NATIONAL QUALITY FORUM

Agenda

Priority Setting for Health Care Performance Measurement: Addressing Performance Measure Gaps in Priority Areas

Public Webinar to Highlight Three Draft Reports: Person-Centered Care and Outcomes, Health Workforce, and Care Coordination

June 30, 2014 | 3:00 pm – 5:00 pm ET

Participant Instructions:

Follow the instructions below 15 minutes prior to the scheduled start time.

1. Direct your web browser to the following URL: nqf.commpartners.com
2. Under "Enter a meeting," type in the meeting number **994152** and click on "Enter."
3. In the "Display Name" field, type in your first and last name and click on "Enter Meeting."
4. To participate in discussion over the phone, dial **1-855-366-2249** and use confirmation code **57039625.**
5. If you need technical assistance during the meeting, you may press *0 to alert an operator or send an email to: nqf@commpartners.com.

Web Meeting Objectives:

- Build a shared understanding of the results of the committee deliberations
- Review highlights and themes from the draft reports to inform public commenters
- Answer participant questions related to the Prioritizing Measure Gaps projects

3:00 pm **Welcome, Review of Meeting Objectives**
Wendy Prins, Senior Director, NQF

- Provide an overview of the Prioritizing Measure Gaps project

3:10 pm **Person- Centered Care and Outcomes**
Sally Okun, Co-Chair, Person-Centered Care and Outcomes Committee

Uma Kotagal, Co-Chair, Person-Centered Care and Outcomes Committee

- Review the major themes of the conceptual framework
- Describe committee recommendations on prioritized areas for future measure development
- Participant questions and comments

3:45 pm **Health Workforce**
Melissa Gerdes, Co-Chair, Health Workforce Committee

Ann Lefebvre, Co-Chair, Health Workforce Committee

- Review the major themes of the conceptual framework
- Describe committee recommendations on prioritized areas for future measure development
- Participant questions and comments

4:20 pm **Care Coordination**
Susan Reinhard, Co-Chair, Care Coordination Committee

Mark Redding, Co-Chair, Care Coordination Committee

- Review the major themes of the conceptual framework
- Describe committee recommendations on prioritized areas for future measure development
- Participant questions and comments

4:55 pm **Next Steps**
Wendy Prins

5:00 pm **Adjourn**

Priority-Setting for Healthcare Performance Measurement

Person-Centered Care and Outcomes
Health Workforce
Care Coordination

June 30, 2014

NATIONAL QUALITY FORUM

Welcome

Agenda

- Project Overview
- Person-Centered Care and Outcomes
- Health Workforce
- Care Coordination
- Wrap Up

Project Overview

The Affordable Care Act: A Framework and Resources for Measurement-Based Improvement

- Section 3014 amended Section 1890 of the Social Security Act requiring the consensus-based entity (NQF) to "synthesize evidence and convene key stakeholders to make recommendations…on…priorities for health care performance measurement in all applicable settings," to include:
  - gaps in endorsed quality measures, including measures within priority areas identified by the Secretary under the national strategy;
  - areas in which quality measures are unavailable or inadequate to identify or address such gaps; and
  - areas in which evidence is insufficient to support endorsement of quality measures in priority areas identified by the Secretary.

The National Quality Strategy: Three Aims and Six National Priorities

Priority Setting for Health Care Performance Measurement: 2013-14 Focus Areas

- Adult Immunizations
- Alzheimer's Disease and Related Dementias
- ***Care Coordination***
- ***Health Workforce***
- ***Person-Centered Care and Outcomes***

Project Purpose and Objectives

To provide HHS with recommendations on priorities for performance measurement by:

- Providing multistakeholder guidance on high-leverage measurement areas in each topic area
- Identifying existing measures and measure concepts that may be useful for performance measurement
- Prioritizing opportunities and next steps for measure development and endorsement

Step 1. Convene Multistakeholder Committees

- For each topic, NQF convened a multistakeholder committee (five separate committees) to provide guidance to meet the project objectives.
- A small subgroup of thought leaders provided preliminary input on each project while the full committees were being seated.

Step 2. Identify and Modify Conceptual Frameworks for Measurement

- NQF considered relevant conceptual frameworks for the project.
- Committee members and other stakeholders provided guidance to staff on the development of the conceptual frameworks.
- The frameworks offer measure domains (and subdomains) that align with the three-part aim of improving health, quality, and cost.

Step 3. Conduct Measure Gap Analyses

- NQF staff conducted an environmental scan of measures and measure concepts and mapped them to the domains and subdomains of the conceptual frameworks.
- The committees considered high-priority opportunities for measure development and endorsement and identified promising measures and concepts.
- The committee considered the relevance and applicability of identified measures and concepts based on identified domains/subdomains .

Step 4. Develop Committee Recommendations

- The committees prioritized opportunities for performance measure development, endorsement, and use.
- To prioritize, the committees considered importance, level of evidence, and feasibility of measurement.
- The committee developed final recommendations for submission to HHS.

