

THE NATIONAL QUALITY FORUM

CARE COORDINATION

CONFERENCE CALL SUMMARY

A conference call of the Care Coordination Steering Committee was held on May 6, 2009, to review the submitted care coordination measures.

Steering Committee members present: Donald Casey, Jr., MBA, MD, MPH (co-chair); Gerri Lamb, PhD, RN (co-chair); Michael O'Dell, MD, MSHA; Richard Antonelli, MD, MS; Michael Kern, MD; Alice Petrusis, MD; Jennifer Sweeney, MA; David Stumpf, MD, PhD; Robert Bonow, MD; Brent Asplin, MD, MPH; Kathryn Bowles, PhD, RN; Dexanne Clohan, MD; Mary Driscoll, MPH, RN; Karen Farris, PhD; Eric Holmboe, MD; Christine Klotz, MHA; Joan Quinn, MS, RN; Karlene Ranghell, MBA; Carolyn Scott, MEd, MHA, RN; Neil Wenger, MD

NQF staff: Nicole McElveen, MPH; Robyn Y. Nishimi, PhD; Tina Grannis, RN, BSN; Hawa Camara

WELCOME AND INTRODUCTIONS

Ms. McElveen welcomed the Steering Committee members, and reviewed the agenda and objectives for the conference call. Ms. McElveen clarified that the purpose of the conference call was to provide an initial review of the candidate measures to determine whether the measures fit within the scope of this project. Before the review of the measures, the Steering Committee members disclosed all interests they may have in regards to the candidate measures: Dr. Michael O'Dell affirmed that he worked on some of the PCPI measures and Dr. David Stumpf stated that he helped with the Ingenix measures.

REVIEW OF MEASURES APPROACH

Dr. Casey and Dr. Lamb led the discussion on the review of the measures. A preliminary scan of the measures was conducted by the Steering Committee members prior to the call, wherein they were asked to address the following questions during their review: (1) Is this measure really measuring care coordination? (2) Is this measure related to a process of care coordination or an outcome of care coordination? (3) Are all measures focused on referrals across settings reflective of care coordination? (4) Are measures of case management reflective of care coordination? (5) Do the condition-specific measures look at what should be standard care or do they actually measure care coordination?

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Based on the results from this preliminary scan, the measures were categorized into three groups according to whether they fit into the scope of Care Coordination; Yes, No, and Uncertain.

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The discussion points for each of the measures are below:

Measure Number / Developer	Measure Title	Description	Steering Committee Discussion
CC-001-09 / ©New York State Department of Health	Average Caseload for Members with Diabetes in case management in managed care	The average diabetic caseload per case manager.	<p>The Steering Committee members felt this measure does not fit within the scope of care coordination for this project based on their review of the measure against the five questions and in the context of the framework.</p> <p>Discussions centered on the operational difficulties of this measure. Specifically, attaining the right level of caseload per case manager; the measure did not specify what a 'caseload' should be, therefore the measure outcome could be severe (could not find) if the caseload was too high. The Committee also discussed the workload between the manager and team, and the comprehensiveness of services. Lastly, the Committee concluded that this measure will not have a big impact as a consensus standard for measuring and reporting</p>

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			<p>care coordination.</p> <p>This measure will <u>not</u> be further evaluated.</p>
<p>CC-002-09 /</p> <p>©New York State Department of Health</p>	<p>Diabetic Care- BP Outcome Measure for Members in managed care</p>	<p>The measure describes the changes in the proportion of BP control for people in case management by using level of self reported blood pressure at initial assessment and after 3 months in case management or upon graduation from case management if less than 3 months.</p>	<p>The Steering Committee members felt this measure does not fit within the scope of care coordination for this project and concluded that this measure will not have a big impact as a consensus standard for measuring and reporting care coordination.</p> <p>This measure will <u>not</u> be further evaluated.</p>
<p>CC-003-09 /</p> <p>©New York State Department of Health</p>	<p>Diabetes Care-Service Measures for Members in managed care</p>	<p>The percentage of members with diabetes who were in case management for 3 months, or until graduation if less than 3 months, who self reported having the following services within the past year:</p> <ul style="list-style-type: none"> • Hemoglobin A1c (HbA1c) testing • Eye exam (retinal) performed LDL-C screening • Blood pressure screening • Foot examination • Smoking status assessment <p>This will be measured at initial assessment and at reassessment period following 3 months of case management, or at time of graduation from case management if less than 3 months. In addition to the percentage of members having each service at the two intervals, the differences between the percentages at the two intervals will also be reported. For example if A1c testing</p>	<p>The Steering Committee felt this measure does not fit within the scope of care coordination for this project.</p> <p>During discussions, the Committee agreed this measure is more of a standard of care within case management rather than care coordination, focusing on the quality of case management services and following clinical guidelines, which does not give an indication of whether a patient receives coordination of care.</p> <p>This measure will <u>not</u> be further evaluated.</p>

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		went for 40% to 60% in the two intervals, the reporting tool calculates the change between the two rates.	
CC-004-09 / ©New York State Department of Health	Timely Case Management Assessment Rate for Members with Diabetes in managed care	Percentage of diabetic members, who were triggered for case management and had complete assessments within 15 business days.	<p>The Steering Committee reviewed this measure and discussed the need to be consistent with the definition of standards of care for case management.</p> <p>The Committee agreed that case management is an aspect of care coordination, however it wants to identify which aspect(s) of case management is important to care coordination.</p> <p>The Committee ultimately decided to move this measure into a separate group for further discussion.</p> <p>This measure <u>will</u> be further evaluated.</p>
CC-005-09 / ©New York State Department of Health	Case Management Enrollment Rate for Members with Diabetes in managed care	The proportion of diabetic members who were enrolled in case management within 15 business days after being triggered, assessed, and found to meet the criteria for case management.	<p>The Steering Committee reviewed this measure and agreed it fit within the scope of this project.</p> <p>This measure <u>will</u> be further evaluated.</p>
CC-006-09 / ©New York State Department of Health	Medication Adherence for Members with Diabetes in managed care	Medication adherence is a reflection of the member's ability to manage their medication. This is the percentage of members who were confident in managing their medication or who increased their level of confidence between the initial assessment and after 3 months in case management.	<p>The Steering Committee reviewed this measure and agreed it fit within the scope of this project.</p> <p>This measure <u>will</u> be further evaluated.</p>

