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Care Coordination: Moving towards Practices and Measures

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Care Coordination

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NQF Care Coordination Framework:

- Care Coordination **is** a function that helps ensure that the patient's needs and preferences for health services and information sharing across people, functions, and sites are met over time.
  - The framework encompasses five domains and four principles.

Domains for Care Coordination

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- The 5 domains represent essential components for which performance measures should be developed to drive improvement:
  - Healthcare Home
  - Proactive Plan of Care & Follow-up
  - Communication
  - Information systems
  - Transitions or Hand-offs

Principles for Care Coordination

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1. Care coordination is important for everyone.
2. Some populations are particularly vulnerable to fragmented, uncoordinated care.
3. Suitable for measurement and accountability at multiple levels, including the clinician level.
4. Patient and family surveys of their experience with care coordination efforts are essential.

Healthcare Home

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- A source of usual care selected by the patient
- The medical home should function as the central point for coordinating care around the patient's needs and preferences.
- The medical home should also coordinate between all of the various team members and non-clinical services as needed and desired by the patient :
  - includes the patient, family members, other caregivers, primary care providers, specialists, other healthcare services

Proactive Plan of Care

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- An established and current care plan that anticipates routine needs and actively tracks up-to-date progress toward patient goals:
  - System in place for developing a plan of care
  - Goal setting with patients and joint management of the plan of care; assess progress toward goals
  - Follow-up of tests, referrals, and treatments
  - Self-management support
  - Community services and resources

Communication

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- Communication available to all team members, including patients and family.
  - Shared plan of care
  - Patient safety/avoid errors in diagnosis and treatment – importance of shared patient information
  - Shared decision-making with patient and family.
  - Not limited to office visits
  - Privacy and information access

Information Systems

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- The use of standardized, integrated electronic information systems with functionalities essential to care coordination is available to all providers and patients.
  - Seamless interoperability
  - An evidence-based plan of care management
  - Effective integration of patient information
  - Patient registries and population-based data
  - Support for quality improvement and safety
  - Decision support tools, including provider alerts and patient reminders.

Transitions and Hand-Offs

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- Transitions between settings of care are a special case because currently they are fraught with numerous mishaps that can make care uncoordinated, disconnected, and unsafe.
  - Medication reconciliation
  - Follow-up tests and services
  - Changes in plan of care
  - Involvement of team during hospitalization and beyond
  - Communication between settings of care

NQF Endorsed Measure

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Care Transitions Measure: CTM-3

1. The hospital staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left the hospital.
2. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.
3. When I left the hospital, I clearly understood the purpose for taking each of my medications.

Potential HIT Structural Measures

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Draft report announced May 16, 2008 for public comment on 9 measures to foster adoption of HIT:

- **Adoption of Medication e-Prescribing**
- **EHR with EDI prescribing**
- **Adoption of HIT**
- **Ability to receive lab data electronically**
- **Ability to use HIT to perform care management**
- **Tracking of clinical results between visits**
- **Participation in a local database registry with standard measure set**
- **Participation in an external database registry**
- **PPC-PCMH survey tool**

http://www.qualityforum.org/projects/ongoing/hit/comments/index.asp

Measuring Care Coordination

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Care Coordination Domain	NQF-endorsed measures (*draft)
Healthcare Home	PPC-PCMH survey tool*
Proactive Plan of Care	
Communication	
Information Systems	Draft HIT adoption measures*
Transitions/Hand-offs	3-item Care Transitions Measure

NQF Next Steps: Care Coordination

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NQF is pleased to announce a new consensus project to identify a set of preferred practices and measures to improve performance along each of the dimensions in the care coordination framework.