NQF Care Coordination Consensus Standard Endorsement Maintenance: Environmental Scan

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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- 124 measures found: 86(70%) had published specifications while 38(30%) are unpublished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- Only 32 (26%) of measures were electronic, most of which are unpublished.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 framewors 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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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

Outline

- Objectives and Background
- Framework considerations
- Methods
- Environmental Scan: Measure characteristics
- Environmental Scan: Measure mapping
- Future measurement gaps

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"

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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?

1. National Quality Forum. National Quality Forum-endorsed definition and framework for measuring care coordination. Washington, DC: National Quality Forum; 2006.
2. National Quality Forum. Preferred practices and performance measures for measuring and reporting care coordination: a consensus report. Washington, DC: National Quality Forum; 2010.
3. McDonald KM, Schultz E, Albin L, Pineda N, Lonhart J, Sundaram V, Smith-Spangler C, Brustrom J, and Malcolm E. Care Coordination Atlas Version 3 (Prepared by Stanford University under subcontract to Battelle on Contract No. 290-04-0020). AHRQ Publication No. 11-0023-EF. Rockville, MD: Agency for Healthcare Research and Quality. November 2010.

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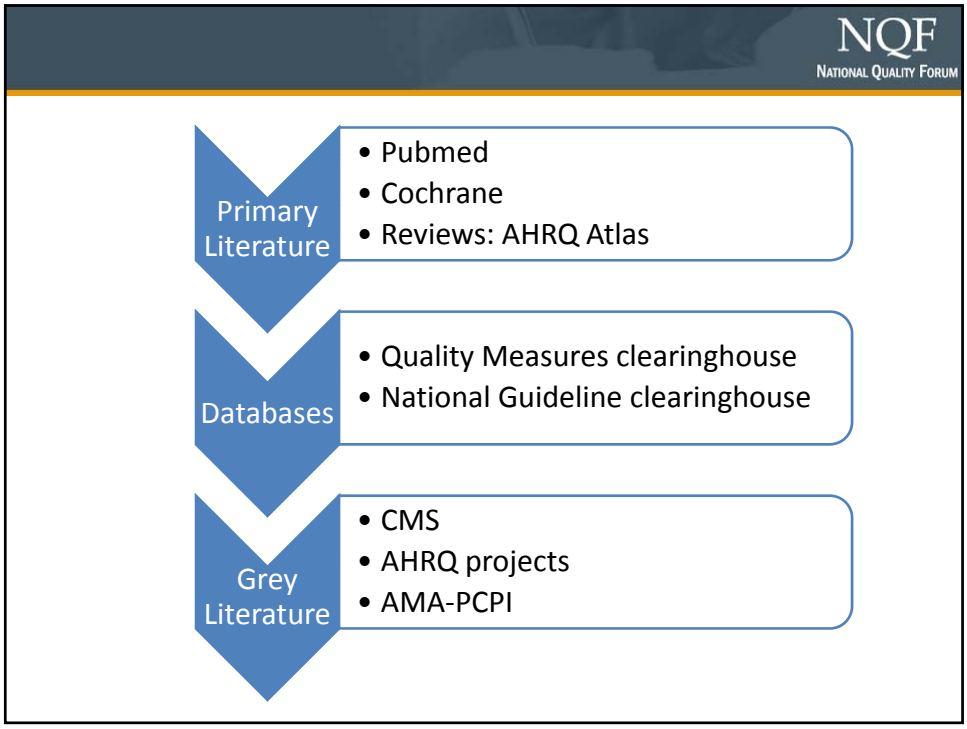
Approach

- "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



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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

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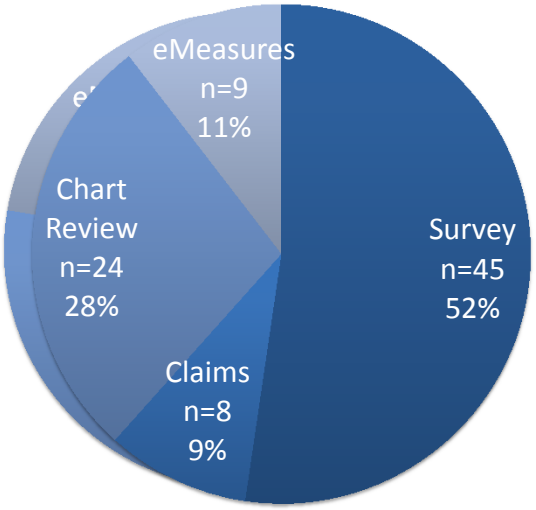
Results: Date Sources