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<p>CC-007-09 / ©New York State Department of Health</p>	<p>Emergency Room Visits for Members with Diabetes in managed care</p>	<p>The difference in self reported emergency room visit use for diabetic members, who were triggered, assessed and engaged in case management, and then remained in case management for three months or until graduation from case management if less than 3 months.</p>	<p>The Steering Committee reviewed this measure and agreed it fit within the scope of this project.</p> <p>This measure <u>will</u> be further evaluated.</p>
<p>CC-008-09 / ©New York State Department of Health</p>	<p>Graduation Rates for Members with Diabetes in case management in managed care</p>	<p>The percentage of members with enrolled in case management, who dis-enrolled from case management due to successfully meeting goals.</p>	<p>The Steering committee reviewed this measure and agreed it would not provide any significant impact as an outcome measure based on their review of the measure against the five questions, in the context of the framework and for purposes of a consensus standard for measuring and reporting care coordination.</p> <p>This measure will <u>not</u> be further evaluated.</p>
<p>CC-009-09 / ©New York State Department of Health</p>	<p>Hospital Admission Rates for Members with Diabetes in managed care</p>	<p>The difference in self reported hospital admissions for diabetic members, who were enrolled in case management, and then remained in case management for three months or until graduation from case management if less than 3 months.</p>	<p>The Steering Committee reviewed this measure and agreed it fit within the scope of this project.</p> <p>This measure <u>will</u> be further evaluated.</p>
<p>CC-010-09 / ©New York State</p>	<p>Trigger Rates for Members with Diabetes in managed care</p>	<p>The proportion of adult members known to have a diagnosis of diabetes, who are newly</p>	<p>The Steering Committee reviewed this measure and discussed the need to be consistent with the definition of</p>

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<p>Department of Health</p>		<p>identified as potential people who may benefit from case management for each line of business (i.e. Commercial and Medicaid including Family Health Plus, an insurance expansion program). The members to be included are those who are triggered with the intent that the plan will contact and assess the members' needs relevant to case management.</p>	<p>standards of care for case management.</p> <p>The Committee agreed that case management is an aspect of care coordination, however it wants to identify which aspect(s) of case management is important to care coordination.</p> <p>The Committee ultimately decided to move this measure into a separate group for further discussion.</p> <p>This measure will be further evaluated.</p>
<p>CC-011-09 / ©New York State Department of Health</p>	<p>Average Length of Stay in an Intensive Care Unit for Infants of Women in case management in managed care</p>	<p>The average length of stay in the Intensive Care Unit (ICU) for infants born to women, who were triggered, assessed and engaged in case management.</p>	<p>The Steering Committee reviewed this measure and agreed it does not fit within the scope of care coordination for this project.</p> <p>This measure will <u>not</u> be further evaluated.</p>
<p>CC-012-09 / ©New York State Department of Health</p>	<p>Case Management Enrollment Rate for Pregnant Women at High Risk in managed care</p>	<p>The proportion of pregnant women who were enrolled in case management within 15 business days after being triggered, assessed and found to meet the criteria for case management.</p>	<p>The Steering Committee reviewed this measure and agreed it fit within the scope of this project.</p> <p>This measure <u>will</u> be further evaluated.</p>
<p>CC-013-09 / ©New York State Department of Health</p>	<p>Crude Low Birth Weight Rate for Members in High Risk case management in managed care</p>	<p>The percentage of live infants weighing less than 2500 grams born to women who were triggered, assessed and engaged in case management.</p>	<p>The Steering Committee reviewed this measure and discussed the need to be consistent with the definition of standards of care of case management.</p>

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			<p>The Committee agreed that case management is an aspect of care coordination, however it wants to identify which aspect(s) of case management is important to care coordination.</p> <p>The Committee ultimately decided to move this measure into a separate group for further discussion.</p> <p>This measure will be further evaluated.</p>
<p>CC-014-09 / ©New York State Department of Health</p>	<p>Intensive Care Unit Admission Rate for Infants of Women in case management in managed care</p>	<p>Percentage of infants, born to women in high risk OB case management, who utilize Intensive Care Unit (ICU) services within 30 days of birth.</p>	<p>The Steering Committee reviewed this measure and agreed that it fits within the scope of care coordination.</p> <p>Discussions centered on whether this measure was focusing on management of care or care coordination. In the context of this measure, care coordination should focus on how effective communication is between the primary care provider/OB and social service agency. The Committee noted that the effectiveness of case management is not an indication of care coordination. The Committee also discussed the need for better care coordination between the nurseries and obstetrics.</p> <p>The Committee ultimately decided to move this measure into a separate group for further discussion.</p>

