

# THE NATIONAL QUALITY FORUM

## CARE COORDINATION PREFERRED PRACTICES AND PERFORMANCE MEASURES.

### Conference call Summary

A conference call of the Care Coordination Steering Committee was held on Monday, December 7, 2009 to review the comments received on the draft report for Care Coordination.

*Steering Committee members present:* Donald Casey, Jr., MBA, MD, MPH (co-chair); Gerri Lamb, PhD, RN (co-chair); Richard Antonelli, MD, MS; Robert Bonow, MD; Kathryn Bowles, PhD, RN; Karen Farris, PhD; Lakshmi Halasyamani, MD; Karen Ann Lichtenstein, MA; Margaret Leonard, MS, RN; Alice Petrulis, MD; Joan Quinn, MS, RN; Jennifer Sweeney, MA; Carolyn Scott, MEd, MHA, RN; Deborah Willis-Fillinger, MD

*NQF staff:* Helen Burstin, MD; Nicole McElveen, MPH; Robyn Y. Nishimi, PhD; Hawa Camara

### WELCOME AND INTRODUCTIONS

Ms. McElveen welcomed the Committee members, and reviewed the agenda and objectives for the conference call. Ms. McElveen clarified that the purpose of the conference call was to review the comments received on the care coordination draft report, as well as the proposed staff actions responding to them. She noted that NQF received 464 comments, many of which were redundant, and that the Committee would be focusing on those comments the staff had identified as needing specific Committee attention.

### REVIEW OF COMMENTS APPROACH

The Committee reviewed and addressed the specific set of comments requiring Committee attention during the conference call. Below is a summary of those comments and discussion points of the Steering Committee:

- **Practice 2** – Several comments were received requesting further clarification on the Committee’s intent for the specific verbiage in the opportunities of measurement section. Reference was made to ‘low-continuity’ populations. The commenter specifically asked whether the referenced populations were within the same medical home or derived from a different care management model (i.e., retail-based clinics).

*Steering Committee Discussion:*

The Steering Committee noted that there is an opportunity to compare populations and individuals within the healthcare home, but it depends on the methodology and research question. In addition, there are strata of populations that require more intense care coordination—therefore, this practice targets populations that require higher intensity of care coordination. It was recommended that the language should be consistent for care coordination targeting at-risk populations; further clarification was added to the draft report.

- **Practice 3** – A comment suggested adding to the specifications of the practice, specifically, criteria for health plan payment or incentivization of clinicians’ development and oversight of the care plan.

*Steering Committee Discussion:*

The Committee discussed their decision to exclude payment policies in the specifications. Ultimately, the Committee reaffirmed its original decision that it was not appropriate to include specific recommendations related to payment or incentives within the practices. However, additional verbiage was added to the body of the report, highlighting the work of the National Priorities Partnership and payment reform.

- **Practice 4/Practice 5** – A comment raised concerns about this practice being too physician focused. Several suggestions were made to further specify which care providers this practice is intended for (e.g., nurse practitioner, case manager, etc.)

*Steering Committee Discussion:*

The Steering Committee discussed the concerns raised in the comment and agreed it was best *not* to specify healthcare providers within the context of the practice, but rather include a general term ‘primary care and specialist providers.’ The Committee noted that the roles and responsibilities of the providers should be defined by the healthcare home, which is the suggested implementer of the practice; this is also indicated in the specifications of practices 4 & 5. Licensure requirements also were raised and discussed as a component of indicating roles and responsibilities for healthcare providers. The Committee concluded that this practice was intended to be delivered within the core care delivery team, since, in terms of large scale care coordination teams; there is a mixture of licensed and non-licensed providers.

- **Practice 5** – A comment suggested adding specific verbiage to incorporate youth/children who are at risk for adverse outcomes in education, mental health, and family functioning.

*Steering Committee Discussion:*

The Committee discussed the concerns presented in this comment and noted the importance of youth/children who are at risk for adverse outcomes. The Committee also agreed that the practice does not specify age and therefore could be applicable to youth/children; in addition, the specifications of the practice mention assessments of a patient’s functional, cognitive, behavioral, social, preventive health behaviors, and medical needs. The Committee felt the concerns presented in the comment were already addressed within the practice and specifications. No further action was taken.

- **Practice 7** – A comment suggested that specific language be incorporated to emphasize the role of the case manager/care coordinator to coordinate and manage activities related to patient services.

*Steering Committee Discussion:*

The Steering Committee agreed that this commenter’s concerns were similar to another comment to further specify the providers within the practices. The Committee discussed the implications of specifically including the role of the case manager/care coordinator and concluded it would be best *not* to provide those specifics, but rather indicate in the practice more general terms, such as ‘primary care and specialist providers.’ The Committee noted that the roles and responsibilities of the providers should be defined by the healthcare home, which is the suggested implementer of the practice. Licensure requirements also were raised and discussed as a component of indicating roles and responsibilities for healthcare providers. The Committee concluded that this practice was intended to be delivered within the core care delivery team, since, in terms of large scale care coordination teams; there is a mixture of licensed and non-licensed providers.