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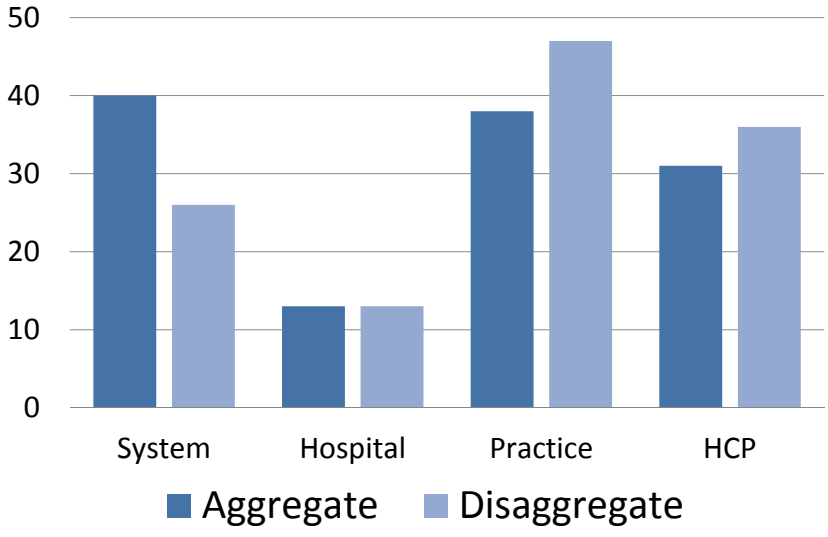
Results: Level of Measurement



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Frameworks for Mapping

NQF Framework

- 5 Domains
  - Healthcare Home
  - Proactive Plan of Care and Follow-up
  - Communication
  - Information Systems
  - Transitions
- Principles
  - Important for everyone
  - Vulnerable populations
  - Variable level of measurement
  - Need to ensure patient/family experience

AHRQ Atlas

- Mechanisms
  - Coordination Activities
  - Broad Approaches
- Effects (Perspective)
  - Patient
  - Healthcare professional
  - System
- Participants

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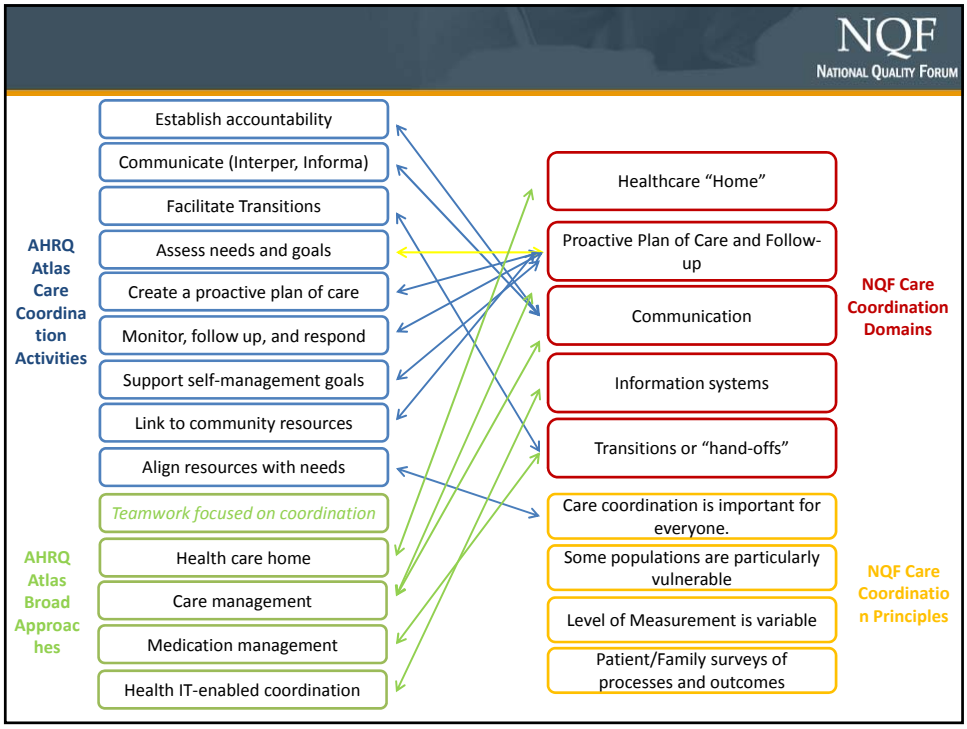
Broad Approaches **Coordination Activities** **Effects**

