Agenda

Care Coordination Committee Web Meeting
January 16, 2014 | 2:00 pm – 4:00 pm ET

Committee Member 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 **365569** and click on "Enter."
3. In the "Display Name" field, type in your first and last name and click on "Enter Meeting." Audio will be transmitted through the phone, so turn off your computer speakers.
4. Dial **1-877-829-9898** and use confirmation code **99039300**. Note: All advisory participants will have an open line.
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.

Public Participant Instructions:

1. Direct your web browser to the following URL: nqf.commpartners.com
2. Under "Enter a meeting," type in the meeting number **365569** and click on "Enter."
3. In the "Display Name" field, type in your first and last name and click on "Enter Meeting."
4. Steps 1-3 will allow you to access streaming audio and slides. Should you wish to make a comment over the phone during the meeting, also dial **1-855-226-0347** and use confirmation code **99039300**.
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:

- Review project scope, committee's role, and timeline
- Review draft conceptual framework and environmental scan of measures
- Discuss key questions to further refine framework and scan

2:00 pm **Welcome, Committee Introductions, and Disclosures of Interest**

Sarah Lash, Senior Director, NQF

Mark Redding, Co-Chair

Susan Reinhard, Co-Chair

Samantha Meklir, Program Analyst, HRSA

2:20 pm **Background and Project Design**

Wendy Prins, Senior Director, NQF

- 2013 Focus Areas for Priority Setting for Health Care Performance Measurement
- Project overview
- Project timeline

2:35 pm **Project Objectives and Draft Conceptual Framework**

Lauralei Dorian, Project Manager, NQF

- Project Objectives

- Key inputs and information sources
- Draft conceptual framework
- Questions and comments from committee

3:00 pm **Draft Environmental Scan of Measures**

Sarah Lash

- Draft conceptual framework
- Questions and comments from committee

3:25 pm **Committee Discussion of Key Questions Raised by Conceptual Framework**

Mark Redding

Susan Reinhard

- What are the direct outcomes of care coordination? To what other outcomes does care coordination contribute?
- How can shared-decision making and care planning be captured in measures of care coordination?
- How much reliance is appropriate to place on care recipients and caregivers to serve as the coordinators between the medical and non-medical community?
- Given the proliferation of care coordination activities, is there a role for measurement in “coordinating the coordinators?”

3:45 pm **Opportunity for Public Comment**

3:50 pm **Next Steps**

Severa Chavez, Project Analyst, NQF

- Post-meeting assignment
- April 3-4, 2014: Committee In-Person Meeting

4:00 pm **Adjourn**

Priority Setting for Health Care Performance Measurement: Addressing Performance Measure Gaps in Priority Areas
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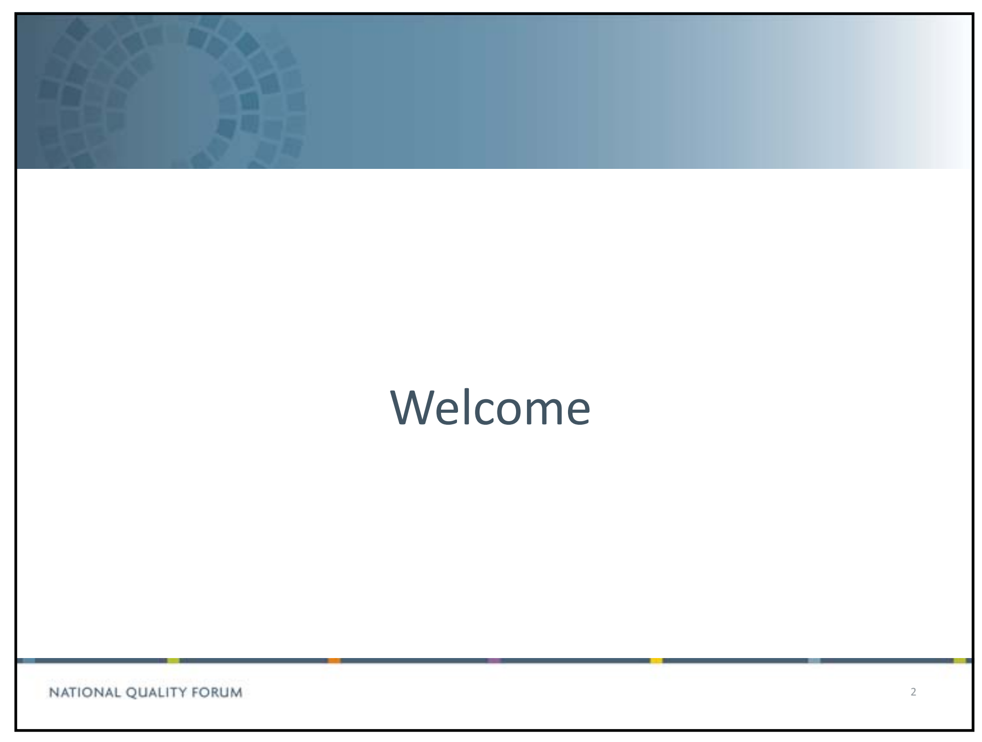
Care Coordination Committee Web Meeting
January 16, 2014