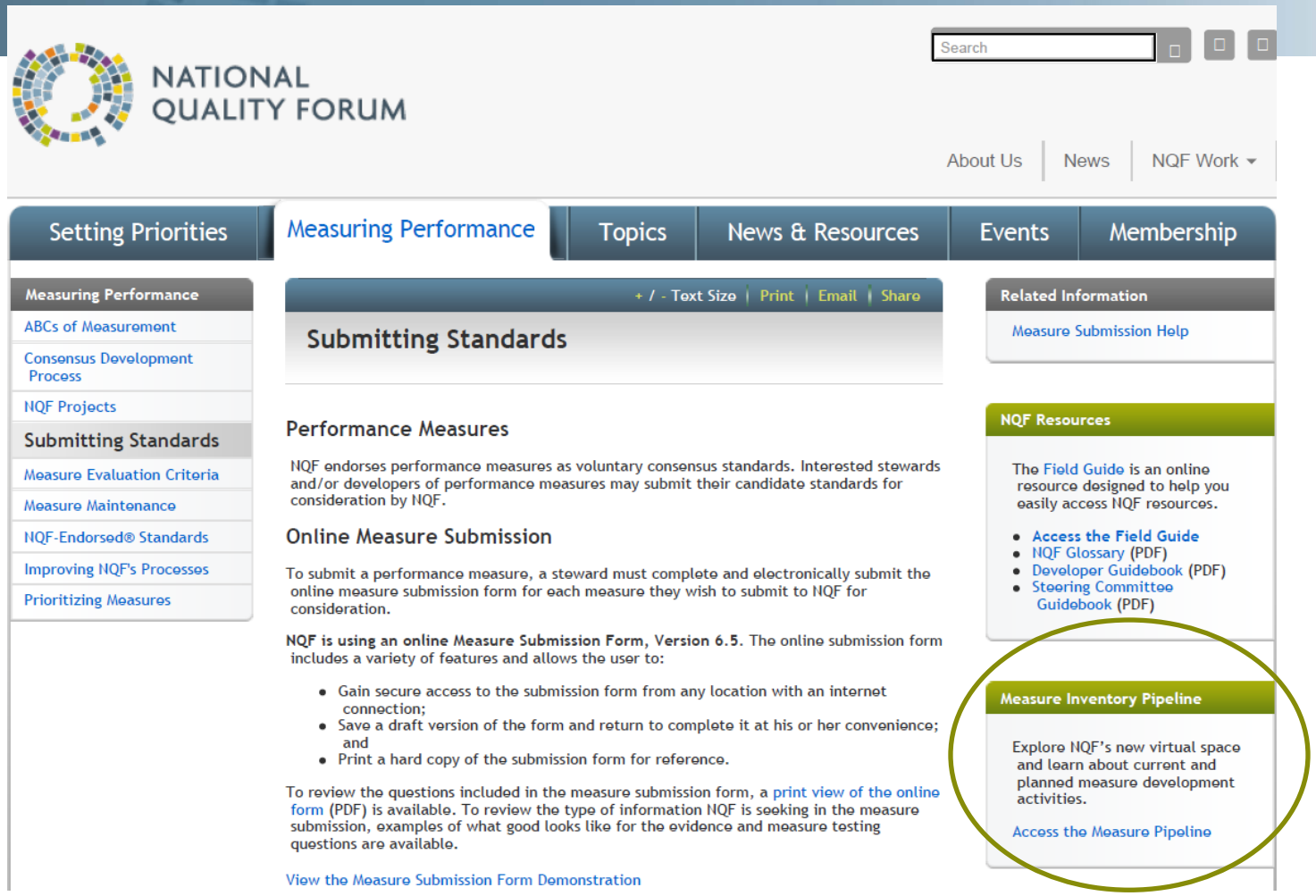
General Overview of Project Timeline

Oct-Dec	• Nominations and seating of Committees
Jan-May	• Committee meetings: Developed conceptual frameworks; prioritized domains/subdomains; reviewed results of environmental scans; identified and prioritized gaps for measure development and endorsement
June-July	• Public comment period (June 23-July 14)
June 30	• Public webinar: Feedback on report recommendations
August 15	• Deliverable: Final Committee Reports

*Project timeline for Alzheimer's Disease and Related Dementias: Final deliverable due October 15, 2014