McDonald KM, Schultz E, Albin L, Pineda N, Lonhart J, Sundaram V, Smith-Spangler C, Brustrom J, and Malcolm E. Care Coordination Atlas Version 3 (Prepared by Stanford University under subcontract to Battelle on Contract No. 290-04-0020). AHRQ Publication No. 11-0023-EF. Rockville, MD: Agency for Healthcare Research and Quality. November 2010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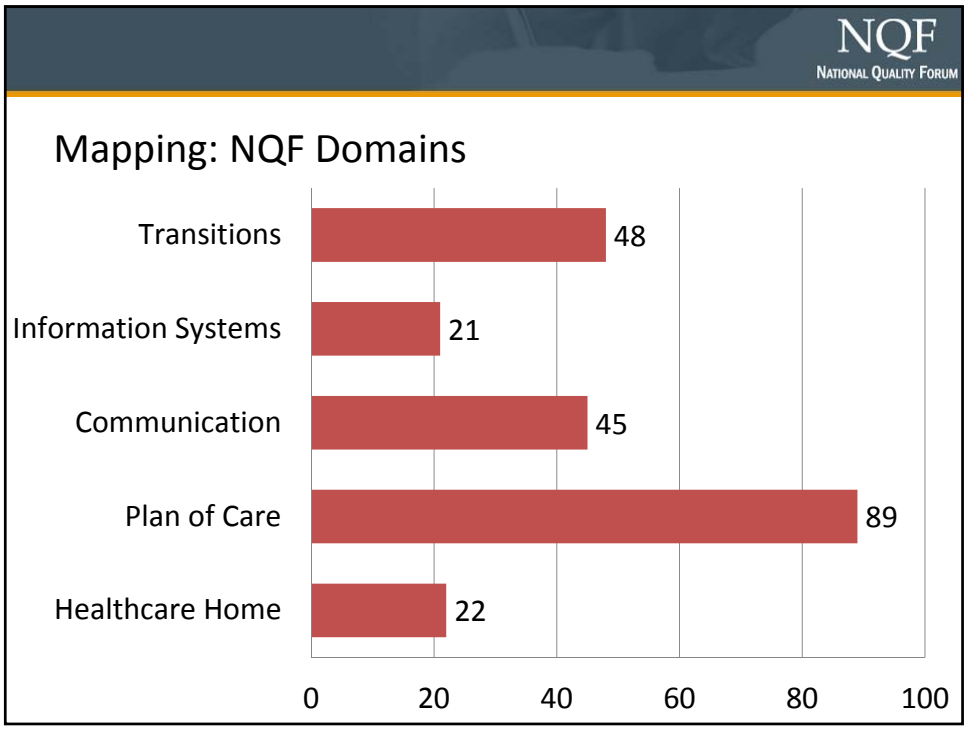
AHRQ Atlas Care Coordination Activities
Establish accountability
Communicate (Interper, Informa)
Facilitate Transitions
Assess needs and goals
Create a proactive plan of care
Monitor, follow up, and respond
Support self-management goals
Link to community resources
Align resources with needs
Teamwork focused on coordination
AHRQ Atlas Broad Approaches
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"
NQF Care Coordination Domains
Care coordination is important for everyone.
Some populations are particularly vulnerable
Level of Measurement is variable
Patient/Family surveys of processes and outcomes
NQF Care Coordination Principles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Mapping: NQF Domains
Transitions
48
Information Systems
21
Communication
45
Plan of Care
89
Healthcare Home
22
0
20
40
60
80
100

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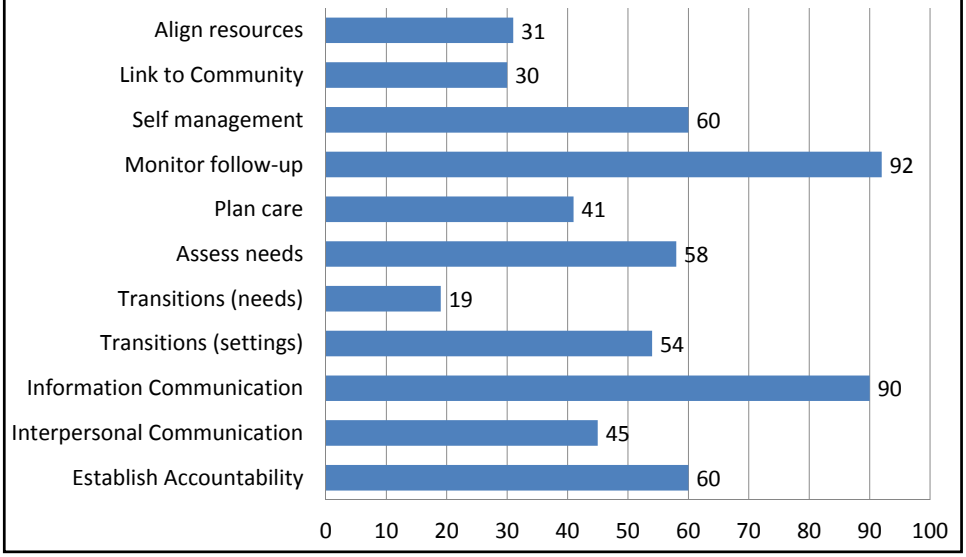
Mapping: AHRQ Atlas



