NATIONAL QUALITY FORUM

NQF Care Coordination Standing Committee Quarterly Off-Cycle Webinar

Looking Back to Plan Ahead

October 11, 2016

Introductions and Welcome

Objectives & Agenda

- Discuss how the Committee's Portfolio of Work can inform upcoming measure review work
  - Review the contents of the Committee's Portfolio of Work
  - Discuss the Portfolio's strengths and identify opportunities for additional portfolio development

New Work:
Care Coordination 2016-2017 Project

Care Coordination 2016-2017 Project

- **New project team**
  - Senior Director, Margaret (Peg) Terry
  - Senior Project Manager, Katie Streeter
  - Project Analyst, Yetunde Ogungbemi

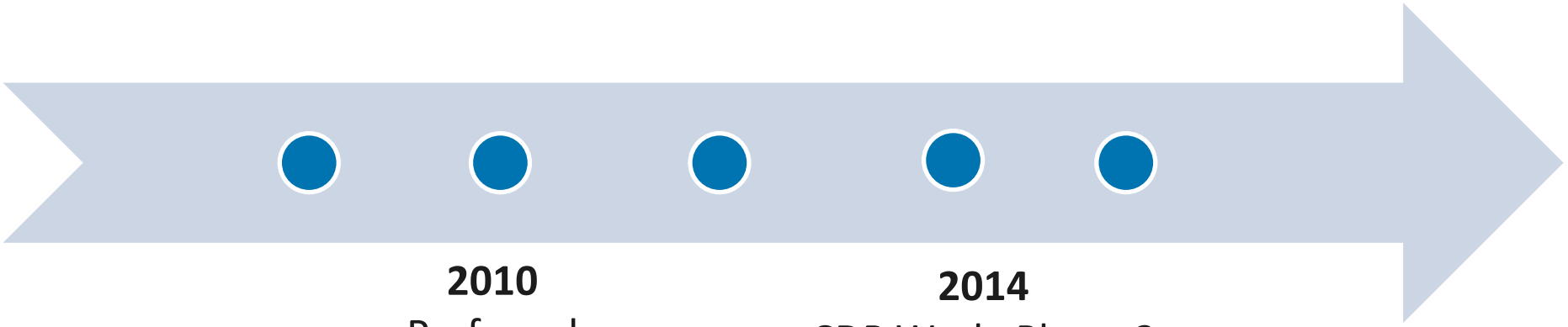
- **New round of the consensus development process**
  - Review performance measures in care coordination, including measures focused on patient experience of care, health information technology, transitions of care, and structural measures.

Care Coordination 2016-2017 Project

- **Measures up for review**
  - 6 maintenance measures
    - 0326: Advance Care Plan
    - 0526: Timely Initiation of Care
    - 0646: Reconciled Medication List Received by Discharged Patients
    - 0647: Transition Record with Specified Elements Received by Discharged Patients (d/c from inpatient facility to home/self care or other site)
    - 0648: Timely Transmission of Transition Record (d/c from inpatient facility to home/self care or other site)
    - 0649: Transition Record w/Specified Elements Received by Discharged Patients (ED d/c to ambulatory or home health care)
  - Any new measure submissions

Review of the Standing Committee's Portfolio of Work

Timeline


2006
Definition/
Framework
2010
Preferred
Practices
2012
CDP Work:
Phases 1 & 2
2014
CDP Work: Phase 3
Performance Gaps in Care
Coordination Report
2016
Off-Cycle
Work

2006
Care Coordination Definition & 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"

2006
Care Coordination Definition & Framework

5 key domains:

1. Healthcare “Home”
2. Proactive Plan of Care and Follow-up
3. Communication
4. Information Systems
5. Transitions or Handoffs

2010 & 2014
Preferred Practices and Performance Measures

- **Purpose**:
  - Provide structure, process, and outcome measures required to assess progress toward the care coordination goals of:
    - » Facilitating and carefully considering feedback from all patients regarding coordination of their care
    - » Improve communication around medication information
    - » Work to reduce 30-day readmission rates
    - » Work to reduce preventable ED visits by 50 %
  - Evaluate access, continuity, communication, and tracking of patients across providers and settings.

2010 & 2014
Preferred Practices: Healthcare "Home" Examples

The patient shall be provided the opportunity to select the healthcare home that provides the best and most appropriate opportunities to the patient to develop and maintain relationship with healthcare providers.
The healthcare home or sponsoring organizations shall be the central point for incorporating strategies for continuity of care between medical treatment, behavioral health services, long-term support services, and the community.*

*Revised in 2014

2014
Updated Definition

Care coordination is:

"…the deliberate synchronization of activities and information to improve health outcomes by ensuring that care recipients' and families' needs and preferences for healthcare and community services are met over time."