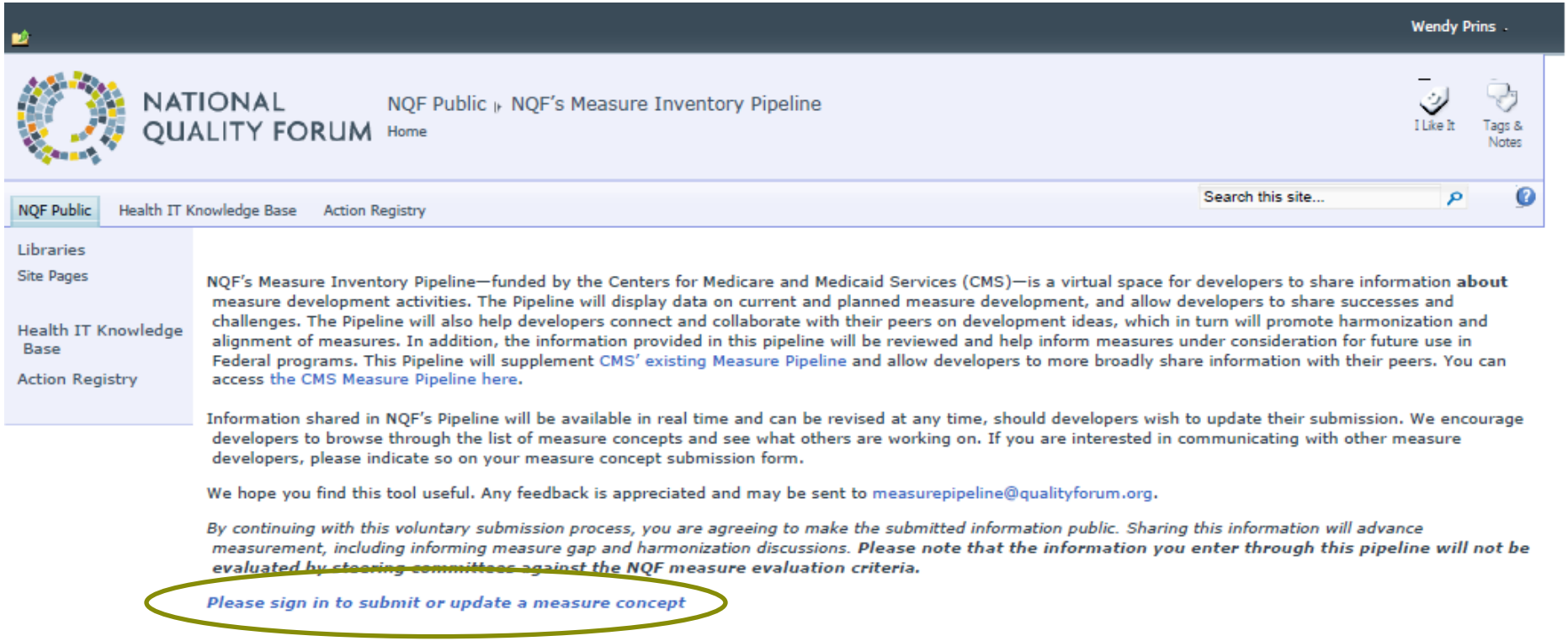
Submit Measures/Measure Concepts to NQF

http://www.qualityforum.org/Measuring_Performance/Submitting_Standards.aspx



Submit Measures/Measure Concepts to NQF

http://public.qualityforum.org/Pages/Measure-Concept.aspx



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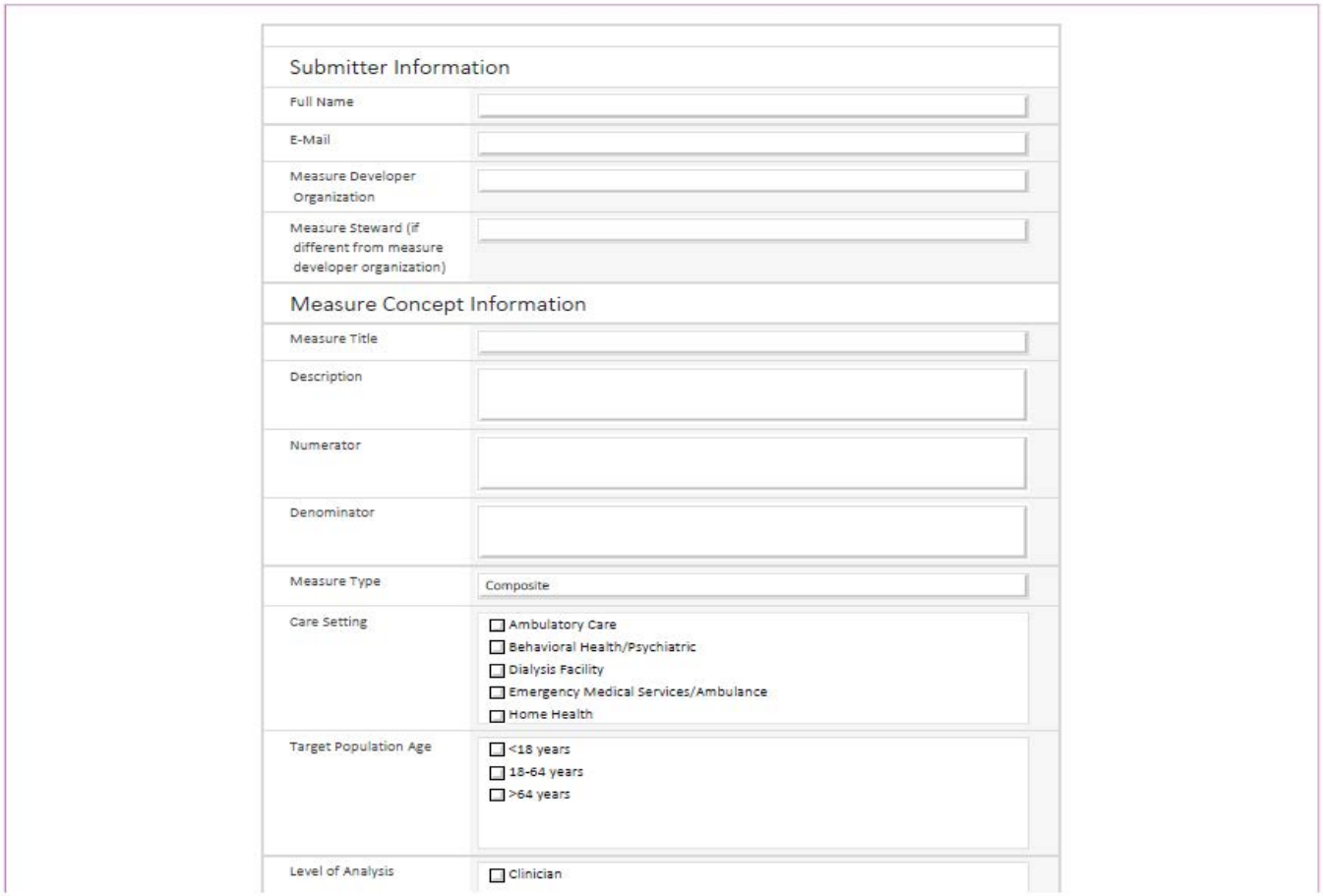


Submitter Information

Full Name	
E-Mail	
Measure Developer Organization	
Measure Steward (if different from measure developer organization)	

Measure Concept Information

Measure Title	
Description	
Numerator	
Denominator	
Measure Type	Composite
Care Setting	☐ Ambulatory Care ☐ Behavioral Health/Psychiatric ☐ Dialysis Facility ☐ Emergency Medical Services/Ambulance ☐ Home Health
Target Population Age	☐ <18 years ☐ 18-64 years ☐ >64 years
Level of Analysis	☐ Clinician

Person-Centered Care and Outcomes

Uma Kotagal, Co-Chair

Sally Okun, Co-Chair

PERSON-CENTERED CARE AND OUTCOMES COMMITTEE MEMBERS	
Sally Okun, RN (co-chair)	PatientsLikeMe
Uma Kotagal, MBBS, MSc (co-chair)	Cincinnati Children's Hospital Medical Center
Ethan Basch, MD, MSc	University of North Carolina at Chapel Hill
Dave deBronkart, Jr.	Society for Participatory Medicine
Joyce Dubow, MUP	AARP
Jennifer Eames-Huff, MPH	Consumer-Purchaser Disclosure Project
Troy Fiesinger, MD	Memorial Family Medicine Residency
Christopher Forrest, MD, PhD	The Children's Hospital of Philadelphia, University of Pennsylvania
Lori Frank, PhD	Patient-Centered Outcomes Research Institute
Priti Jhingran, BPharm, PhD	GlaxoSmithKline
Lisa Latts, MD, MSPH, MBA, FACP	LML Health Solutions, LLC
Bruce Leff, MD	Johns Hopkins University School of Medicine
Michael Lepore, PhD	Planetree
Mary MacDonald, MS, BA	American Federation of Teachers
Mary Minniti, BS, CPHQ	Institute for Patient-and Family-Centered Care
Eugene Nelson, MPH, DSc	Dartmouth Institute for Health Policy and Clinical Practice
Mark Nyman, MD, FACP	Mayo Clinic
Laurel Radwin, RN, PhD	Veterans Administration
Anne Walling, MD, PhD	University of California-Los Angeles

Project Overview

Specific Tasks for Person-Centered Care and Outcomes Priority Setting Project

1. Convene a multistakeholder committee of experts including patients and patient advocates
2. Identify existing models and core concepts as a basis for envisioning the ideal state or "north star" of person-centered care
   - Draft definition and draft core concepts
3. Seek input from patients (and families) on what information (i.e., performance measures) would be useful for assessing person-centered care (i.e., "nutrition label" or dashboard of person-centered care).
   - Explore what already has been done by groups such as the Institute for Patient and Family Centered Care and Patients Like Me to find out what matters most to patients and families
   - Explore whether there are any existing measures/tools used by patient advocacy groups for assessing person centered care

Specific Tasks for Person-Centered Care and Outcomes Priority Setting Project

4. Conduct an environmental scan of potential performance measures, status of development, and alignment with concepts of person-centered care
   - Draft environmental scan
   - Input of this committee and prior PRO Expert Panel to identify examples where measurement of performance on person-centered care is occurring
5. At the in-person meeting, review the above inputs and create the vision of the ideal state or "north star" of person-centered care and identify how best to measure performance and progress in the delivery of person-centered care.
6. Based on the ideal person-centered care, recommend specific measures for implementation or specific concepts for development of performance measures
   - Short-term and longer-term recommendations
7. Obtain public comment, and then finalize recommendations.

Vignette- Individualized Care

"Molly" is 50 years old, has chronic, disabling pain in her back and knees, and is the primary caregiver for her ailing mother. Having moved recently, Molly felt isolated and struggled with depression and alcohol misuse. When she sought healthcare services, she immediately found a comforting environment, and a tightly integrated care team. At her first visit, she met with her new doctor, her nurse, a personal health coach, and an onsite behavioral health specialist. This team has partnered with Molly to address her health issues and personal goals that she herself prioritized. During this tough time, Molly lost her driver's license, due to an episode of DWI. She was unable to drive to her orthopedic appointment, but her health coach took a morning to drive her there. This specialist visit proved essential for later scheduling of pain-reducing surgery. On the drive back, they chose a scenic route, stopping at a mountain view, which gave Molly quiet time to re-center herself. Molly still recounts that day as transformative. When she briefly became homeless, the care team helped her find housing and also coached her on job interviewing skills. Molly continues to work on mental health issues, but now does so with regular support from her care team, and she has much less physical pain. She has found a job, is highly engaged in her healthcare, and feels empowered.

