Washington Common Measure Set on Healthcare Quality and Cost

Care Coordination Measurement Roadmap – Ad Hoc Work Group

Meeting #3

August 9, 2017

WASHINGTON HEALTH ALLIANCE

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Today's Meeting Agenda

9:00	Welcome, Introductions
9:05	Review decisions from July 26 meeting
9:15	Availability of CDR to support measurement using clinical data and associated recommendation
9:45	Review of claims-based measures
10:20	Opportunity for Public Comment
10:30	Adjourn

Workgroup Membership

- Leah Hole Marshall, Labor & Industries
- Julie Lindberg, Molina Healthcare of Washington
- Elya Moore, Olympia Community of Health
- Laura Pennington, Washington State Health Care Authority
- Britt Reddick, WA State Health Care Authority
- Jonathan Sugarman, Qualis Health
- Emily Transue, Washington State Health Care Authority

Our Charge

- Review the status of measuring care coordination/care transitions (for public reporting) – what is going on elsewhere in the country, what measures are in use, what data is necessary to support measurement?
- Formulate advice and/or recommendations to the PMCC re:
  - Is the time right for creating a "roadmap?" Do we know enough about the options, data sources, etc.?
  - If so, what should be included in this "roadmap?"
  - What topics are we trying to address with measurement of care coordination/care transitions?
  - What measures exist?
  - What data would we need to implement and is there a potential source of the necessary data to support measurement?

Decisions Made at Last Meeting

1. **The work group will recommend that the PMCC 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.

   <u>Rationale</u>: 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 <u>nationally agreed-upon</u> definition of care coordination that we were able to find.

Decisions Made at Last Meeting

2. **This is the broad topic that we are trying to address with measurement of care coordination:**

   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?

Preliminary Decisions Made at Last Meeting

3. **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)**

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

Rationale: 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.

Preliminary Decisions Made at Last Meeting

4. **The work group will 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.

Decisions Tabled at Last Meeting

We tabled decisions related to:

- Recommendation re: access to clinical data for measurement and public reporting
  - Follow-up today from Health Care Authority
- Recommendation re: use of survey data for measurement and public reporting
  - Follow-up at next meeting

Access to Clinical Data

Availability of CDR to support measurement and statewide, public reporting using clinical data

Public Reporting	Statewide
• Public scrutiny • Tracking performance • Purchasing/contracting	• Total population vs. subsets of population • Counties/ACHs • Clinics/Medical Groups • Hospitals

Availability of CDR to support measurement using clinical data

- **Robust**
  - Data that is sufficiently "complete" to publicly report statistically valid and reliable results from the CDR
    - for the Medicaid population
    - 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)

- **Capability-ready**
  - 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 the Medicaid population
    - 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

Availability of CDR to support measurement using clinical data

Questions for the Health Care Authority:

1. When will it be possible to report the following process measure from the CDR? Please specify a projected date (e.g., Dec 2017, Dec 2018, etc.)
   - Summary of care records were submitted for X% of the Medicaid encounters during the measurement period (e.g., 3 months, 6 months, 1 year) – Likely for 2017
   - Summary of care records were submitted for X% of all medical encounters (Washington state population) during the measurement period (note: I'm not sure how we will calculate a denominator for a measure like this) – Unknown – not sure when this information will be available

Availability of CDR to support measurement using clinical data

Questions for the Health Care Authority:

2. When will the CDR be capability-ready and contain robust data to support measurement of process and/or outcome measures for the purpose of public reporting in WA state?
   - For the Medicaid-only population? – Useful data in 2018 and a robust Medicaid data set in 2019
   - For the WA state population (all payer and uninsured)? – Unknown at this time and difficult to predict as there is no requirement in commercial contracts for providers to contribute to the CDR

NOTE: An example of a process measure would be, "percentage of patients 18-75 years of age with a diagnosis of diabetes that had at least one HbA1c test during the measurement period." An example of an outcome measure would be, "percentage of patients 18-75 years of age with a diagnosis of diabetes whose most recent HbA1c level was greater than 9.0%."

Draft recommendation to PMCC re: Use of CDR for Measurement/Public Reporting

- At the present time and for approximately the next XX 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.
- Given this, we do not recommend any EHR-based care coordination measures for the Common Measure Set at this time.
- We do recommend that the PMCC periodically monitor:
  - EHR data availability within Washington state to support statewide measurement and public reporting; and,
  - EHR-based care coordination measure development occurring nationally with an emphasis on the following focal areas:
    - Communication between providers and between providers and patients
    - Facilitation of transitions in care
    - Medical management
    - Health IT-enabled coordination

Review of Claims-based Measures

Key Measure Selection Criteria

1. Measures are based on *readily available data in WA (*we must identify the data source).
2. Preference given to nationally-vetted measures (e.g., NQF-endorsed) and other measures currently used by public agencies within WA.
3. Each measure should be valid and reliable, and produce sufficient numerator and denominator size to support credible public reporting.
4. 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.

Review of Claims-based measures

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. 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
13. Advance Care Plan (Medicare) (NCQA, NQF-endorsed #0326)

Public Comment
Next Steps
Wrap-up