmit (CMS, NQF-endorsed #0330)
   f) Coronary Artery Bypass Graft 30-day Readmit (CMS, NQF-endorsed #2515)
   g) Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty 30-day Readmit (CMS, NQF-endorsed #1551)
   h) 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)
   i) Acute Care Hospitalization During the First 60 Days of Home Health (Medicare) (CMS, NQF-endorsed #171)
   j) Emergency Department Use Without Hospitalization During the First 30 Days of Home Health (CMS, NQF-endorsed #173)
   k) Proportion of Patients with a Chronic Condition that Have a Potentially Avoidable Complication During the Calendar Year (Altarum Institute, NQF-endorsed #709)
   l) Patients with a Transient Ischemic Event ER Visit That Had a Follow Up Office Visit (Optum, NQF-endorsed #0644)
   m) Advance Care Plan (Medicare) (NCQA, NQF-endorsed #0326)

The work group will not recommend any of these thirteen measures for inclusion in the Common Measure Set at this time (for 2018). But they will recommend that the following measures be included in a "watch list" for future consideration.

a) 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)
b) Proportion of Patients with a Chronic Condition that Have a Potentially Avoidable Complication During the Calendar Year (Altarum Institute, NQF-endorsed #709)
c) Advance Care Plan (Medicare) (NCQA, NQF-endorsed #0326)

4. The work group discussed the possibility of utilizing measures derived from survey data. The only likely data source at this time (to support statewide reporting) is the Washington Health Alliance CG-CAHPS survey. The work group will recommend that the PMCC discuss and consider adding the following measure to the Common Measure Set:
   a) How Well Providers Use Information to Coordinate Care
      This is a composite measure that combines results for three survey questions, including:
      i. Provider knew important information about patient's medical history
      ii. Someone from provider's office followed up with patient to give results of blood test, x-ray or other test
      iii. Someone from provider's office talked about all prescription medications being taken

   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 • Doesn't include specialists • Survey is expensive to implement and done every other year

5. The meeting adjourned at 10:30 am.