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			This measure will be further evaluated.
CC-015-09 / ©New York State Department of Health	Average Caseload with Members in High Risk OB case management in managed care	The average high risk OB caseload per case manager.	The Steering Committee reviewed this measure and agreed that since most women go for a post-partum visit; this measure would not add value for the purpose of measuring and reporting care coordination. This measure will <u>not</u> be further evaluated.
CC-016-09 / ©New York State Department of Health	Trigger Rates of Members with High Risk OB in managed care	The proportion of members known by the plan to be pregnant who are newly identified as potential people who may benefit from case management for each line of business (i.e. Commercial, and Medicaid including Family Health Plus and Child Health Plus, NYS insurance expansion programs). The members to be included are those who are triggered with the intent that the plan will contact and assess the members' needs relevant to case management.	The Steering Committee reviewed this measure and agreed it fit within the scope of this project. This measure <u>will</u> be further evaluated.
CC-017-09 / ©New York State Department of Health	Post Partum Care Visits Rate for Pregnant Women in case management in managed care	The percentage of women in the case management cohort who's self reported post partum visit met HEDIS numerator specifications for post partum visit within 21-56 days after delivery.	The Steering Committee reviewed this measure and agreed it does not fit within the scope of care coordination for this project. The Committee felt this measure focuses on the standard of care not care coordination. This measure will <u>not</u> be further evaluated.
CC-018-09 /	Timely Case Management Assessment	Percentage of pregnant woman who trigger for	The Steering Committee reviewed this

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<p>©New York State Department of Health</p>	<p>Rates for Pregnant Women at High Risk in managed care</p>	<p>case management and had complete assessments within 15 business days.</p>	<p>measure and discussed the time specificity for completing assessments. It was noted that there is no medical evidence that 15 days is better than 21 days or 7 days.</p> <p>The Committee ultimately decided to move this measure into a separate group for further discussion.</p> <p>This measure will be further evaluated.</p>
<p>CC-019-09 / © ACCF/AHA Task Force</p>	<p>Cardiac Rehabilitation Patient Referral From an Inpatient Setting</p>	<p>Percentage of patients admitted to a hospital with a primary diagnosis of an acute myocardial infarction or chronic stable angina or who during hospitalization have undergone coronary artery bypass (CABG) surgery, a percutaneous coronary intervention (PCI), cardiac valve surgery (CVS), or cardiac transplantation who are referred to an early outpatient cardiac rehabilitation/secondary prevention program.</p>	<p>The Steering Committee reviewed this measure and agreed it fit within the scope of this project.</p> <p>This measure <u>will</u> be further evaluated.</p>
<p>CC-020-09 / © ACCF/AHA Task Force</p>	<p>Cardiac Rehabilitation Patient Referral From an Outpatient Setting</p>	<p>Percentage of patients evaluated in an outpatient setting who in the previous 12 months have experienced an acute myocardial infarction or chronic stable angina or who have undergone coronary artery bypass (CABG) surgery, a percutaneous coronary intervention (PCI), cardiac valve surgery (CVS), or cardiac transplantation, who have not already participated in an early outpatient cardiac rehabilitation/secondary prevention program for the qualifying event, and who are referred to an outpatient cardiac rehabilitation/secondary prevention program.</p>	<p>The Steering Committee reviewed this measure and agreed it fit within the scope of this project.</p> <p>This measure <u>will</u> be further evaluated.</p>

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<p>CC-021-09 / © ACCF/AHA Task Force</p>	<p>Cardiac Rehabilitation/Secondary Prevention (CR) Program Structure-Based Measurement Set to Set Safety Standards for CR Programming</p>	<p>Percent of CR programs that have policies in place to demonstrate that appropriate personnel and equipment are available to satisfy high quality standards of care.</p>	<p>The Steering Committee reviewed this measure and agreed it does not fit within the scope of care coordination for this project.</p> <p>This measure will <u>not</u> be further evaluated.</p>
<p>CC-022-09 / © ACCF/AHA Task Force</p>	<p>Cardiac Rehabilitation/Secondary Prevention (CR) Program Measurement Set to Assess Risk for Adverse Cardiovascular Events</p>	<p>Percent of CR programs in the health care system that meet the performance measure for assessment of risk for adverse cardiovascular events.</p>	<p>The Steering Committee reviewed this measure and agreed it fit within the scope of this project.</p> <p>This measure <u>will</u> be further evaluated.</p>
<p>CC-023-09 / © ACCF/AHA Task Force</p>	<p>Cardiac Rehabilitation/Secondary Prevention (CR) Measurement Set to Assure Individualized Assessment and Evaluation of Modifiable Cardiovascular Risk Factors, Development of Individualized Interventions, and Communication With Other Health Care Providers</p>	<p>Percent of patients in the health care system's CR program(s) who meet the performance measure for individualized assessment and evaluation of modifiable cardiovascular risk factors, development of individualized interventions, and communication with other health care providers. This measure also includes the requirement that the CR Program have a policy in place to ensure communication with health care providers related to modifiable risk factors.</p>	<p>The Steering Committee reviewed this measure and agreed it fit within the scope of this project.</p> <p>This measure <u>will</u> be further evaluated.</p>
<p>CC-024-09 / © ACCF/AHA Task Force</p>	<p>Cardiac Rehabilitation/Secondary Prevention (CR) Program Measurement Set Related to Monitoring Response to Therapy and Documenting Program Effectiveness</p>	<p>Percent of CR programs in the health care system that meet the performance measure for monitoring response to therapy and documenting program effectiveness.</p>	<p>The Steering Committee reviewed this measure and agreed that this measure was an effectiveness measure for a cardiac rehabilitation program and therefore not within the scope of care coordination for this project based on their review of the measure against the five questions and in the context of the</p>

