Meaningful Measures of Care Coordination

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NCQA
Measuring quality.
Improving health care.

Key Points

- **Care coordination measures should address structure, process and outcomes**
- **Process are most actionable but are lacking**
- **Process measures should be routine by-products of the care process**
  - **Support care delivery, decision support, and quality monitoring and improvement**
- **Care coordination measures depend on**
  - **HIT systems that track essential data elements**
  - **Effective workflows for clinicians and staff**

Definition

- **Care coordination is a function that supports information-sharing across providers, patients, types and levels of service, sites and time frames.**
- **The goal of coordination is to ensure that patients' needs and preferences are achieved and that care is efficient and of high quality.**
- **Care coordination is most needed by persons who have multiple needs that cannot be met by a single clinician or by a single clinical organization, and which are ongoing, with their mix and intensity subject to change over time**

Care Coordination Measures

- **Structure**
  - **a feasible starting place**
  - **articulating expectations of individuals and organizations**
- **Process**
  - **evaluate whether information is being exchanged and used to support an evidence-based, efficient care plan that address patient and family needs**
- **Outcomes**
  - **more relevant for families and policymakers**
  - **require risk adjustment**
  - **difficult to attribute to particular actions or players**

Care Coordination for Vulnerable Children

- **To identify an approach for measurement and feasible implementation strategies for monitoring and improving care coordination for children with or at risk of developmental delay**

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Care Coordination Measurement Approach

Levels for Measurement	Structure	Process	Outcomes
Primary care practice	• Process for tracking referrals • Designated staff to coordinate with other services	• Reason for referral provided to family • PCP discusses results with patients	• Clinical outcomes • Functional status • Patient/ Family perceptions of care • Value
Medical specialty practices	• Process for tracking consult request	• Results sent to PCP • Specialist discusses results with patients	
Other service providers (e.g. early Intervention, rehabilitation services)	• Designated staff to coordinate with other services	• Results sent to PCP • Treatment plan updated	
Hospitals/Facilities	• Designated staff for post-admission f-up	• Admission info shared with PCP	
Community	• Navigator to work with families	• Updated care plan	
State	• Service Capacity	• Updated care plan	