- **Practice 9** – A comment suggested incorporating legal and advocacy services into the specifications of this practice, which focuses on community and nonclinical services.

*Steering Committee Discussion:*

The Committee agreed that the notion of ‘nonclinical services’ in the practice statement includes legal services, and thus that no modifications are required to the practice statement or specifications.

- **Practice 10** – A comment requested clarification on the use of the verbiage ‘accessible’ within the practice statement.

*Steering Committee Discussion:*

The Committee discussed the importance of cardiac rehabilitation services, noting a large barrier to services is availability and accessibility for patients. The Committee also discussed the issue of holding entities accountable for providing/identifying these services and the low rate of reimbursement from insurance companies. The Committee noted that there needs to be economic support, appropriateness criteria and accessibility, and all three need to be in place for cardiac rehab services to take place. No further changes were incorporated into the report.

- **Practice 15** – Several comments appeared to object to the qualification within the practice that indicates only health information which is “needed” will be provided to the patient. It was suggested that the practice should be modified to allow patient access to all health information within an electronic system.

*Steering Committee Discussion:*

The Committee discussed the concerns of the commenters – specifically the notion of the patient’s right to personal health information. The original specification read, *Electronic information systems should be structured so that patients and providers have secured access to the best and most appropriate information needed.* The Committee agreed that this may have indicated that the provider would pre-determine what information the patient needs and therefore can access. Therefore, the Committee agreed to revise the specification to read: *Electronic information systems should be structured so that patients have secured access to the best and most appropriate information to guide care.*

- **Practice 16** – A comment was submitted requesting clarification between the use of the terms health information and health data (used in Practice 11). Practice 11 refers to health information whereas practice 16 (line 996-997) refers to health data.

*Steering Committee Discussion:*

The Committee discussed the intention of these terms to mean the same thing. However, one Steering Committee member noted that traditionally, ‘health data’ are usually a subset of ‘health information’ and therefore the terms should not be used interchangeably. The Committee agreed to modify the terms ‘data’ and ‘information’ for consistency in the practice statement and within the report. All references to *health data* were replaced with *health information*.

- **Practice 17** – A comment was submitted suggesting modifications to the specifications of the practice, in regard to the patient's access to their electronic medical records through a Regional Health Information system.

*Steering Committee Discussion:*

The Steering Committee noted that RHIOs are separate entities and do not currently enable their individual participating practices to provide information to their individual members. The Committee also discussed revising the practice statement to be more specific on the intentions of including the regional health information system. The practice statement was revised to read: *Regional health information systems governed by public/private partnerships should enable healthcare home teams to access all patient information.* The reference to the patient and their designees was removed.

- **Practice18/Practice 22** – A comment suggested modifying the specifications of the practice to include mental health treatments within transitions. In addition, another comment requested clarification to the term “transitions,” suggesting it include life transitions (e.g., child to adult).

*Steering Committee Discussion:*

The Committee agreed that ‘life transitions’ would be an interesting addition to address, however, it was not the initial approach taken by the Committee. The term ‘transitions’ is defined by NQF in the Care Coordination framework as a transition between settings of care, specifically identifying certain care processes during transitions that require particular attention. The Committee utilized this definition to define the practices under the transition domain and agreed that the practices, as drafted, were applicable to transitions related to mental health and ‘life transitions.’

- **Measures Not Recommended (CC-018-09)** - Several comments expressed concern about the Committee’s decision to not recommend the measure, *Timely Care Management Assessment Rates for Pregnant Women at High Risk in Managed Care.*

*Steering Committee Discussion:*

The Committee’s discussions centered on the recognition of the need to have a measure to address this high-risk population. It was noted, however, that this particular measure was recommended with conditions for the measure developer to consider. The Committee’s recommend conditions were not fully met (e.g., lack of specifications), and therefore the Committee agreed to keep the measure with their original recommendation of “do not recommend”.

**Additional Steering Committee Discussion Points:**

The Steering Committee provided further clarification on the use of the terms ‘healthcare home’ and ‘medical home’. Several comments were submitted suggesting better consistency and clarification of these terms throughout the report. The Committee noted that the ‘Healthcare Home’ is the overarching domain consistent with the NQF Care Coordination framework. The term ‘Healthcare Home’ is consistently used throughout the report, and the term ‘medical home,’ is used when research-based evidence is provided to support it.

Several comments were also received that noted that additional models besides the “medical home” fit within the NQF definition of a ‘healthcare home,’ including nurse-managed care health centers. The Committee agreed to cite these examples in the Problem Statement under the Healthcare Home Domain.

**Next Steps:**

The voting period on the Care Coordination measures and practices open only to NQF Members, will be conducted from December 18, 2009 to January 19, 2010. The redline changes to the draft report will show the progression of the work on the measures and practices, and will be posted for during the voting period. The Consensus Standards Approval Committee is scheduled to review the report in February 2010. Ms. McElveen will keep the Committee abreast of the project’s development.