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			<p>framework.</p> <p>This measure will <u>not</u> be further evaluated.</p>
<p>CC-025-09 / © Ingenix</p>	<p>Patient(s) 65 years of age and older that received a high risk medication.</p>	<p>Patients 65 years of age and older that received one or more high-risk medications in the elderly in the last 12 reported months (EBM Connect criteria).</p>	<p>The Steering Committee reviewed this measure and agreed that it fits within the scope of care coordination for this project against the five questions and in the context of the framework. The Steering Committee acknowledged that this is a common problem for patient receiving wrong medications, which is usually a result of poor coordination of care.</p> <p>This measure <u>will</u> be further evaluated.</p>
<p>TCC-026-09 / © Ingenix</p>	<p>CHF Cardiology Consultation</p>	<p>Patient(s) with heart failure and 2 or more recent heart failure ER encounters or hospitalizations that had cardiology consultation in last 24 reported months.</p>	<p>The Steering Committee reviewed this measure and agreed that referrals could positively impact care coordination. However the discussion also centered on the idea that this measure does not measure care coordination, but rather a failed outcome of poor coordination of care.</p> <p>The Committee ultimately decided to move this measure into a separate group for further discussion.</p> <p>This measure <u>will</u> be further evaluated.</p>
<p>CC-027-09 / © Ingenix</p>	<p>Atrial Fibrillation Cardiology Consultation</p>	<p>Patient(s) with atrial fibrillation and evidence of problematic atrial fibrillation control that had</p>	<p>The Steering Committee reviewed this measure and agreed that referrals</p>

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		cardiology consultation in last 12 reported months.	<p>could positively impact care coordination. However the discussion also centered on the idea that this measure does not measure care coordination, but rather poor coordination of care.</p> <p>The Committee ultimately decided to move this measure into a separate group for further discussion about when referral/consultation measures were truly measures of care coordination.</p> <p>This measure <u>will</u> be further evaluated.</p>
CC-028-09 / © Ingenix	Patient(s) with diabetes that had an office visit in last 6 reported months.	Patient(s) that had an office visit for diabetes care in last 6 reported months.	<p>The Steering Committee reviewed this measure and agreed it fit within the scope of this project.</p> <p>This measure <u>will</u> be further evaluated.</p>
CC-029-09 / © Ingenix	Patient(s) with asthma that had an office visit in last 6 reported months.	Patient(s) that had an office visit for asthma care in last 6 reported months.	<p>The Steering Committee reviewed this measure and agreed it fit within the scope of this project.</p> <p>This measure <u>will</u> be further evaluated.</p>
CC-030-09/ © Ingenix	Asthma office visit for patients with poorly controlled disease	Patient(s) with asthma and evidence of poor disease control that had an office visit in last 3 reported months.	<p>The Steering Committee reviewed this measure and agreed it fit within the scope of this project.</p> <p>This measure <u>will</u> be further evaluated.</p>
CC-031-09/ © Ingenix	Asthmatics with problematic asthma control who had specialty consultation.	Patient(s) exhibiting problematic asthma control who had pulmonary or allergy consultation in last 12 reported months.	<p>The Steering Committee reviewed this measure and agreed that referrals could positively impact care</p>

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			<p>coordination. However the discussion also centered on the idea that this measure does not measure care coordination, but rather poor coordination of care.</p> <p>The Committee ultimately decided to move this measure into a separate group for further discussion about when referral/consultation measures were truly measures of care coordination.</p> <p>This measure <u>will</u> be further evaluated.</p>
CC-032-09 / © Ingenix	Patient(s) with hypertension that had an annual physician visit.	Patient(s) with hypertension that had an annual physician visit.	<p>The Steering Committee reviewed this measure and agreed it fit within the scope of this project.</p> <p>This measure <u>will</u> be further evaluated.</p>
CC-033-09 / © Ingenix	Patients with problematic COPD control who had pulmonary consultation.	Patient(s) exhibiting problematic COPD control who had pulmonary consultation in last 12 reported months.	<p>The Steering Committee reviewed this measure and agreed that referrals could positively impact care coordination. However the discussion also centered on the idea that this measure does not measure care coordination, but rather poor coordination of care.</p> <p>The Committee ultimately decided to move this measure into a separate group for further discussion about when referral/consultation measures were truly measures of care coordination.</p>

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			This measure will be further evaluated.
CC-034-09 / © Ingenix	Psychiatry consultation for patients with severe depression.	Patient(s) with evidence of severe depression that had psychiatric consultation in last 3 reported months.	The Steering Committee reviewed this measure and agreed it fit within the scope of care coordination. This measure <u>will</u> be further evaluated.
CC-035-09 / © Ingenix	Migraine office visit for patients with poorly controlled disease	Patient(s) with frequent emergency room migraine encounters or frequent acute migraine medication use that had an office visit in last 6 reported months.	The Steering Committee reviewed this measure and agreed it fit within the scope of care coordination. This measure <u>will</u> be further evaluated.
CC-036-09 / © Ingenix	Patients with poor migraine control who had specialty consultation.	Patient(s) with one or more hospitalizations for migraines that had neurology or anesthesiology consultation in last 6 reported months.	The Steering Committee reviewed this measure and agreed that referrals could positively impact care coordination. However the discussion also centered on the idea that this measure does not measure care coordination, but rather a failed outcome of poor coordination of care. The Committee ultimately decided to move this measure into a separate group for further discussion. This measure will be further evaluated.
CC-037-09 / © Ingenix	Annual serum creatinine for patients with chronic kidney failure.	Patient(s) with chronic kidney disease that had a serum creatinine in last 12 reported months.	The Steering Committee reviewed this measure and agreed it was not within scope of care coordination for this project. This measure addresses guidelines/standards of care (lab tests on a schedule) not coordination of care. The Committee felt the focus should be