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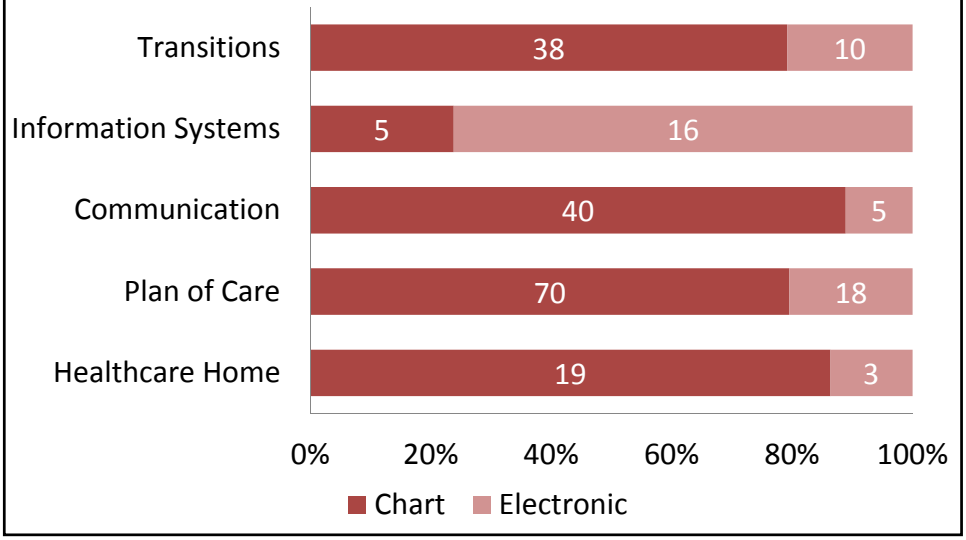
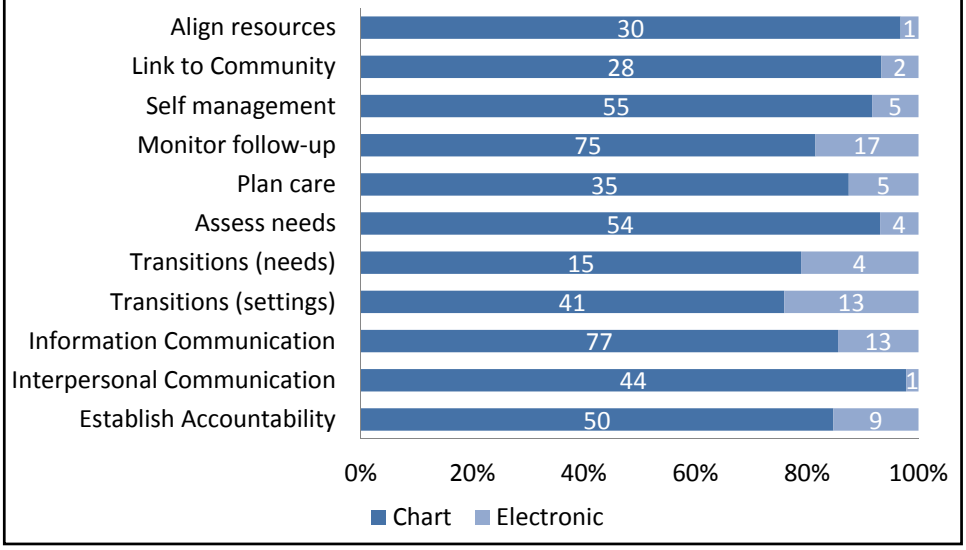
Where are current gaps in electronic measurement?

Mapping: NQF Mapping



Mapping: AHRQ Atlas



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Does measure availability create apparent gaps?