Existing Person-Centered Care Frameworks and Key Attributes

Picker Institute's Principles of patient-centered care	Commonwealth Fund Key Attributes of Patient-Centered Care	Institute for Patient- and Family-Centered Care Core Concepts	Planetree Core Dimensions
• Respect for patients' values, preferences and expressed needs • Coordination and integration of care • Information, communication and education • Physical comfort • Emotional support and alleviation of fear and anxiety • Involvement of family and friends • Continuity and transition • Access to care	• Education and shared knowledge • Involvement of family and friends • Collaboration and team management • Sensitivity to nonmedical and spiritual dimensions of care • Respect for patient needs and preferences • Free flow and accessibility of information	• Respect and dignity • Information sharing • Participation • Collaboration	• Structures and functions necessary for culture change • Human interactions • Patient education and access to information • Family involvement • Nutrition program • Healing environment • Arts program • Spirituality and diversity • Integrative therapies • Healthy communities • Measurement

Definition and Core Concepts for Person- and Family-Centered Care

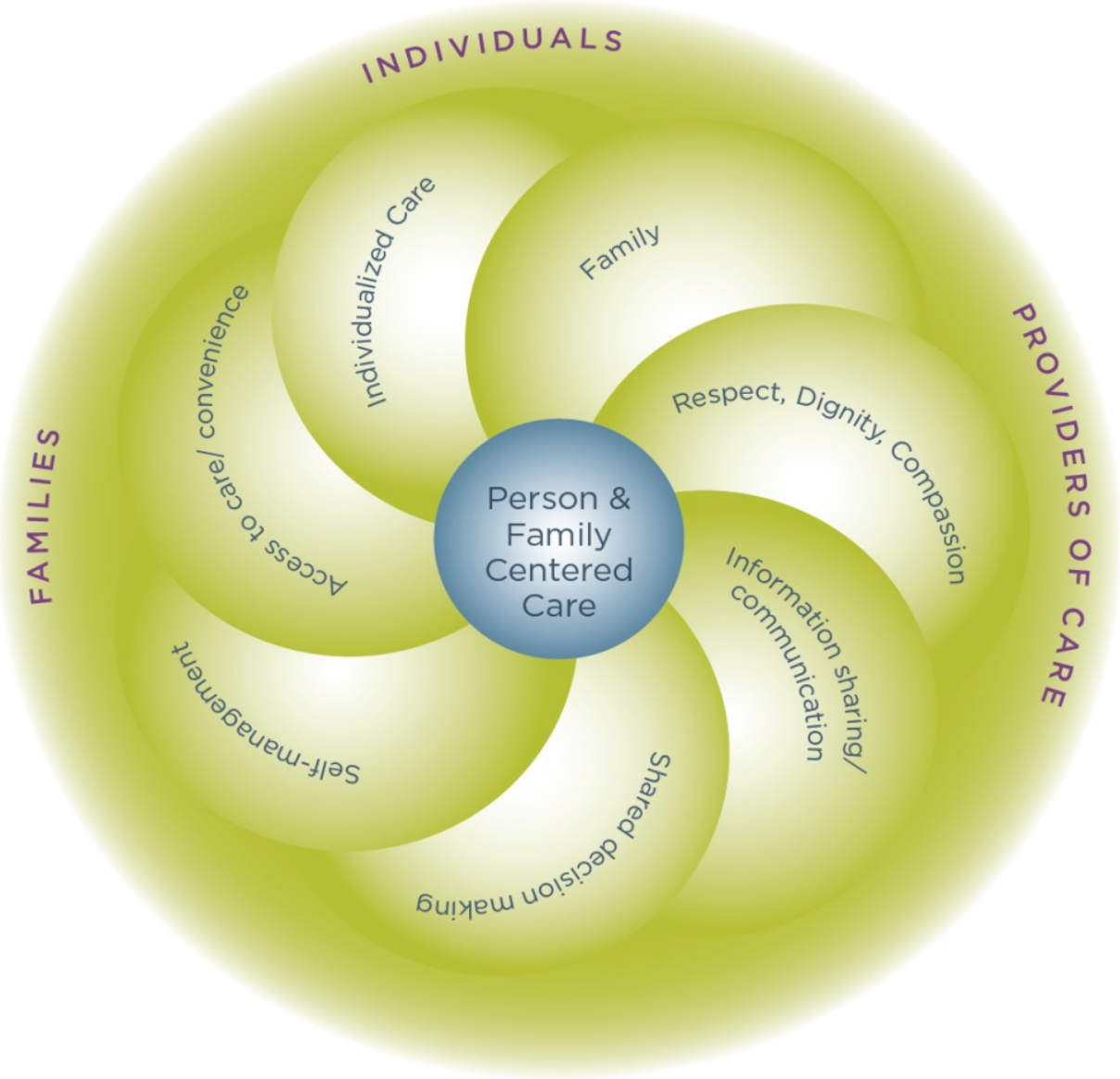
Definition for Person- and Family-Centered Care

Person- and Family-Centered Care is:

An approach to the planning and delivery of care across settings and time that is centered around collaborative partnerships among individuals, their defined family, and providers of care. It supports health and well-being by being consistent with, respectful of, and responsive to an individual's priorities, goals, needs, and values.

Above definition was developed through the Measure Gaps: Person-Centered Care and Outcomes Project.

Person- and Family-Centered Care Core Concepts



Person- and Family-Centered Care Core Concepts

1. Individualized care—I work with other members of my care team so that my needs, priorities, and goals for my physical, mental, spiritual, and social health guide my care.
2. Family—My family is supported and involved in my care as I choose.
3. Respect, dignity, and compassion are always present.
4. Information sharing/communication—There is an open sharing of information with me, my family, and all other members of my care team(s).
5. Shared decisionmaking—I am helped to understand my choices and I make decisions with my care team, to the extent I want or am able.
6. Self-management—I am prepared and supported to care for myself, to the extent I am able.
7. Access to care/convenience—I can obtain care and information, and reach my care team when I need and how I prefer.

Measurement Framework

Principles for Measure Development

- Selected and/or developed in partnership with individuals to ensure measures are meaningful to those receiving care
- Focused on the person's entire care experience, rather than a single setting, program, or point in time; and
- Measured from the person's perspective and experience (i.e., generally person-reported unless the person/consumer is not the best source of the information).

Person- and Family-Centered Care

- Outcome – Desired outcomes of person- and family-centered care (particularly the experience with care)
- Process - Interaction between person/family and the care team that are intended to facilitate achieving the experience reflected in the core concepts
- Structure - Organizational structure or systems that support person- and family-centered care