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			<p>on linking the patient with activities that produce better outcomes.</p> <p>This measure will <u>not</u> be further evaluated.</p>
<p>CC-038-09 / © Ingenix</p>	<p>Annual hemoglobin/hematocrit for patients with moderate CKD, severe CKD, or kidney failure.</p>	<p>Patient(s) with moderate CKD, severe CKD, or kidney failure that had a hemoglobin/hematocrit in last 12 reported months.</p>	<p>The Steering Committee reviewed this measure and agreed it was not within scope of care coordination for this project.</p> <p>This measure addresses guidelines/standards of care (lab tests on a schedule) not coordination of care. The Committee felt the focus should be on linking the patient with activities that produce better outcomes.</p> <p>This measure will <u>not</u> be further evaluated.</p>
<p>CC-039-09 / © Ingenix</p>	<p>Annual serum calcium for patients with moderate CKD, severe CKD, or kidney failure.</p>	<p>Patient(s) with moderate CKD, severe CKD, or kidney failure that had a serum calcium in last 12 reported months.</p>	<p>The Steering Committee reviewed this measure and agreed it was not within scope of care coordination for this project.</p> <p>This measure addresses guidelines/standards of care (lab tests on a schedule) not coordination of care. The Committee felt the focus should be on linking the patient with activities that produce better outcomes.</p> <p>This measure will <u>not</u> be further evaluated.</p>

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<p>CC-040-09 / © Ingenix</p>	<p>Annual serum phosphorus for patients with moderate CKD, severe CKD, or kidney failure.</p>	<p>Patient(s) with moderate CKD, severe CKD, or kidney failure that had a serum phosphorus in last 12 reported month.</p>	<p>The Steering Committee reviewed this measure and agreed it was not within scope of care coordination for this project.</p> <p>This measure addresses guidelines/standards of care (lab tests on a schedule) not coordination of care. The Committee felt the focus should be on linking the patient with activities that produce better outcomes.</p> <p>This measure will <u>not</u> be further evaluated.</p>
<p>CC-041-09 / © Ingenix</p>	<p>CKD nephrology consultation for patients with severe kidney disease or kidney failure.</p>	<p>Patient(s) with severe chronic kidney disease or kidney failure that had nephrology consultation in last 12 reported months.</p>	<p>The Steering Committee reviewed this measure and agreed that referrals could positively impact care coordination. However the discussion also centered on the idea that this measure does not measure care coordination, but rather poor coordination of care.</p> <p>The Committee ultimately decided to move this measure into a separate group for further discussion about when referral/consultation measures were truly measures of care coordination.</p> <p>This measure will be further evaluated.</p>
<p>CC-042-09 /</p>	<p>Annual serum PTH for patients with</p>	<p>Patient(s) with severe chronic kidney disease or</p>	<p>The Steering Committee reviewed this</p>

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<p>© Ingenix</p>	<p>severe kidney disease or kidney failure.</p>	<p>kidney failure that had a serum PTH in last 12 reported months.</p>	<p>measure and agreed it was not within scope of care coordination for this project based on their review of the measure against the five questions and in the context of the framework.</p> <p>This measure addresses guidelines/standards of care (lab tests on a schedule) not coordination of care. The Committee felt the focus should be on linking the patient with activities that produce better outcomes.</p> <p>This measure will <u>not</u> be further evaluated.</p>
<p>CC-043-09 / © Ingenix</p>	<p>Annual LDL cholesterol for patients with chronic kidney disease.</p>	<p>Adult(s) with CKD that had a LDL cholesterol test in last 12 reported months.</p>	<p>The Steering Committee reviewed this measure and agreed it was not within scope of care coordination for this project based on their review of the measure against the five questions and in the context of the framework.</p> <p>This measure addresses guidelines/standards of care (lab tests on a schedule) not coordination of care. The Committee felt the focus should be on linking the patient with activities that produce better outcomes.</p> <p>This measure will <u>not</u> be further evaluated.</p>
<p>CC-044-09 / © Ingenix</p>	<p>Annual HDL cholesterol for patients with chronic kidney disease.</p>	<p>Adult(s) with CKD that had a HDL cholesterol test in last 12 reported months.</p>	<p>The Steering Committee reviewed this measure and agreed it was not within</p>

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			<p>scope of care coordination for this project.</p> <p>This measure addresses guidelines/standards of care (lab tests on a schedule) not coordination of care. The Committee felt the focus should be on linking the patient with activities that produce better outcomes.</p> <p>This measure will <u>not</u> be further evaluated.</p>
CC-045-09 / © Ingenix	Annual triglyceride for patients with chronic kidney disease.	Adult(s) with CKD that had a triglyceride test in last 12 reported months.	<p>The Steering Committee reviewed this measure and agreed it does not fit within the scope of care coordination for this project.</p> <p>This measure will <u>not</u> be further evaluated.</p>
CC-046-09 / © Ingenix	Nephrology consultation for patients with CKD and other specific diagnosis.	Patient(s) with chronic kidney disease and specific indications that had nephrology consultation in last 12 reported months.	<p>The Steering Committee reviewed this measure and agreed that referrals could positively impact care coordination. However the discussion also centered on the idea that this measure does not measure care coordination, but rather poor coordination of care.</p> <p>The Committee ultimately decided to move this measure into a separate group for further discussion about when referral/consultation measures were truly measures of care</p>

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			<p>coordination.</p> <p>This measure <u>will</u> be further evaluated.</p>
<p>CC-047-09 / © Ingenix</p>	<p>Annual urine protein/microalbumin for selected patients with chronic kidney failure.</p>	<p>Patient(s) with chronic kidney disease and additional indications that had a urine microalbumin or protein test in last 12 reported months.</p>	<p>The Steering Committee reviewed this measure and agreed it was not within scope of care coordination for this project.</p> <p>This measure addresses guidelines/standards of care (lab tests on a schedule) not coordination of care. The Committee felt the focus should be on linking the patient with activities that produce better outcomes.</p> <p>This measure will <u>not</u> be further evaluated.</p>
<p>CC-048-09 / © Ingenix</p>	<p>Patients with poor epilepsy control who had neurology consultation.</p>	<p>Patient(s) with one or more hospitalizations or two or more emergency room encounters for epilepsy that had neurology consultation in last 3 reported months.</p>	<p>The Steering Committee reviewed this measure and agreed that referrals could positively impact care coordination. However the discussion also centered on the idea that this measure does not measure care coordination, but rather a failed outcome of poor coordination of care.</p> <p>The Committee ultimately decided to move this measure into a separate group for further discussion about when referral/consultation measures were truly measures of care coordination.</p>

