Executive Summary of 10/19/2011 Steering Committee Presentation

Background:
- Following the 2006 development of a Care Coordination Framework, NQF has only convened a single Care Coordination CDP in 2010 that endorsed 10 measures.
- The AHRQ Care Coordination Atlas published in 2010 was the last comprehensive assessment of care coordination measures while also presenting a more granular framework for measure classification. The Atlas identified no electronic measures.

Objective: To Identify and map all current measures of care coordination to the NQF endorsed™ Definition and Framework for Measuring Care Coordination

Approach: An organized, but not systematic, review of primary literature, grey literature and expert opinion was used to identify measures that were either published or presumed to be in active use. Each measure was mapped to the NQF and AHRQ frameworks.

Results:
- 124 measures found: 86(70%) had published specifications while 38(30%) are unpublished
- 78 (63%) of measures are broad or cross-cutting, while 46 (37%) were condition specific
- 30 measures (24%) were NQF endorsed (from various CDPs)
- Only 32 (26%) of measures were electronic, most of which are unpublished.
  - 45 (34% of all measures, 52% of all published measures) are surveys

Key Findings-Descriptive:
- Most electronic measures are not formally specified or published
- Almost all measures are process measures (only one outcome measure found)
- Most measures are patient experience surveys: therefore most measures are at the healthcare provider or practice level of measurement. Very few measures of hospital performance.
- Over 20 years, measures have evolved from surveys of patient experience → condition specific measures using claims data → process measures using electronic data sources.

Key Findings-Mapping: Major gaps in measurement found in this scan include:
- **Measure formats**: Electronic Measures/IS Process Measures
- **Measure Areas**: Healthcare home, Transitions within the ambulatory setting (between home and specialists, home and allied health, etc), Community Linkage, Transition needs assessment.
- While many measures currently fall within the Care Planning domain, most are measures of patient experience and fail to measure critical coordination activities including: Establishing accountability/Negotiating responsibility, Critical Information Communication, and

Conclusions:
- Applying different frameworks reveals distinct measurement gaps: we need a framework that accounts for the sequential and networked nature of care coordination.
- There are significant gaps in process measurement, particularly with respect to areas of coordination vulnerability such as community linkage, establishing accountability and information management/transfer.
Care Coordination Consensus
Standards Endorsement Maintenance:
Environmental Scan

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October 19, 2001

Disclosures

• Unrelated Grant Support
  – Emergency Medicine Foundation
  – Massachusetts College of Emergency Physicians
  – Harvard Catalyst/NIH
  – Society of Chest Pain Centers

• Consulting
  – Agency for Healthcare Research and Quality
  – American College of Emergency Physicians
Objective

- Identify all current measures that “are related to” the NQF endorsed™ Definition and Framework for Measuring Care Coordination.
- NQF Definition (2006)
  “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”
Background

• 2010 NQF Care Coordination Project
  – 10 Measures and 25 preferred practices
• 2011 AHRQ Atlas of Care Coordination Measures
  – 61 measures
• Key themes and directions in 2011
  – HIT, Broad Based, Outcomes not Process
• Where are the current gaps in measurement?

Approach

• “System”atic review
  – Primary Literature search
  – Grey Literature search
  – Expert opinion Interview
• Anticipated outcomes
  – Inventory of existing care coordination measures
  – Mapping analysis to NQF and AHRQ frameworks
  – Qualitative conclusions about trend
Measure Inclusions/Exclusions

- **Included**
  - Broad-based and condition specific
  - Paper survey, electronic, or claims based

- **Excluded**
  - Setting specific measures of team communication
  - Measures without completed testing or structured assessment of face validity (if published)
  - Measures of screening practices
  - Single intervention response (BP control at 6mos)
  - Measures designed to measure non-US systems
  - 30 day re-admission
  - ED throughput
Analysis

• Key measure elements abstracted
  – NQF endorsement, electronic support, date, etc.

• Mapping to Care Coordination Frameworks
  – NQF: Assigned by single reviewer (AKV)
  – AHRQ: per Atlas if reported, otherwise by AKV

Results

• 124 measures identified
  – 86 (70%) published specifications
• 32 (26%) electronically measured
• Only 1 “outcome measure” (PDRM)
• 78 (63%) Broad / 46 (37%) Condition Specific
• 30 (24%) NQF Endorsed
Results: Date Sources

Results: Level of Measurement
## Frameworks for Mapping

<table>
<thead>
<tr>
<th>NQF Framework</th>
<th>AHRQ Atlas</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 5 Domains</td>
<td>• Mechanisms</td>
</tr>
<tr>
<td>• Healthcare Home</td>
<td>• Coordination Activities</td>
</tr>
<tr>
<td>• Proactive Plan of Care and Follow-up</td>
<td>• Broad Approaches</td>
</tr>
<tr>
<td>• Communication</td>
<td>• Effects (Perspective)</td>
</tr>
<tr>
<td>• Information Systems</td>
<td>• Patient</td>
</tr>
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<td>• Transitions</td>
<td>• Healthcare professional</td>
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<tr>
<td>• Principles</td>
<td>• System</td>
</tr>
<tr>
<td>• Important for everyone</td>
<td>• Participants</td>
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<td>• Vulnerable populations</td>
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<tr>
<td>• Variable level of measurement</td>
<td></td>
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<tr>
<td>• Need to ensure patient/family</td>
<td></td>
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<tr>
<td>experience</td>
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</table>