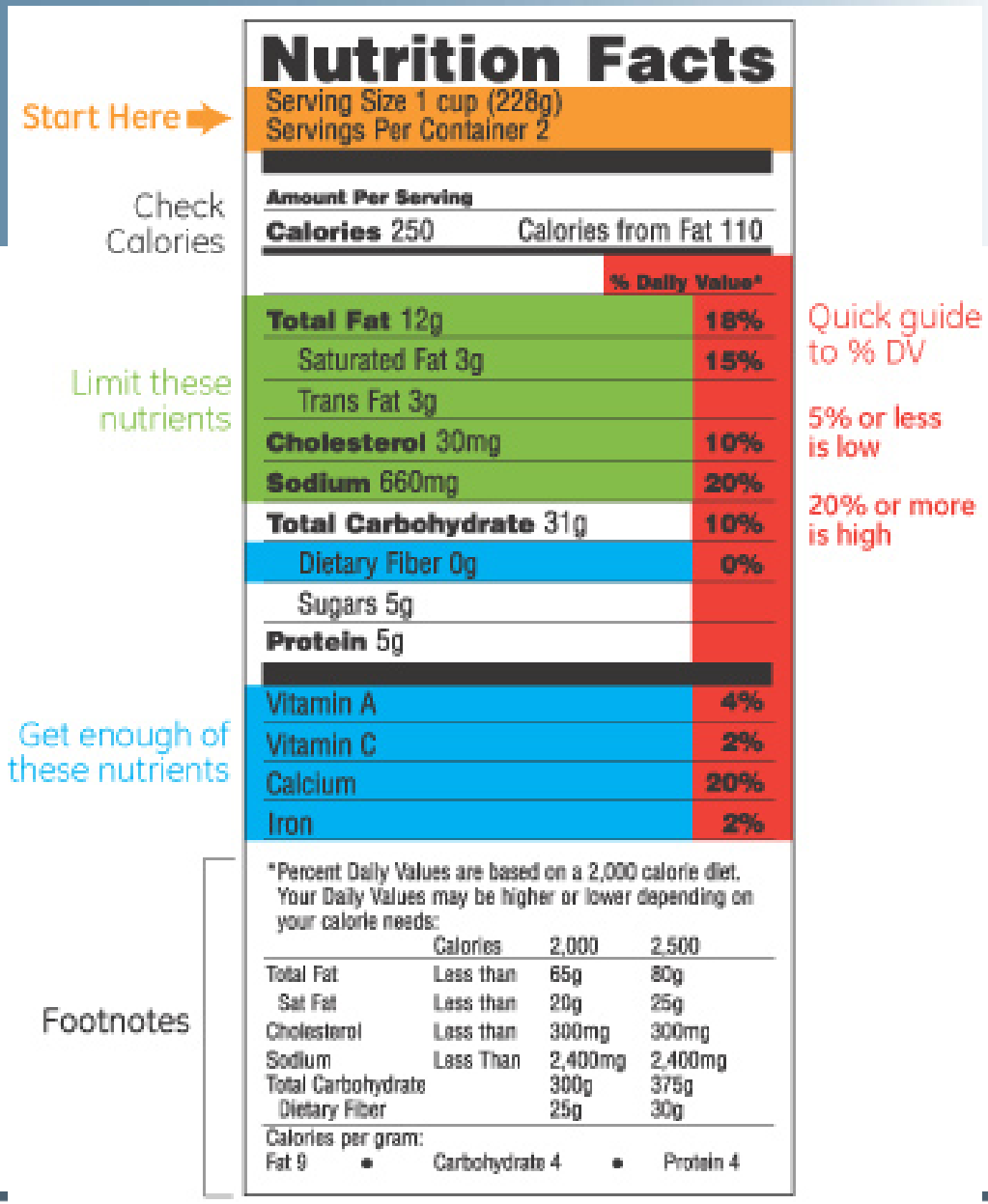
Measurement Framework for Person- and Family-Centered Care

Core Concept	Structure Concepts	Process Concepts	Outcome Concepts
1. Individualized care—I work with other members of my care team so that my needs, priorities, and goals for my physical, mental, spiritual, and social health guide my care.	System supports use of person-reported tools: 1. Standard person reported outcome measures (PROMs) that match the person's view of what matters or what bothers or interferes with their life 2. Person centered outcome measures (PCOMs) that may be highly individualized (e.g., my treatment will be successful if I can walk the bleachers at Fenway Park on July 4th with my grandkids, I can tend my garden without being in constant pain, etc.)	• Find out what the individual's health care priorities and goals are --what matters most and/or what is most bothersome to the person using standard PROMs and PCOMs • Provide systematic assessment of PROs and well-being • Use the PROM and/or PCOM with persons to co-develop the plan, manage care, and monitor progress	• My care team members know me • My preferences for care/treatment are supported • What's important to me is at the center of my care • The care I received matches my goals and preferences • My care team asks me about my top health goals and most important health problems

Label for Person- and Family Centered Care

"Nutrition Label" Idea

- Standard set of items
- Standard definitions
- Standard ways to present information
- Standard format/layout



Label for Person- and Family Centered Care

Person- and Family-Centered Care

Organizational Statement of Person- and Family-Centered Care: 2-3 sentences

Individual/Family Advisory Group: Yes/No, URL link

Individual Portal to Electronic Health Record: Yes/No
- **Entire Record:** Yes/No
- **Partial Access – Test Results:** Yes/No; **Clinical Notes:** Yes/No

Link to Personal Health Record: Yes/No

Non-emergency Communication Options – Phone: Yes/No, **email:** Yes/No, **text:** Yes/No
Languages spoken/translators available:

Hours of Operation: (including extended hours evenings, weekends)
Ease of Scheduling Appointments
- **Same-day appointments:** yes/no
- **Avg. # days to available appointment:** xx days

For Facilities:
- **Open visiting policy:** Yes/No
- **Open staff reports (change of shift, rounds):** Yes/No

Average wait time (from appointment/arrival to see clinician): xx minutes

Individual/Family Support
Navigator/coordinator/coach: Yes/No
Individual support groups: Yes/No, URL link
Family support groups: Yes/No, URL link

Profiles of the Care Team: URL link (education, training, certification, specialties, languages)

Participate in External Quality Performance Measurement: Yes/No
- **Person-centered care measures:** Yes/No, URL link
- **Other quality measures:** Yes/No, URL link

Affordability
Insurance Plans Accepted: URL link
Price List: URL link

Identify Short-Term and Intermediate-Term Recommendations

Overarching recommendations

- Integrate individual and family input into the ongoing dialogue and decisions as performance measures are developed.
- Focus measurement on person-reported experiences and other outcomes over structures and processes.
- Highlight and build on work underway whenever possible.
- Consider the evolving healthcare system.
- Go beyond silos of accountability and measurement.
- Consider actionability by those being measured.

Short-Term Recommendations

- Consider starting with one simple question from the individual's perspective such as "how is your care working out for you?"
- Consider initially focusing on patients with higher levels of need (e.g., individuals with multiple comorbidities, and serious illnesses or those in underserved or disadvantaged populations)
- Consider available CAHPS measures.
- Convene a group comprised of experts on CAHPS and PROMIS for mutual learning and measure development.
- Explore the person-centered care label concept.

Intermediate-Term Recommendations

- Explore developing a “Person-centered Care 10” measure.
- Incorporate the full healthcare experience beyond a single setting.
- Advance family experience measures.
- Fund research to advance measurement of person-and family-centered care.