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			This measure <u>will</u> be further evaluated.
CC-049-09 / © Ingenix	Patients with bariatric surgery who had complications.	Patient(s) with bariatric surgery who had a defined complication during hospitalization or 30 days after discharge.	<p>The Steering Committee reviewed this measure and agreed it was an outcome measure of bariatric surgery and does not fit within the scope of care coordination for this project based on their review of the measure against the five questions and in the context of the framework.</p> <p>This measure will <u>not</u> be further evaluated.</p>
CC-050-09 / © Ingenix	Patients with a transient ischemic event ER visit that had a follow up office visit.	Patient(s) with a recent emergency room encounter for a transient cerebral ischemic event that had any physician visit within 30 days of the acute event.	<p>The Steering Committee reviewed this measure and agreed it fit within the scope of this project.</p> <p>This measure <u>will</u> be further evaluated.</p>
CC-051-09 / © Ingenix	Patients hospitalized with an acute cerebral ischemic event that had specialty consultation.	Patient(s) with a recent hospitalization for an acute cerebral ischemic event that had neurology, neurosurgery, vascular surgery or thoracic surgery consultation during the hospitalization or within 30 days of discharge.	<p>The Steering Committee reviewed this measure and agreed that referrals could positively impact care coordination. However the discussion also centered on the idea that this measure does not measure care coordination, but rather a failed outcome of poor coordination of care.</p> <p>The Committee ultimately decided to move this measure into a separate group for further discussion about when referral/consultation measures were truly measures of care coordination.</p>

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			This measure <u>will</u> be further evaluated.
CC-052-09 / © Ingenix	Gastroenterology consultation for patients on simple chronic medication regimens for inflammatory bowel disease.	Patient(s) taking certain medications for inflammatory bowel disease treatment that had gastroenterology consultation in last 12 reported months.	<p>The Steering Committee reviewed this measure and agreed that referrals could positively impact care coordination. However the discussion also centered on the idea that this measure does not measure care coordination, but rather poor coordination of care.</p> <p>The Committee ultimately decided to move this measure into a separate group for further discussion about when referral/consultation measures were truly measures of care coordination.</p> <p>This measure <u>will</u> be further evaluated.</p>
CC-053-09 / © Ingenix	Gastroenterology consultation for patients on complex treatment regimens or chronic corticosteroid therapy for inflammatory bowel disease.	Patient(s) with complex inflammatory bowel disease treatment regimens or chronic corticosteroid therapy that had gastroenterology consultation in last 6 reported months.	<p>The Steering Committee reviewed this measure and agreed that referrals could positively impact care coordination. However the discussion also centered on the idea that this measure does not measure care coordination, but rather poor coordination of care.</p> <p>The Committee ultimately decided to move this measure into a separate group for further discussion about when referral/consultation measures were truly measures of care coordination.</p>

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			This measure <u>will</u> be further evaluated.
CC-054-09 / © Ingenix	Gastroenterology consultation for patients hospitalized or received ER care for inflammatory bowel disease.	Patient(s) with inflammatory bowel disease complications that had gastroenterology consultation in last 3 reported months.	<p>The Steering Committee reviewed this measure and agreed that referrals could positively impact care coordination. However the discussion also centered on the idea that this measure does not measure care coordination, but rather poor coordination of care.</p> <p>The Committee ultimately decided to move this measure into a separate group for further discussion about when referral/consultation measures were truly measures of care coordination.</p> <p>This measure <u>will</u> be further evaluated.</p>
CC-055-09 / © Ingenix	Patient(s) with newly diagnosed with breast cancer who received prompt specialty care.	Patient(s) newly diagnosed with breast cancer that received radiation or chemotherapy treatment, or had medical oncology or radiation oncology consultation within 90 days of the diagnostic procedure.	<p>The Steering Committee reviewed this measure and agreed it was appropriate for care coordination. Discussion focused on the measure being prospective and the importance of proactive care to help the patient achieve positive outcomes.</p> <p>The Committee ultimately decided to move this measure into a separate group for further discussion about when referral/consultation measures were truly measures of care coordination.</p> <p>This measure <u>will</u> be further evaluated.</p>

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<p>CC-056-09 / © Ingenix</p>	<p>Patient(s) with a CABG procedure who received a beta-blocker.</p>	<p>Patient(s) 20 years of age and older hospitalized for a CABG procedure taking a beta-blocker at admission or within seven days of discharge.</p>	<p>The Steering Committee reviewed this measure and agreed it needs to be discussed further to provide a more accurate assessment. about when referral/consultation measures were truly measures of care coordination</p> <p>Discussions focused on this measure possibly addressing transitions because it is tracking medication adherence across discharge. A similar candidate measure was submitted (Reconciled Medication List Received by Discharged Patients - Inpatient discharges to home/self-care or any other site of care). The Committee felt this measure would address the same concept.</p> <p>This measure <u>will</u> be further discussed by the Committee.</p>
<p>CC-057-09 / © Ingenix</p>	<p>Patient(s) with a CABG procedure who received a lipid-lowering agent.</p>	<p>Patient(s) 20 years of age and older hospitalized for a CABG procedure taking a lipid-lowering medication at admission or within seven days of discharge.</p>	<p>The Steering Committee reviewed this measure and agreed it needs to be discussed further to provide a more accurate assessment.</p> <p>Discussions focused on this measure possibly addressing transitions because it is tracking medication adherence across discharge. A similar candidate measure was submitted (Reconciled Medication List Received by Discharged Patients - Inpatient discharges to home/self-care or any other site of care). The Committee felt</p>