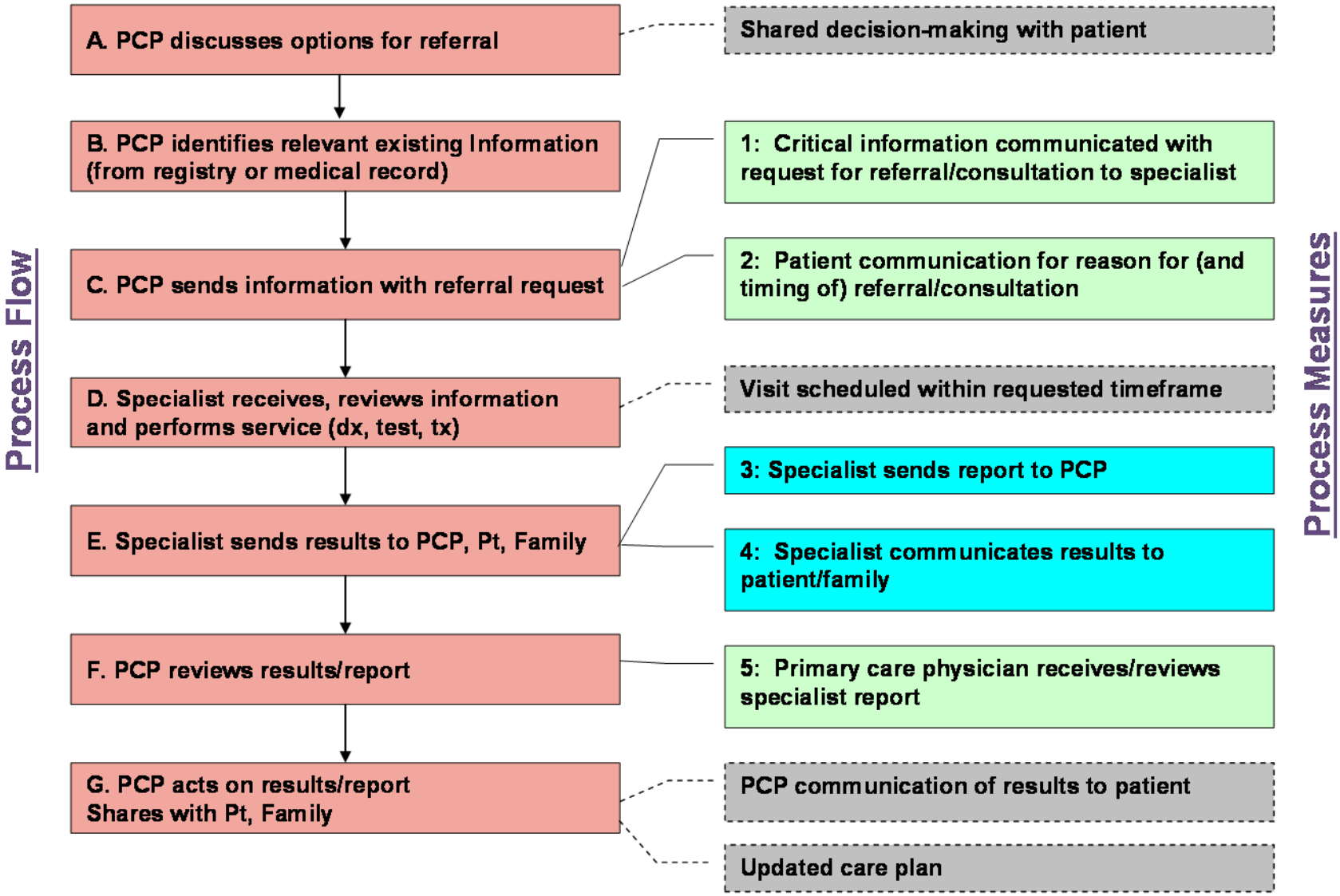
PPC-PCMH Standards

1. Access and Communication
2. Patient Tracking and Registry Functions
3. Care Management
4. Patient Self-Management Support
5. Electronic Prescribing
6. Test Tracking
7. Referral Tracking
8. Performance Reporting and Improvement
9. Advanced Electronic Communications

Development of Ambulatory Care Coordination Measures

- ***Project led by Johns Hopkins University, NCQA and Park Nicollet***
- **Identify existing care coordination measures, develop candidate measure concepts, and review and prioritize measures for further specification**
- **Develop preliminary technical specifications for care coordination measures prioritized by a stakeholder panel and practicing physicians**
- **Test the measures' usability, acceptability, and technical feasibility in settings with different levels of EHR support**
- **Disseminate the draft measures and testing results**

Figure 1. Model for Ambulatory Care Coordination



Issues in Measurement

- **Urgency of referral/Expected timing of visit**
  - **Which referrals should be followed**
  - **What is expected time frame?**
- **Effective communication with patients and families**
- **Accountability**
  - **Primary care vs. medical specialist**
  - **System-wide accountability**

Issues in Measurement

- **Different issues in integrated versus non-integrated settings**
  - **Patient dumping vs. patient stealing**
  - **Referral vs. consultation**
  - **Definition of "exchanging information" with shared EMR**

EHR and Care Coordination

- **Even in practices committed to improved care coordination….**
  - **Organizations and practices lacked the electronic functionality to report on care coordination**
  - **Clinician and staff workflows did not use the care coordination capacity of HIT effectively**

Cautions about EHR-based Measures

- **Underreporting of numerator - “apparent quality failures” are false negatives**
  - **free text fields**
  - **faxed or scanned documents**
- **Identification of eligible population**
  - **Will tools be used for all referrals**
  - **Should all referrals be in here**

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