2014
Performance Measure Gaps

- Linkages and synchronization
- Progression toward goals
- Comprehensive assessment
- Shared accountability

2014
Measure Domains and Sub-Domains

Joint creation of a person-centered plan of care	Utilization of the health neighborhood to execute plan of care	Achievement of outcomes
Comprehensive Assessment	Linkages/ Synchronization	Experience
Goal Setting	Quality of Services	Progression Towards Goals
Shared Accountability		Efficiency

2014 Recommendations

- Building the evidence base on effective care coordination practices
- Accelerating health workforce culture change in pursuit of partnerships and team-based care
- More rapid standardization of care plan data
- Adjusting the nature and intensity of care coordination to respond to individuals' needs
- Careful consideration of the interplay between measurement and payment incentives

Reviewed Measures

PHASES 1 & 2	
Measure #	Measure Title
0171	Acute care hospitalization (risk-adjusted)
0173	Emergency Department Use without Hospitalization
0526	Timely initiation of care
0097	Medication Reconciliation
0553	Care for Older Adults – Medication Review
0554	Medication Reconciliation Post Discharge
0646	Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
0494	Medical Home System Survey (NCQA)
0326	Advance Care Plan

Reviewed Measures

PHASES 1 & 2	
Measure #	Measure Title
0647	Transition Record with Specified Elements Received by Discharged Patients (Discharged from an Inpatient Facility to Home/Self Care or Any other Site of Care)
0648	Timely Transmission of Transition Record (Discharged from an Inpatient Facility to Home/Self Care or Any other Site of Care)
0649	Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharged to Ambulatory Care or Home Health Care)
Not Endorsed	
0511	Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy
0520	Drug Education on All Medications Provided to Patient/Caregiver During Short-Term Episodes of Care
0645	Biopsy Follow-up

Reviewed Measures

PHASE 3	
Measure #	Measure Title
0291	Emergency transfer Communication
0495	Median time from ED arrival to ED departure for admitted ED patients
0496	Median time from ED arrive to ED departure for discharged ED patients
0497	Admit decision time to ED departure time for admitted patients
2456	Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient
0487	EHR with EDI prescribing used in encounters where a prescribing event occurred
Not Endorsed	
0487	EHR with EDI prescribing used in encounters where a prescribing event occurred

Reviewed Measures

PHASE 3	
Withdrawn from Consideration	
Measure #	Measure Title
0486	Adoption of Medication e-Prescribing
0488	Adoption of Health Information Technology
0489	The Ability of Providers with HIT to Receive Laboratory Data Electronically Directly into their qualified/certified EHR system as Discrete Searchable Data Element
0491	Tracking of Clinical Results between Visits
0493	Participation by a physician or other clinician in systematic clinical database registry that include consensus endorsed quality measures
0292	Vital Signs
0293	Medication Information
0294	Patient Information
0295	Physician Information
0293	Nursing Information
0297	Procedures and Tests

Off-Cycle Activities: Lessons Learned

1. Care coordination is about closing loops and completing connections.
2. Measures capturing only one segment of the process are insufficient and ultimately, invalid.
3. Our ability to recognize high quality care coordination exceeds our ability to measure it.
4. Preferred practices in care coordination are important and largely overlooked sources of insight into effective care coordination and potential performance measures.
5. General care coordination processes, like communication of information across settings and providers, are important and need to be measured for all recipients of health care regardless of diagnosis or setting.

Off-Cycle Activities: Lessons Learned

6. General care coordination processes should be distinguished from more complex care coordination processes targeted to the needs of high risk individuals and populations.
7. Care coordination, by definition, occurs between and across people and settings; capturing attribution in measures will likely be difficult and controversial.
8. Patient and family experience with care coordination is central to performance measurement.
9. Meaningful care coordination measurement requires strong process and outcome measures and rigorous research supporting their relationships.
10. Structural measures may be important for evaluating capacity to deliver the necessary dose of care coordination for achieving outcomes.