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			<p>this measure would address the same concept.</p> <p>This measure <u>will</u> be further discussed by the Committee.</p>
<p>CC-058-09 / © Ingenix</p>	<p>Patient(s) with a CABG procedure who had a post-operative stroke.</p>	<p>Patient(s) 20 years of age and older hospitalized for a CABG procedure that have evidence of a CVA during the hospitalization or within seven days of discharge.</p>	<p>The Steering Committee reviewed this measure and agreed it was measuring a complication of surgery and does not fit within the scope of care coordination for this project based on their review of the measure against the five questions and in the context of the framework.</p> <p>This measure will <u>not</u> be further evaluated.</p>
<p>CC-059-09 / © Audiology Quality Consortium</p>	<p>Baseline audiologic assessment for ototoxicity</p>	<p>Percentage of patients aged one month and older referred for a baseline comprehensive audiologic assessment prior to the administration of a prescribed ototoxic medication(s) or therapeutic agent(s).</p>	<p>The Steering Committee reviewed this measure and agreed it fit within the scope of this project.</p> <p>This measure <u>will</u> be further evaluated.</p>
<p>CC-060-09 / © Audiology Quality Consortium</p>	<p>Audiologic monitoring for ototoxicity</p>	<p>Percentage of patients aged one month and older referred for an audiologic monitoring protocol subsequent to the administration of a prescribed ototoxic medication(s) or therapeutic agent(s).</p>	<p>The Steering Committee reviewed this measure and agreed that referrals could positively impact care coordination. Discussions focused on how a referral is made for a patient to ensure that the test/assessment could be interpreted by a specialist.</p> <p>The Committee ultimately decided to move this measure into a separate group for further discussion about when referral/consultation measures were truly measures of care</p>

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			<p>coordination.</p> <p>This measure <u>will</u> be further evaluated.</p>
<p>CC-061-09 / © Audiology Quality Consortium</p>	<p>Baseline vestibular assessment for vestibulotoxicity</p>	<p>Percentage of patients aged three years and older referred for a baseline comprehensive vestibular assessment prior to the administration of a prescribed vestibulotoxic medication(s) or therapeutic agent(s).</p>	<p>The Steering Committee reviewed this measure and agreed that referrals could positively impact care coordination. Discussions focused on how a referral is made for a patient to ensure that the test/assessment could be interpreted by a specialist.</p> <p>The Committee ultimately decided to move this measure into a separate group for further discussion about when referral/consultation measures were truly measures of care coordination.</p> <p>This measure <u>will</u> be further evaluated.</p>
<p>CC-062-09 / © Audiology Quality Consortium</p>	<p>Vestibular monitoring for vestibulotoxicity.</p>	<p>Percentage of patients aged three years and older referred for a vestibular monitoring protocol subsequent to the administration of a prescribed vestibulotoxic medication(s) or therapeutic agent(s).</p>	<p>The Steering Committee reviewed this measure and agreed that referrals could positively impact care coordination. Discussions focused on how a referral is made for a patient to ensure that the test/assessment could be interpreted by a specialist.</p> <p>The Committee ultimately decided to move this measure into a separate group for further discussion about when referral/consultation measures were truly measures of care coordination.</p>

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			This measure <u>will</u> be further evaluated.
CC-063-09 / © Audiology Quality Consortium	Referral for otologic evaluation for patients with visible congenital or traumatic deformity of the ear.	Percentage of patients aged birth and older referred to a physician (preferably a physician specially trained in disorders of the ear) for an otologic evaluation subsequent to an audiologic evaluation after presenting with a visible congenital or traumatic deformity of the ear.	The Steering Committee reviewed this measure and agreed it fit within the scope of care coordination. This measure <u>will</u> be further evaluated.
CC-064-09 / © Audiology Quality Consortium	Referral for otologic evaluation for patients with a history of active drainage from the ear within the previous 90 days.	Percentage of patients referred to a physician (preferably a physician specially trained in disorders of the ear) for an otologic evaluation subsequent to an audiologic evaluation after presenting with a history of active drainage from the ear within the previous 90 days.	The Steering Committee reviewed this measure and agreed that referrals could positively impact care coordination. Discussions focused on how a referral is made for a patient to ensure that the test/assessment could be interpreted by a specialist. The Committee ultimately decided to move this measure into a separate group for further discussion about when referral/consultation measures were truly measures of care coordination. This measure <u>will</u> be further evaluated.
CC-065-09 / © Audiology Quality Consortium	Referral for otologic evaluation for patients with a history of sudden or rapidly progressive hearing loss.	Percentage of patients aged birth and older referred to a physician (preferably a physician specially trained in disorders of the ear) for an otologic evaluation immediately following an audiologic evaluation after presenting with a history of sudden or rapidly progressive hearing loss.	The Steering Committee reviewed this measure and agreed that referrals could positively impact care coordination. Discussions focused on how a referral is made for a patient to ensure that the test/assessment could be interpreted by a specialist. The Committee ultimately decided to move this measure into a separate group for further discussion about when referral/consultation measures