Comments and Questions from Participants

Health Workforce

Ann Lefebvre, Co-Chair

Melissa Gerdes, Co-Chair

HEALTH WORKFORCE COMMITTEE MEMBERS	
Ann Lefebvre, MSW, CPHQ (co-chair)	University of North Carolina at Chapel Hill
Melissa Gerdes, MD (co-chair)	Methodist Health System
Evaline Alessandrini, MD, MSCE	Cincinnati Children's Hospital Medical Center
Howard Berliner, ScD	Service Employees International Union (SEIU)
Barbara Brandt, PhD	University of Minnesota
Amy Khan, MD, MPH	Saint Mary's Health Plan
Christine Kovner, PhD, RN, FAAN	New York University, College of Nursing
Peter Lee, MD, MPH, FACOEM	General Electric
Gail MacInnes, MSW	Paraprofessional Healthcare Institute (PHI)
Tami Mark, PhD, MBA	Truven Health Analytics
Jean Moore, BSN, MSN	State University of New York at Albany School of Public Health
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Robert Phillips, MD, MSPH	American Board of Family Medicine
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George Zangaro, PhD, RN	Health Resources and Services Administration (HRSA)
Andrew Zinkel, MD, FACEP	HealthPartners

Project Overview

Health Workforce Project Objectives

- Consider, prioritize opportunities to measure workforce deployment in the context of prevention efforts and care coordination
- Broaden the scope of workforce measurement, considering elements across the healthcare delivery spectrum and examining measurement opportunities beyond healthcare delivery
- Identify existing measures and measure concepts that could successfully measure the health workforce in targeted areas
- Provide recommendations regarding high-leverage opportunities, and next steps for measure development, endorsement and use

Measurement Framework

Framework Definitions

Healthcare Workforce

- WHO definition: "all people engaged in actions whose primary intent is to enhance health." Includes:
  - Clinical workforce (e.g., physicians, nurses, behavioral health professionals, oral health professionals, allied health, and clinical social workers)
  - Non-clinical workforce (e.g., public health and human service professionals)
  - Long-term services and supports (LTSS) personnel

Care Coordination

- "The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshaling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care." - AHRQ Care Coordination Measures Atlas
  - Includes perspectives of patients and families, health professionals, system representatives, and the community and volunteer workforce

Framework Definitions, continued

Primary Care

- "Primary Care is the provision of integrated, accessible health services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community." – IOM

Health

- "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." – WHO
  - Includes consideration of capacity to achieve and maintain health

National Prevention Strategy

- Aim: identify the most effective, achievable means for improving health and well-being
- Vision: improve the health and quality of life for individuals, families and communities by moving the nation from a focus on sickness and disease to one based on prevention and wellness
- Goal: Increase the number of Americans who are healthy at every stage of life.

Frameworks and Resources Considered

- AHRQ Care Coordination Measures Atlas
- AHRQ Clinical-Community Relationships Measures Atlas and Evaluation Roadmap
- Institute of Medicine - Health Professions Education: A Bridge to Quality
- NQF Multiple Chronic Conditions Measurement Framework
- HHS and Health Resources and Services Administration input

Conceptual Framework

Development of the Framework

Committee Recommendations

Prioritized Measurement Domains

Prioritized Measurement Concepts

Infrastructure

- Enabled electronic prior-authorization approval
- Use of telehealth by ACOs, health systems or facilities
  - Behavioral health
  - Workforce extender
  - Health maintenance, decision-making, prescribing
- Integrated IT personnel needed to facilitate HIE
- Health IT training programs for workers
  - Improve patient access
  - Quality improvement

Prioritized Measurement Concepts

Training and Development

- Core competencies education in the care of older adults (educational institutions)
- Faculty to teach in new competencies and new models of care (hours and re-teachability are measured) (educational institutions)
- Number of hours of training devoted to delivering care in new delivery systems (educational institutions)
- Organizational training/retraining programs for workers delivering care in new models, including team based care delivery and community-sensitive competencies

Prioritized Measurement Concepts

Capacity and Productivity

- Patient access to primary care physician or specialist care, social worker, allied health professional, measured by percentage of time patients received desired appointments or saw desired professional
- Patient and family overall experience of care delivered by interdisciplinary teams at the health system or facility level
- Patient and family perceptions of the adequacy of, efficiency of team based care at the health system or facility level
- Mean score at the facility level for cultural competency on existing standardized tools for patient experience of care
- Infant mortality rates at the national or state level, compared to workforce credentials at the national or state level

Prioritized Measurement Concepts

Clinical Community and Cross-Disciplinary Relationships

- Performance of ACOs, health systems, facilities on national measure sets (e.g. the ACO measure set), compared to team mix

Prioritized Measurement Concepts

Diversity and Retention

- ACO, Health System, facility workforce retention, measured by: discipline area, geographic region, organization, industry and employment vs. unemployment
- Community level minority representation of the health workforce as represented in census data
- Amount of variation in the number of health workers from ideal forecasting at the state level
- Measurement at the national or state level of the ratio of discipline-specific workers to the baseline needs of specific populations, using census data
- Cultural competency scores on existing standardized tools measuring patient experience

Aspirational Measurement Concepts

Measurement of Team-based and Interdisciplinary Care

- Ideal composition of teams; dependent on patient needs
- Defining, measuring new categories of workers and understanding how they might be expected to function on a team

Measuring Effectiveness and Efficiency

- Number or percent of times a patient is touched by each health worker, comparing metrics to population health metrics
- Measuring outcomes, efficiency based on team mix, by credentials or percent of team working to the top of education and training
- Efficiency of mix of workforce for a given population to determine most effective and efficient mix of workers

Key Research Recommendations

Team-based, Interdisciplinary Care

- Define terms related to interdisciplinary teams: composition of teams and the functional roles within them
  - Functions of “care coordinators” and “care navigators”
- Influencing factors such as changing payment models, and community-specific needs
  - Qualitative descriptions of how the workforce is deployed
- Study scope of practice laws to get a sense of areas of greatest variability
  - physicians, dentists, nurses, nurse practitioners, and others

Population Needs

- Relationship between curriculum of clinical educational institutions and projected population health needs
- Study international models that require medical students practice in underserved areas

The Path Forward

- Efficiency should always be linked with the quality of care delivery
- Future measurement efforts should avoid bucketing providers by specialties in determining workforce needs for care coordination and prevention
- Focus on fluid, dynamic, patient centered measures that enable users to better recognize needs (services and models of care)
- Focus on measuring activities that are most powerful attaining and maintaining better health
- Some areas with the greatest potential for transforming how the health workforce delivers care lie outside the formal healthcare system and within the communities, particularly for high-need, at-risk patients with the most need for social services

Comments and Questions from Participants

Care Coordination

Susan Reinhard, Co-Chair

Mark Redding, Co-Chair

CARE COORDINATION COMMITTEE MEMBERS

Susan Reinhard, PhD, RN, FAAN (co-chair)	AARP
Mark Redding, MD (co-chair)	Community Health Access Project
David Ackman, MD, MPH	Amerigroup
Richard Birkel, PhD, MPA	National Council on Aging
Don Casey, MD, MPH, MBA	IPO4Health
David Cusano, JD	Georgetown University Health Policy Institute
Woody Eisenberg, MD, FACP	Pharmacy Quality Alliance
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Carolyn Ingram, MBA	Center for Health Care Strategies, Inc.
Gerri Lamb, PhD, RN, FAAN	Arizona State University
Russell Leftwich, MD	State of Tennessee, Office of eHealth Initiatives
Linda Lindeke, PhD, RN, CNP	University of Minnesota, School of Nursing
Rita Mangione-Smith, MD, MPH	Seattle Children's Research Institute
Sharon McCauley, MS, MBA, RDN, LDN, FAND	Academy of Nutrition and Dietetics
Judy Ng, PhD, MPH	National Committee for Quality Assurance
Michael Parchman, MD, MPH	MacColl Center for Health Care Innovation
Fred Rachman, MD	Alliance of Chicago Community Health Services
Robert Roca, MD, MPH, MBA	American Psychiatric Institute for Research and Education
Vija Sehgal, MD, PhD, MPH	Waianae Coast Comprehensive Health Center
Daniel Stein, MBA	Stewards of Change
Ilene Stein, JD	Service Employees International Union

