NATIONAL QUALITY FORUM

PREFERRED PRACTICES AND PERFORMANCE MEASURES FOR MEASURING AND REPORTING CARE COORDINATION

Table 1: National Voluntary Consensus Standards for Care Coordination
Preferred Practices: Healthcare "Home" Domain
Preferred Practice 1: 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 a relationship with healthcare providers.
Preferred Practice 2: The healthcare home or sponsoring organizations shall be the central point for incorporating strategies for continuity of care.
Preferred Practice 3: The healthcare home shall develop infrastructure for managing plans of care that incorporate systems for registering, tracking, measuring, reporting, and improving essential coordinated services.
Preferred Practice 4: The healthcare home should have policies, procedures, and accountabilities to support effective collaborations between primary care and specialist providers, including evidence-based referrals and consultations that clearly define the roles and responsibilities.
Preferred Practices 5: The healthcare home will provide or arrange to provide care coordination services for patients at high risk for adverse health outcomes, high service use, and high costs.
Preferred Practices: Proactive Plan of Care and Follow-up Domain
Preferred Practice 6: Healthcare providers and entities should have structured and effective systems, policies, procedures, and practices to create, document, execute, and update a plan of care with every patient.
Preferred Practice 7: A systematic process of follow-up tests, treatments, or services should be established and be informed by the plan of care.
Preferred Practice 8: The joint plan of care should be developed and include patient education and support for self-management and resources.
Preferred Practice 9: The plan of care should include community and nonclinical services as well as healthcare services that respond to a patient's needs and preferences and contributes to achieving the patient's goals.
Preferred Practice 10: Healthcare organizations should utilize cardiac rehabilitation services to assist the healthcare home in coordinating rehabilitation and preventive care for patients with a recent cardiovascular event.
Preferred Practices: Communication Domain
Preferred Practice 11: The patient's plan of care should always be made available to the healthcare home team, the patient, and the patient's designees.
Preferred Practice 12: All healthcare home team members, including the patient and his or her designees, should work within the same plan of care and share responsibility for their contributions to the plan of care and for achieving the patient's goals.
Preferred Practice 13: A program should be used that incorporates a care partner to support family and friends when caring for a hospitalized patient.
Preferred Practice 14: The provider's perspective of care coordination activities should be assessed and documented.
Preferred Practices: Information Systems Domain
Preferred Practice 15: Standardized, integrated, interoperable, electronic, information systems with functionalities that are essential to care coordination, decision support, and quality measurement and practice improvement should be used.

Preferred Practice 16: An electronic record system should allow the patient's health information to be accessible to caregivers at all points of care.
Preferred Practice 17: Regional health information systems, which may be governed by various partnerships, including public/private, state/local agencies, should enable healthcare home teams to access all patient information.
Preferred Practices: Transitions or Handoffs Domain
Preferred Practice 18: Decisionmaking and planning for transitions of care should involve the patient, and, according to patient preferences, family, and caregivers (including the healthcare home team). Appropriate follow-up protocols should be used to assure timely understanding and endorsement of the plan by the patient and his or her designees.
Preferred Practice 19: Patients and their designees should be engaged to directly participate in determining and preparing for ongoing care during and after transitions.
Preferred Practice 20: Systematic care transitions programs that engage patients and families in self-management after being transferred home should be used whenever available.
Preferred Practice 21: For high-risk chronically ill older adults, an evidence-based multidisciplinary, transitional care practice that provides comprehensive in-hospital planning, home-based visits, and telephone follow-up, such as the Transitional Care Model, should be deployed.
Preferred Practice 22: Healthcare organizations should develop and implement a standardized communication template for the transitions of care process, including a minimal set of core data elements that are accessible to the patient and his or her designees during care.
Preferred Practice 23: Healthcare providers and healthcare organizations should implement protocols and policies for a standardized approach to all transitions of care. Policies and procedures related to transitions and the critical aspects should be included in the standardized approach.
Preferred Practice 24: Healthcare providers and healthcare organizations should have systems in place to clarify, identify, and enhance mutual accountability (complete/confirmed communication loop) of each party involved in a transition of care.
Preferred Practice 25: Healthcare organizations should evaluate the effectiveness of transition protocols and policies, as well as evaluate transition outcomes.
Performance Measures for Care Coordination
• Cardiac rehabilitation patient referral from an inpatient setting
• Cardiac rehabilitation patient referral from an outpatient setting
• Patients with a transient ischemic event ER visit who had a follow-up office visit
• Biopsy follow-up
• Reconciled medication list received by discharged patients (inpatient discharges to home/self care or any other site of care)
• Transition record with specified elements received by discharged patients (inpatient discharges to home/self-care or any other site of care)
• Timely transmission of transition record (inpatient discharges to home/self care or any other site of care)
• Transition record with specified elements received by discharged patients (emergency department discharges to ambulatory care [home/self care])
• Melanoma continuity of care – recall system
• 3-Item Care Transitions Measure (CTM-3)[1]

[1] This NQF-endorsed measure was reviewed for continued endorsement.