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**Donabedian Model**

- Structures of Care
- Processes of Care
- Outcomes

- **Broad Approaches**
- **Coordination Activities**
- **Effects**

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Establish accountability
Communicate (Interper, Informa)
Facilitate Transitions
Assess needs and goals
Create a proactive plan of care
Monitor, follow up, and respond
Support self-management goals
Link to community resources
Align resources with needs

Teambwork focused on coordination
Health care home
Care management
Medication management
Health IT-enabled coordination

Healthcare “Home”
Proactive Plan of Care and Follow-up
Communication
Information systems
Transitions or “hand-offs”

Care coordination is important for everyone.
Some populations are particularly vulnerable
Level of Measurement is variable
Patient/Family surveys of processes and outcomes

Mapping: NQF Domains

<table>
<thead>
<tr>
<th>Domain</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>Transitions</td>
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<td>Communication</td>
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<tr>
<td>Plan of Care</td>
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<tr>
<td>Healthcare Home</td>
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Mapping: AHRQ Atlas

<table>
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<tr>
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<th>Percentage</th>
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<td>Align resources</td>
<td>31</td>
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<tr>
<td>Link to Community</td>
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<tr>
<td>Self management</td>
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<tr>
<td>Monitor follow-up</td>
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<tr>
<td>Plan care</td>
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<tr>
<td>Assess needs</td>
<td>58</td>
</tr>
<tr>
<td>Transitions (needs)</td>
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<tr>
<td>Transitions (settings)</td>
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<tr>
<td>Information Communication</td>
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<td>Interpersonal Communication</td>
<td>45</td>
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<tr>
<td>Establish Accountability</td>
<td>60</td>
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</table>

Where are current gaps in electronic measurement?
Mapping: NQF Mapping

- Transitions: 38 Chart, 10 Electronic
- Information Systems: 5 Chart, 16 Electronic
- Communication: 40 Chart, 5 Electronic
- Plan of Care: 70 Chart, 18 Electronic
- Healthcare Home: 19 Chart, 3 Electronic

Mapping: AHRQ Atlas

- Align resources: 30 Chart, 1 Electronic
- Link to Community: 28 Chart, 2 Electronic
- Self management: 55 Chart, 5 Electronic
- Monitor follow-up: 75 Chart, 17 Electronic
- Plan care: 35 Chart, 5 Electronic
- Assess needs: 54 Chart, 4 Electronic
- Transitions (needs): 15 Chart, 4 Electronic
- Transitions (settings): 41 Chart, 13 Electronic
- Information Communication: 77 Chart, 13 Electronic
- Interpersonal Communication: 44 Chart, 1 Electronic
- Establish Accountability: 50 Chart, 9 Electronic
Does measure availability create apparent gaps?

Mapping: NQF Mapping

- Transitions: 5 (Published), 42 (Electronic)
- Information Systems: 8 (Published), 13 (Electronic)
- Communication: 2 (Published), 41 (Electronic)
- Plan of Care: 9 (Published), 61 (Electronic)
- Healthcare Home: 1 (Published), 20 (Electronic)
How do frameworks alter the gap analysis?
Assess needs and goals
Create a proactive plan of care
Monitor, follow up, and respond
Support self-management goals
Link to community resources

Proactive Plan of Care and Follow-up

AHRQ Atlas
Care Coordination Activities

AHRQ Atlas
Broad Approaches

Care management

Assess needs and goals
Create a proactive plan of care
Monitor, follow up, and respond
Support self-management goals
Link to community resources

Proactive Plan of Care and Follow-up

Plan of Care

Total
NQF Endorsed
Published, electronic

Care management
Establish accountability

Communicate (Interpersonal, Informational)

Care management

AHRQ Atlas Care Coordination Activities

AHRQ Atlas Broad Approaches

Communication

NQF Care Coordination Domains

NQF Endorsed

Published, electronic

Total

Care management
Do gaps differ based on measure focus?

Mapping: NQF Domains

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<thead>
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<th>Domain</th>
<th>Condition-Specific</th>
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Mapping: AHRQ Atlas

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Key Findings and Conclusions
Descriptive Analysis: Key Findings

- Most electronic measures are not formally specified or published
  - Is there an electronic measure set our there?
- Almost all measures are process measures
  - What would constitute a care coordination outcome measure?
- Most measures are patient experience surveys
  - How can we comprehensively measure activities across the care coordination spectrum?

Evolution of Care Coordination Measurement

- Patient Experience Surveys
- Condition Specific Claims
- EMR Activity/Process

Now
Framework Considerations

• HIT better described as a broad foundation rather than as an exclusive domain
• Need to consider sub-activities to ensure no measurement gaps across a spectrum
• Can a sequential or networked model for a framework help shape measure development?

Gaps in Care Coordination Measures

• Electronic Measures/IS Process Measures
• Measure Areas
  • Healthcare home
  • Transitions within the ambulatory setting
  • Community linkage
  • Transition needs
• Moving beyond the patient experience survey
  • Care plans
  • Establishing accountability/Negotiating responsibility
  • Information Communication
  • Patient Experience → Patient needs and goal assessment
Questions and Discussion

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