Project Overview

Care Coordination Project Objectives

- Guided by a multistakeholder committee, the project will consider and prioritize opportunities to measure care coordination in the context of a broad "health neighborhood."
- The project considered coordination between safety-net providers of primary care and providers of community and social services that impact health.
- The work is intended to broaden the current scope of care coordination performance measurement to account for the influence of social determinants such as housing, transportation, and the environment.

Care Coordination Project Objectives, Continued

- Interoperable data systems that link health and human services information could provide rich new sources for performance measurement; the project will explore this potential as well as challenges associated with sharing data for the purposes of care coordination.
- The project will identify existing measures and measure concepts that could successfully measure care coordination in targeted areas.
- A final report will provide recommendations on high-leverage opportunities and next steps for measure development, endorsement, and use.

Definition of Care Coordination

What is Care Coordination?

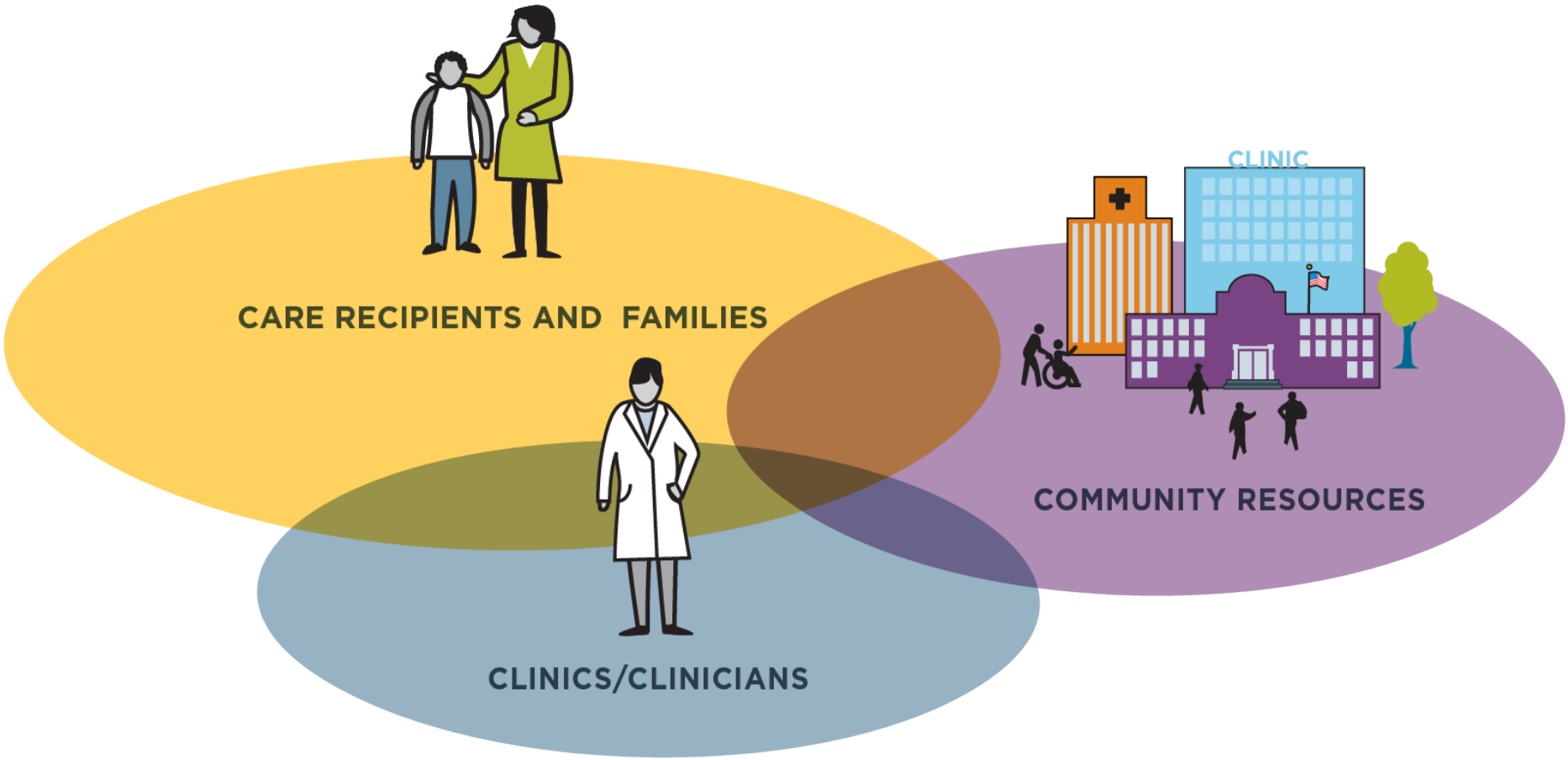
"Care coordination is the deliberate synchronization of activities and information to improve health outcomes by ensuring that care recipients' and families' needs and preferences for healthcare and community services are met over time."

- Developed based on AHRQ *Care Coordination Measures Atlas,* the NQF *Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination,* and committee feedback.

Related Efforts in Care Coordination and Measurement: NQF Consensus Development Process

- 2006: Care Coordination Framework identified five domains essential to the future measurement of care coordination:
  - Healthcare home
  - Proactive plan of care and follow-up
  - Communication
  - Information systems
  - Transitions or handoffs
- 2010: Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination
- 2013-current: Care Coordination 3-Phase Measure Evaluation Project

Care Coordination Conceptual Framework



Committee Recommendations: Priority Measure Domains

Joint Creation of Person-Centered Plan of Care	Utilization of the Health Neighborhood to Execute the Plan of Care	Achievement of Outcomes
Comprehensive Assessment	**Linkages/Synchronization**	Experience
Goal Setting	Quality of Services	**Progression Toward Goals**
Shared Accountability		Efficiency

Comprehensive Assessment Subdomains

- Document care recipient's current supports and assets
- Assess function
- Assess social needs
- Assess behavioral health needs
- Assess medication management needs
- Assess health literacy
- Measure care recipient/family level of activation/engagement
- Capture preferences and goals
- Estimate health risk level and customize care coordination approach appropriately
- Continuous holistic monitoring

Shared Accountability Subdomains

- Plan of care documents all members of the care team, including community providers
- Plan of care assigns responsibilities for meeting care recipients' goals and care team members accept them

Linkages/Synchronization Subdomains

- Shared documentation and understanding of care coordination goals by clinical providers, community providers and care recipient/family
- Appropriate community services identified and contacted based on needs assessment
- Care recipient/family successfully engages with and utilizes community services
- Bi-directional communication to facilitate coordination
- Frequent and accurate communication to solve problems

Progression Toward Goals Subdomains

- Resolution of unmet needs, as documented in ongoing assessment
- Services congruent with person-centered goals and preferences
- Maximized health outcomes and functional status
- Reduce care recipient risk through interventions
- Increased care recipient/family level of activation

HIT Needed to Support Paradigm Shift

- The increasing use of HIT can support a paradigm shift in care coordination, ultimately yielding substantial improvements in health care delivery. Currently, significant HIT efforts are underway:
  - AHRQ is currently gathering information from the field on what is needed to enable electronic quality measurement, particularly testing criteria for Meaningful Use Stage 3.
  - ONC's priorities include promoting more consistent use of data fields within care plans, matching data capture through electronic health records with actual clinical workflows, and the use of clinical decision support. ONC plans to effectively design and implement HIT workflows across provider types.