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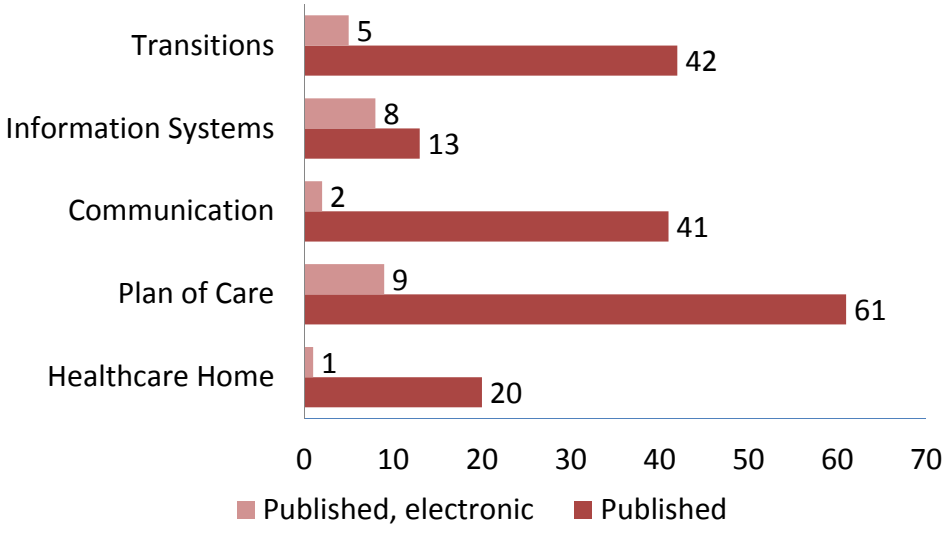
Mapping: NQF Mapping



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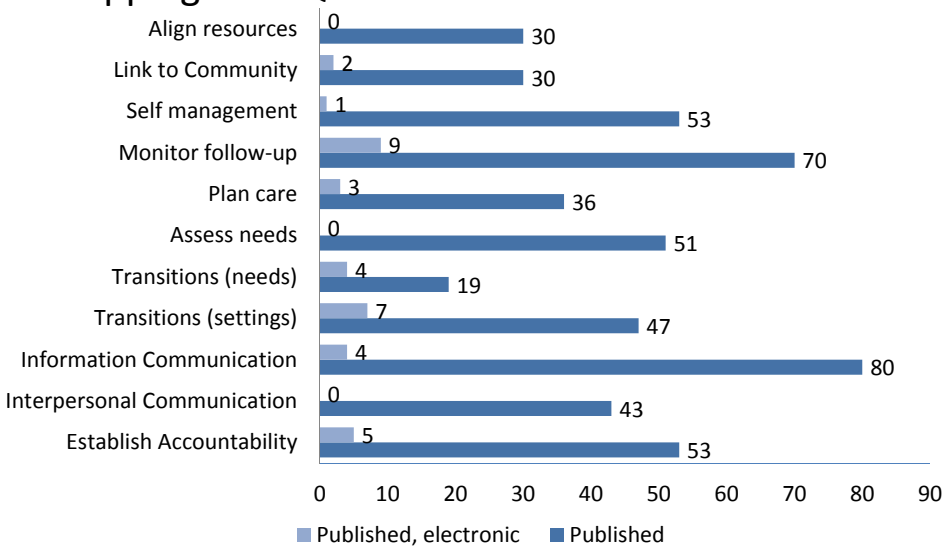
Mapping: AHRQ Atlas