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			<p>were truly measures of care coordination.</p> <p>This measure <u>will</u> be further evaluated.</p>
<p>CC-066-09 / © Audiology Quality Consortium</p>	<p>Referral for otologic evaluation for patients with acute or chronic dizziness.</p>	<p>Percentage of patients referred to a physician (preferably a physician specially trained in disorders of the ear) for an otologic evaluation subsequent to an audiologic evaluation after presenting with acute or chronic dizziness.</p>	<p>The Steering Committee reviewed this measure and agreed it does not fit within the scope of care coordination for this project based on their review of the measure against the five questions and in the context of the framework. The Steering Committee also mentioned that this measure was more of a standard of care and does not measure coordination of care.</p> <p>This measure will <u>not</u> be further evaluated.</p>
<p>CC-067-09 / © Audiology Quality Consortium</p>	<p>Referral for otologic evaluation for patients with a unilateral hearing loss.</p>	<p>Percentage of patients referred to a physician (preferably a physician specially trained in disorders of the ear) for an otologic evaluation subsequent to an audiologic evaluation after presenting with a unilateral hearing loss.</p>	<p>The Steering Committee reviewed this measure and agreed that referrals could positively impact care coordination. Discussions focused on how a referral is made for a patient to ensure that the test/assessment could be interpreted by a specialist.</p> <p>The Committee ultimately decided to move this measure into a separate group for further discussion about when referral/consultation measures were truly measures of care coordination.</p> <p>This measure <u>will</u> be further evaluated.</p>

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<p>CC-068-09 / © Audiology Quality Consortium</p>	<p>Referral for otologic evaluation for patients who present with a conductive hearing loss or air-bone gap.</p>	<p>Percentage of patients aged birth and older referred to a physician (preferably a physician specially trained in disorders of the ear) for an otologic evaluation subsequent to an audiologic evaluation after presenting with a conductive hearing loss or air-bone gap.</p>	<p>The Steering Committee reviewed this measure and agreed it does not fit within the scope of care coordination for this project based on their review of the measure against the five questions and in the context of the framework. The Steering Committee also mentioned that this measure was more of a standard of care and does not measure coordination of care.</p> <p>This measure will <u>not</u> be further evaluated.</p>
<p>CC-069-09 / © Audiology Quality Consortium</p>	<p>Referral for otologic evaluation for patients with evidence of impacted cerumen accumulation or a foreign body in the ear canal</p>	<p>Percentage of patients aged birth and older referred to a physician (preferably a physician specially trained in disorders of the ear) for an otologic evaluation subsequent or prior to an audiologic evaluation after presenting with an accumulation of cerumen or a foreign body that causes symptoms, prevents a needed assessment of the ear canal/ tympanic membrane or audiovestibular system, or both.</p>	<p>The Steering Committee reviewed this measure and agreed it does not fit within the scope of care coordination for this project based on their review of the measure against the five questions and in the context of the framework. The Steering Committee also mentioned that this measure was more of a standard of care and this disorder could be treated by a non-audiologist practitioner. In addition, it does not measure coordination of care.</p> <p>This measure will <u>not</u> be further evaluated.</p>
<p>CC-070-09/ © Audiology Quality Consortium</p>	<p>Referral for otologic evaluation for patients with pain or discomfort in the ear.</p>	<p>Percentage of patients referred to a physician (preferably a physician specially trained in disorders of the ear) for an otologic evaluation subsequent to an audiologic evaluation after presenting with pain or discomfort in the ear.</p>	<p>The Steering Committee reviewed this measure and agreed it does not fit within the scope of care coordination for this project based on their review of the measure against the five questions and in the context of the framework. The Steering Committee also</p>

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			<p>mentioned that this measure was more of a standard of care and this disorder could be treated by a non-audiologist practitioner. In addition, the Steering Committee felt that pain or discomfort in the ear is usually treatable by a primary care physician.</p> <p>This measure will <u>not</u> be further evaluated.</p>
CC-071-09/ ©American Academy of Dermatology	Biopsy Follow-up	Percentage of patients who are undergoing a biopsy whose information is entered into a log to ensure the results of each biopsy performed have been reviewed by the biopsying physician, denoted by a check or physician's initials in the log (for manual, non-electronic submission).	<p>The Steering Committee reviewed this measure and agreed it fit within the scope of care coordination.</p> <p>This measure <u>will</u> be further evaluated.</p>
CC-072-09 / ©American Academy of Dermatology	High Risk Medication Monitoring	Percentage of patients who are newly prescribed high-risk prescription medication (from an approved list of high risk medications) and are placed into a recall system to monitor laboratory results and follow up appointments.	<p>The Steering Committee reviewed this measure and agreed it fit within the scope of care coordination.</p> <p>This measure <u>will</u> be further evaluated.</p>
CC-073-09 / ©AMA-PCPI	Reconciled Medication List Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care)	Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care, or their caregiver(s), who received a reconciled medication list at the time of discharge including, at a minimum, medications in the specified categories.	<p>The Steering Committee reviewed this measure and agreed it fit within the scope of care coordination.</p> <p>This measure <u>will</u> be further evaluated.</p>
CC-074-09/ ©AMA-PCPI	<p>Transition Record with Specified Elements Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care)</p> <p>(Inpatient Discharges to Home/Self Care or Any Other Site of Care)</p>	Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care, or their caregiver(s), who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the specified elements.	<p>The Steering Committee reviewed this measure and agreed it fit within the scope of care coordination.</p> <p>This measure <u>will</u> be further evaluated.</p>

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CC-075-09/ ©AMA-PCPI	Timely Transmission of Transition Record (Inpatient Discharges to Home/Self Care or Any Other Site of Care)	Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care with 24 hours of discharge.	The Steering Committee reviewed this measure and agreed it fit within the scope of care coordination. This measure <u>will</u> be further evaluated.
CC-076-09/ ©AMA-PCPI	Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care]) (Emergency Department Discharges to Ambulatory Care [Home/Self Care])	Percentage of patients, regardless of age, discharged from an emergency department (ED) to ambulatory care or home health care, or their caregiver(s), who received a transition record at the time of ED discharge including, at a minimum, all of the specified elements.	The Steering Committee reviewed this measure and agreed it fit within the scope of care coordination. This measure <u>will</u> be further evaluated.

NEXT STEPS

The next conference call is scheduled for Tuesday, May 26, 2009, from 12:30-2:30PM (ET). During this call, the Steering Committee will evaluate the measures based on the threshold criterion of “importance to measure and report”.