Off-Cycle Work: Recommendations

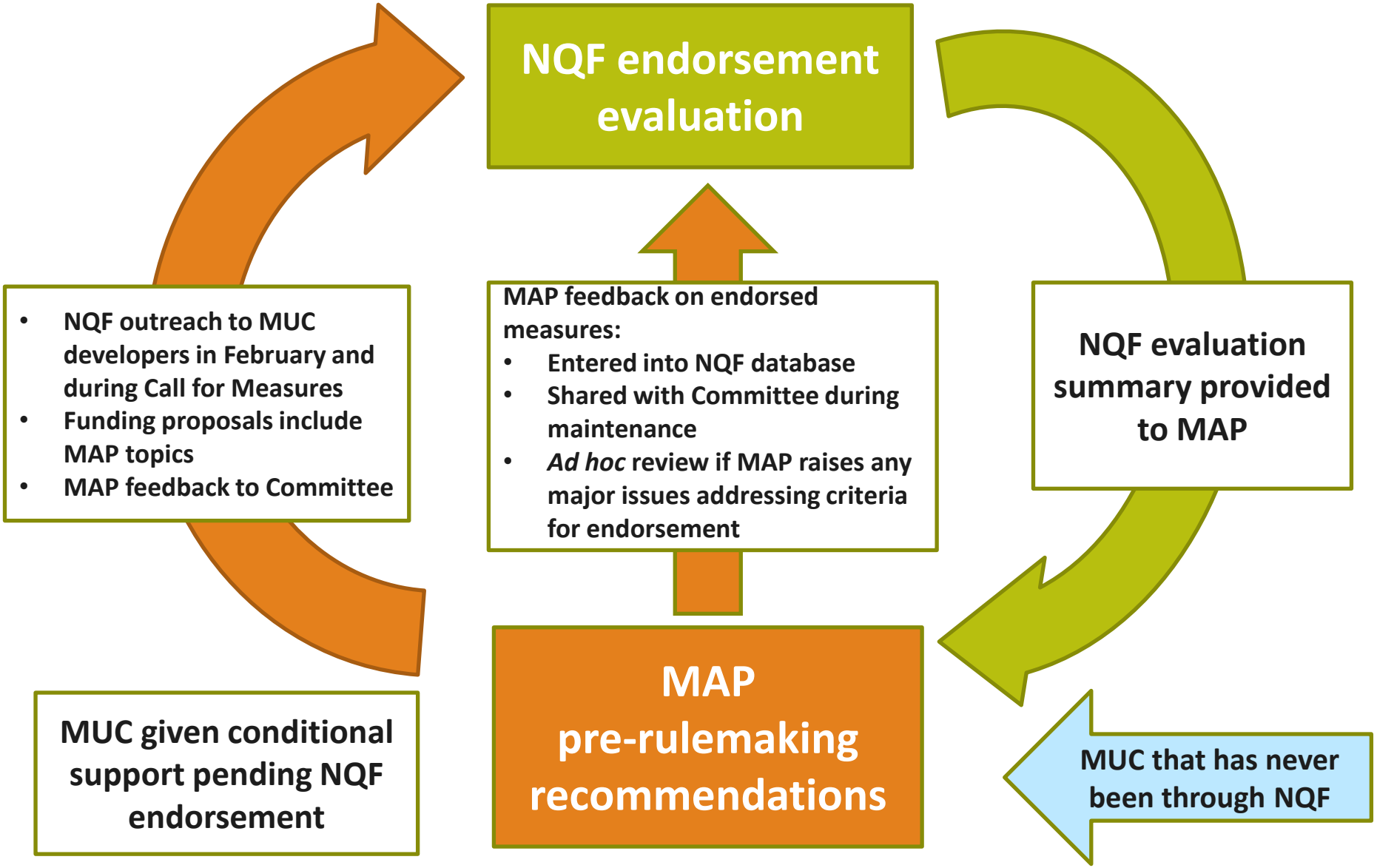
- Clarifying the Standing Committee's Purpose:
  - *To review care coordination performance measures submitted to NQF*
  - *To advise other Standing Committees or other stakeholder groups on issues related to care coordination practice, science, and measurement.*
  - *To anticipate the measurement needs of the field of care coordination and provide strategic guidance on how those needs can be met*

Discussion

Discussion Questions

- What are the strengths of the Portfolio?
- What opportunities are there for further developing the portfolio during this upcoming project?
  - How can we clarify what NQF endorsement means for these measures?
  - How do we define a care coordination measure? How can we use this definition to better understand the number and type of care coordination measures within the NQF portfolio of measures?
  - How can we better describe measure gaps so as to provide more specific guidance to measure developers?

CDP-MAP INTEGRATION – INFORMATION FLOW



Public Comment

What's Next?

Care Coordination 2016-2017 Project

Meeting	Date/Time
Call for Nominations	Closes November 3, 2016 at 6 PM ET
Call of Measures	Closes November 28, 2016 at 6 PM ET
Orientation Call	January 10, 2017 at 12PM-2PM ET
Measure Evaluation Q&A	January 12, 2017 at 2PM-3PM ET
Workgroup Calls	February 6, 2017 at 2PM-4PM ET February 7, 2017 at 2PM-4PM ET
In-person Meeting	February 21 – February 22, 2017

Adjourn