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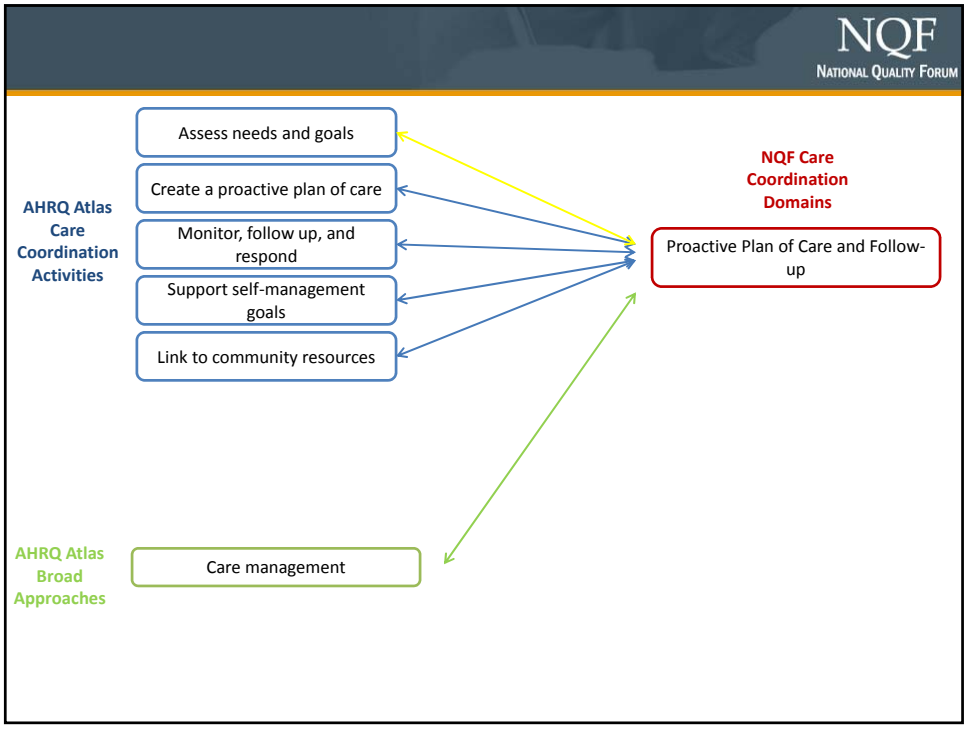
How do frameworks alter the gap analysis?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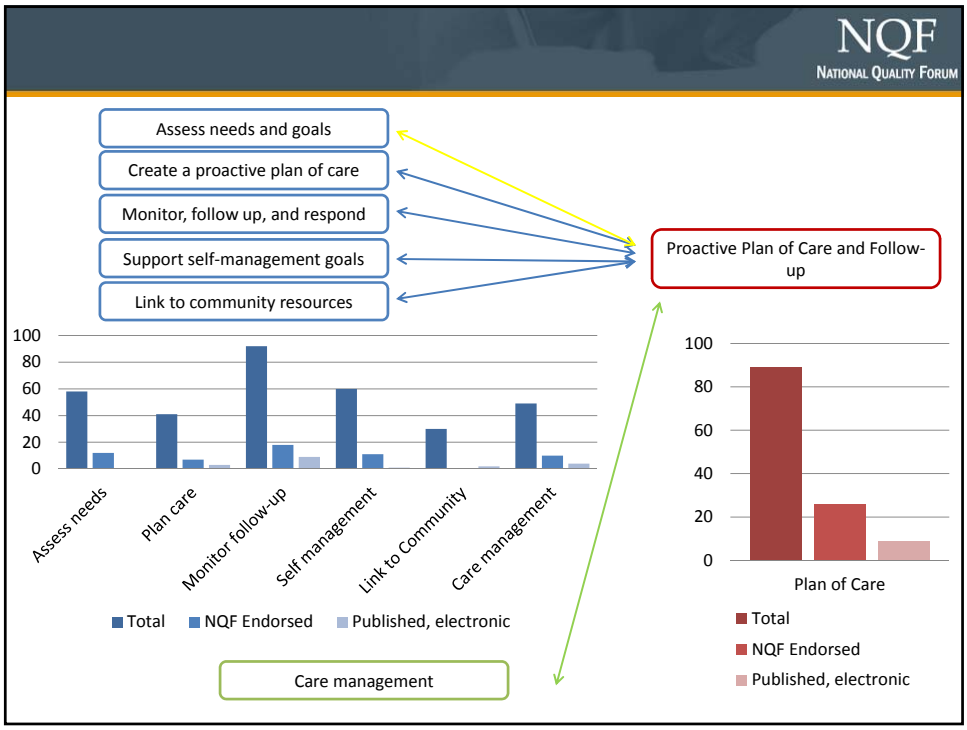
AHRQ Atlas Care Coordination Activities
Assess needs and goals
Create a proactive plan of care
Monitor, follow up, and respond
Support self-management goals
Link to community resources
NQF Care Coordination Domains
Proactive Plan of Care and Follow-up
AHRQ Atlas Broad Approaches
Care management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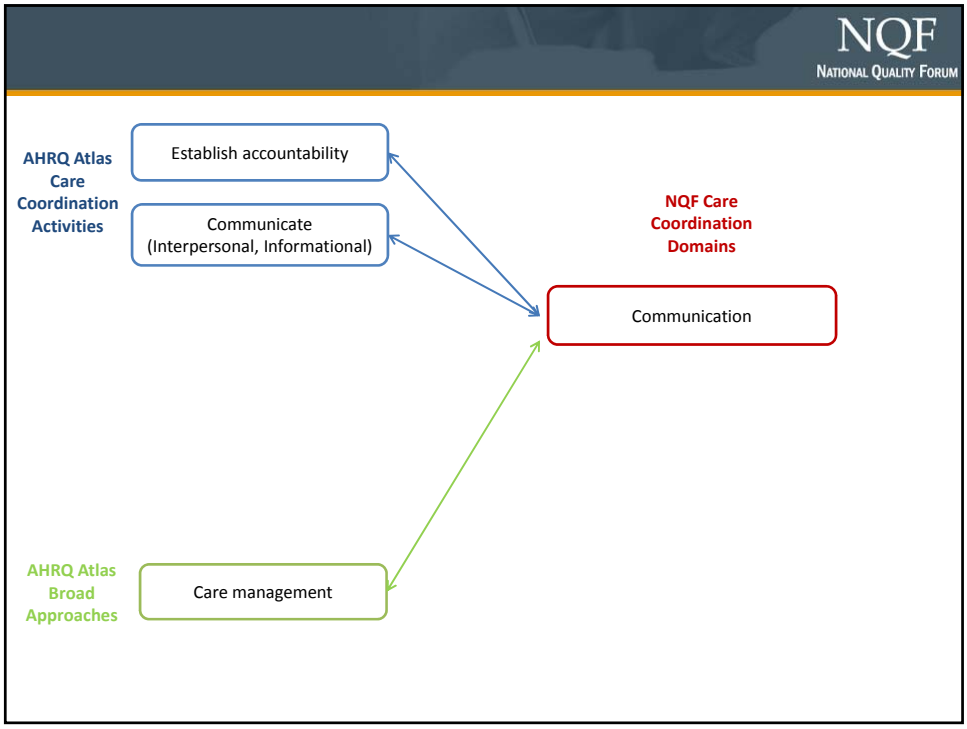
Assess needs and goals
Create a proactive plan of care
Monitor, follow up, and respond
Support self-management goals
Link to community resources
Proactive Plan of Care and Follow-up
100
80
60
40
20
0
Assess needs
Plan care
Monitor follow-up