Data Standards to Support Care Coordination and Plan of Care

- In order for data standards to enable interoperability, specification of a minimum data set around the care team roster is needed. The HL7 Clinical Document Architecture (CDA) supports the representation of the care team and allows for relationships between all care team members to be captured. This specifically includes:
  - Electronic contact information for each team member, the professional role of each provider, and the familial and legal relationship of family care team members to the care recipient.
  - HL7 CDA also allows for relationships between those care team members and other data elements and activities in the care plan.

Front-Line Perspective on Interoperability: Alliance of Chicago

- Alliance of Chicago encourages the use of technology to coordinate services in ways that effectively reduce burden:
  - EHR's with longitudinal records and clinical decision support that includes prompts for non-clinical, community-based elements, prompts for information about a care recipient's visit, and reminders to review previous entries to determine necessary follow ups.
  - EHR's are also connected to a comprehensive and up-to-date list of community resources generated by University of Chicago students
  - Data linkage with the Centers for Disease Control and Prevention (CDC) alerts providers when there is a public health concern or disease outbreak in the community that may be relevant to the individual seeking care

Additional Committee Recommendations: Priorities for Care Coordination and Performance Measurement

- Priority measure domains reflect the need for person-centered, accountable care.
- Innovation is desired, but stronger evidence of effective care coordination practices is fundamental for measure development.
- HHS should measure its own progress in reducing fragmentation experienced by front-line providers.
- Target care coordination efforts based on individuals' needs.

Additional Committee Recommendations, Continued

- Accelerate the work of culture change to achieve person-centered, team-based care.
- Continue standardization of data elements to support care planning and measurement.
- Balance payment incentives carefully to fulfill all three aims of the NQS.

Comments and Questions from Participants

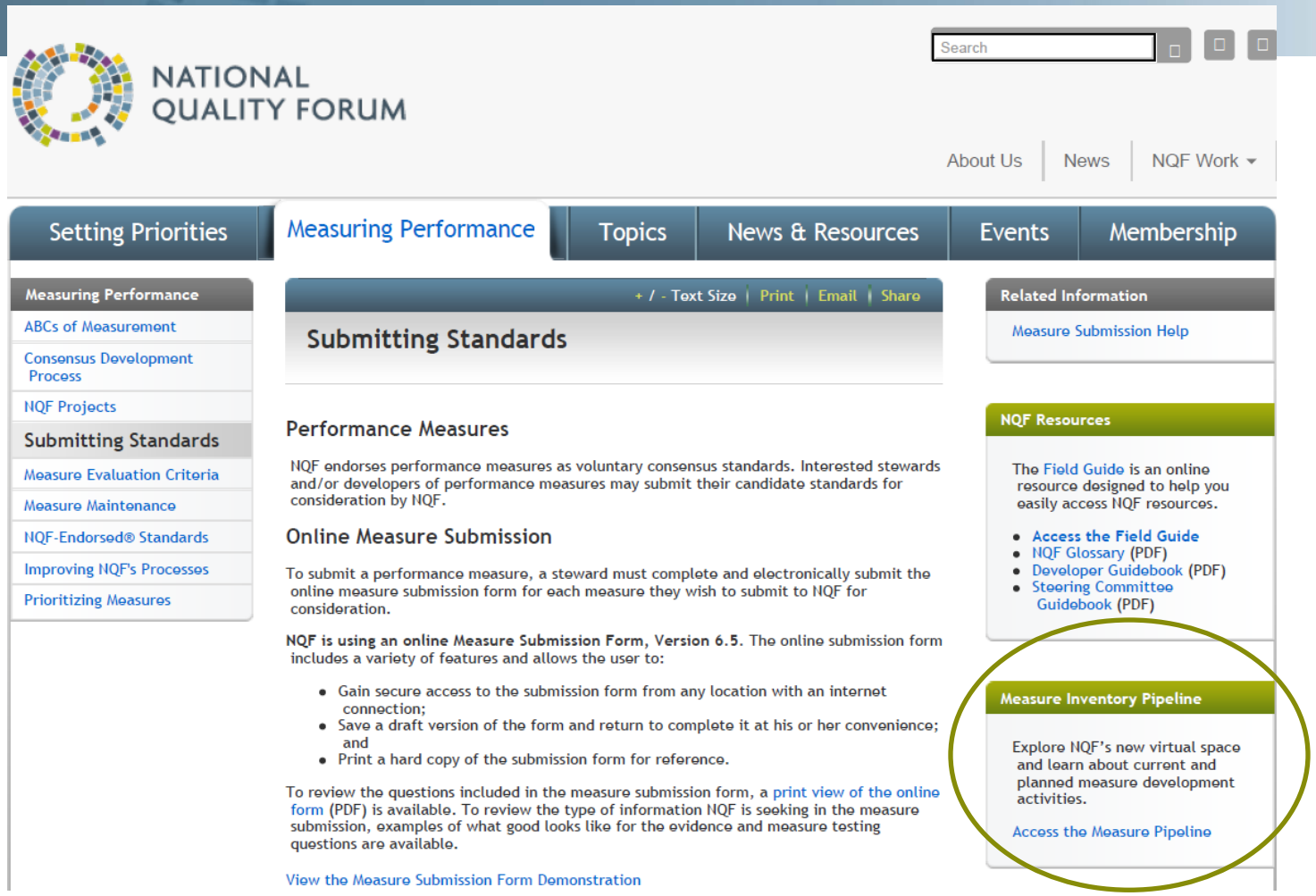
Wrap Up/Next Steps

Upcoming Events

- **Public Comment**
  - Person Centered Care and Outcomes
  - Care Coordination
  - Health Workforce
- **Final Reports Available**
  - August 15, 2014
- **Forthcoming Report on Alzheimer's Disease and Related Dementias**
  - Draft Report for Comment: August 15, 2014
  - Public Comment: August 22- September 12, 2014
  - Public Webinar: Late August/Early September
  - Final Report Date: October 15, 2014

Submit Measures/Measure Concepts to NQF

http://www.qualityforum.org/Measuring_Performance/Submitting_Standards.aspx



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Adjourn

Thank you for participating!