Self management
Link to Community
Care management
Total
NQF Endorsed
Published, electronic
Care management
100
80
60
40
20
0
Plan of Care
Total
NQF Endorsed
Published, electronic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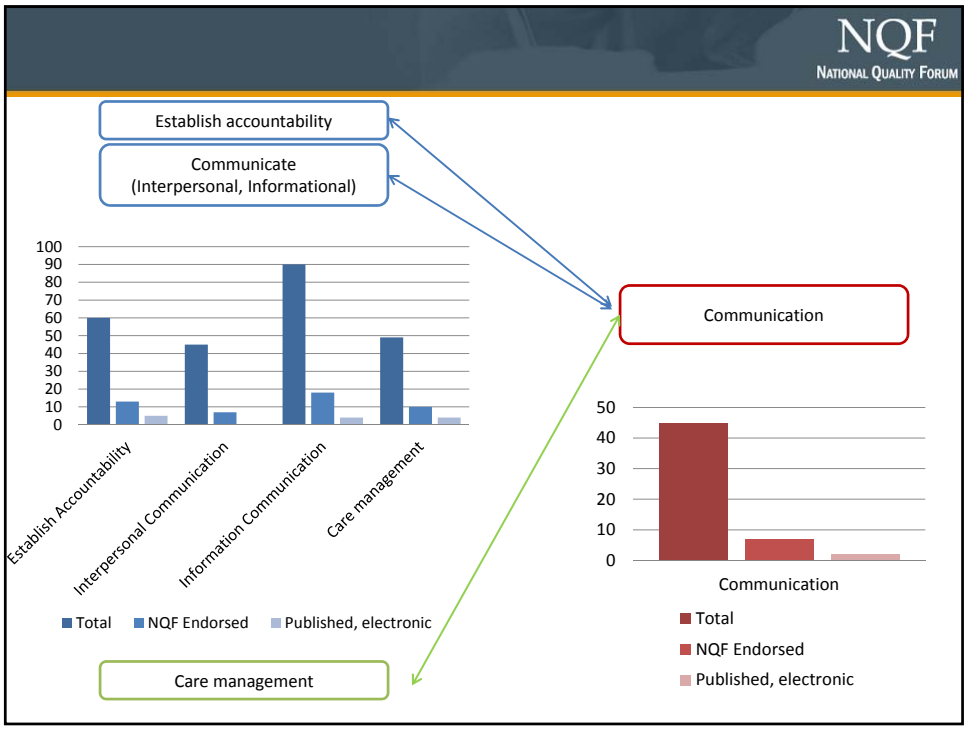
AHRQ Atlas Care Coordination Activities
Establish accountability
Communicate (Interpersonal, Informational)
NQF Care Coordination Domains
Communication
AHRQ Atlas Broad Approaches
Care management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Establish accountability
Communicate (Interpersonal, Informational)
100
90
80
70
60
50
40
30
20
10
0
Establish Accountability
Interpersonal Communication
Information Communication
Care management
Total
NQF Endorsed
Published, electronic
Care management
Communication
50
40
30
20
10
0
Communication
Total
NQF Endorsed
Published, electronic

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Do gaps differ based on measure focus?

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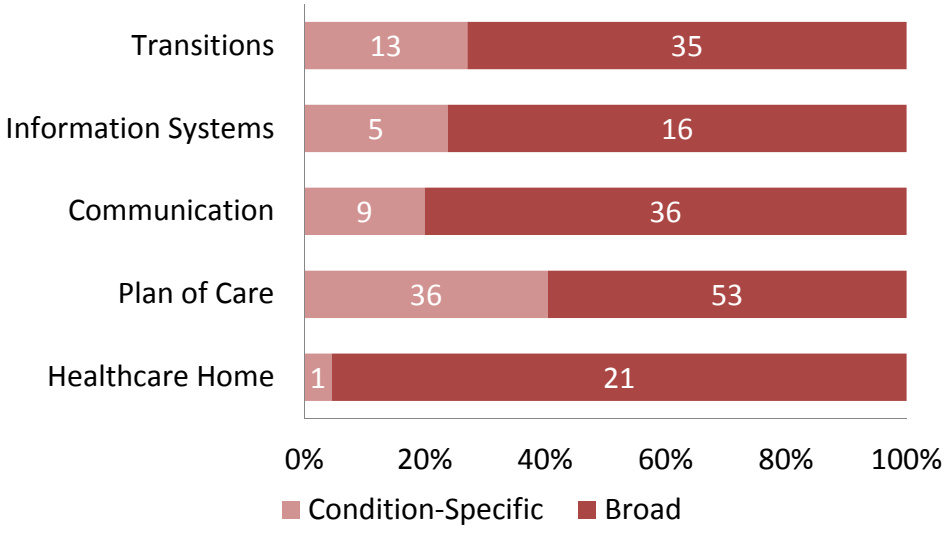
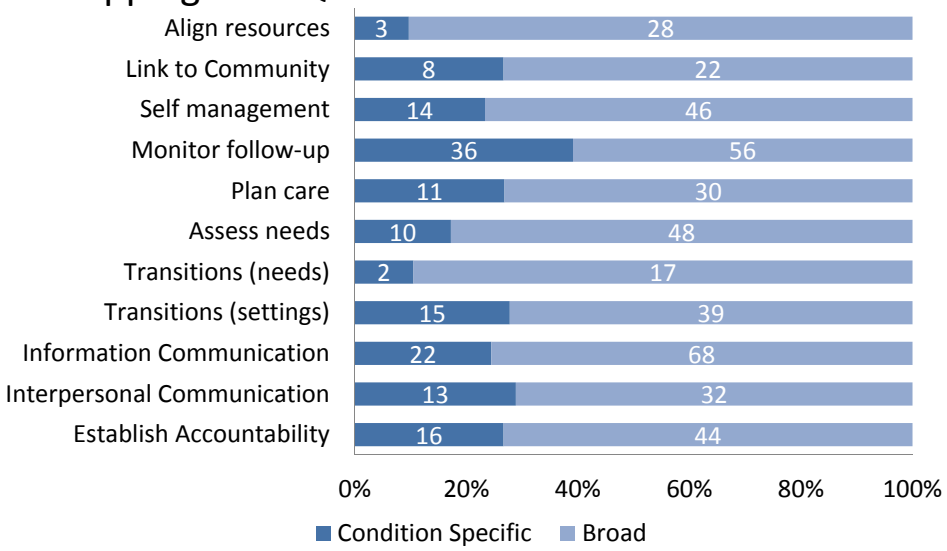
Mapping: NQF Domains



Mapping: AHRQ Atlas



Key Findings and Conclusions

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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?

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Evolution of Care Coordination Measurement

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

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Questions and Discussion

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October 19, 2001