Welcome
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2

Care Coordination
Web Meeting Objectives

- Review project scope, committee's role, and timeline
- Review draft conceptual framework and environmental scan of measures
- Discuss key questions to further refine framework and scan

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	American College of Medical Quality
David Cusano, JD	Georgetown University Health Policy Institute
Woody Eisenberg, MD, FACP	Pharmacy Quality Alliance
Nancy Giunta, PhD, MSW	Silberman School of Social Work, Hunter College, CUNY
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

Background & Project Design

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

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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

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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 Committee

- For each topic area, NQF has convened a multistakeholder committee to provide guidance to meet the project objectives.
- A small subgroup of thought leaders provided preliminary input on the project while the full committee was being seated

Step 2. Identify and Modify Conceptual Framework for Measurement

- NQF has conducted a preliminary environmental scan to select and adapt relevant conceptual frameworks for the project.
- The framework will offer measure domains and subdomains that align with the three-part aim of improving health, quality, and cost.
- Committee members and other stakeholders will provide guidance to staff on the draft framework.

Step 3. Conduct Measure Gap Analysis

- NQF staff will conduct an environmental scan of evidence, measures, and measure concepts that map to the domains and subdomains of the conceptual framework.
- The committee will consider high-priority opportunities for measure development and endorsement and will assist with identifying potential measures and concepts.
- The committee will consider the relevance and applicability of identified measures and concepts.

Step 4. Develop Committee Recommendations

- The committee will prioritize opportunities for performance measure development, endorsement, and use.
- To prioritize, the committee will consider importance, level of evidence, and feasibility of measurement.
- The committee will develop recommendations for submission to HHS.

General Project Timeline (2013-2014)

Sep-Nov	• Scan and synthesize evidence to inform the selection and/or modification of a measurement framework to systematically identify measurement opportunities for care coordination
Oct	• Obtain preliminary multistakeholder guidance and expertise on proposed measurement framework
Nov	• Conduct preliminary environmental scan of measures and outreach to identify measures and measure concepts mapping to proposed framework domains
Dec	• Deliverable #1: Draft conceptual framework and environmental scan
Jan-Mar	• Convene multistakeholder committee for feedback on draft framework; suggested measures and concepts for applicability to framework domains; and suggested priorities for filling critical gaps

General Project Timeline (2013-2014)

Feb	• Conduct broader environmental scan of measures and measure concepts
Mar-Apr	• Analyze **measures and concepts against the framework and obtain committee recommendations on highest-priority gaps**
June	• Deliverable #2: **Draft report** containing conceptual framework, full environmental scan, and committee recommendations on priorities for care coordination measurement
July	• Hold public comment period and **public webinar** to obtain additional multistakeholder input on draft committee recommendations
Aug 2014	• Deliverable #3: **Final report on highest-leverage opportunities for measure development, endorsement, and use**

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 will specifically explore 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.

Developing the Care Coordination Conceptual Framework

Working Definition of Care Coordination

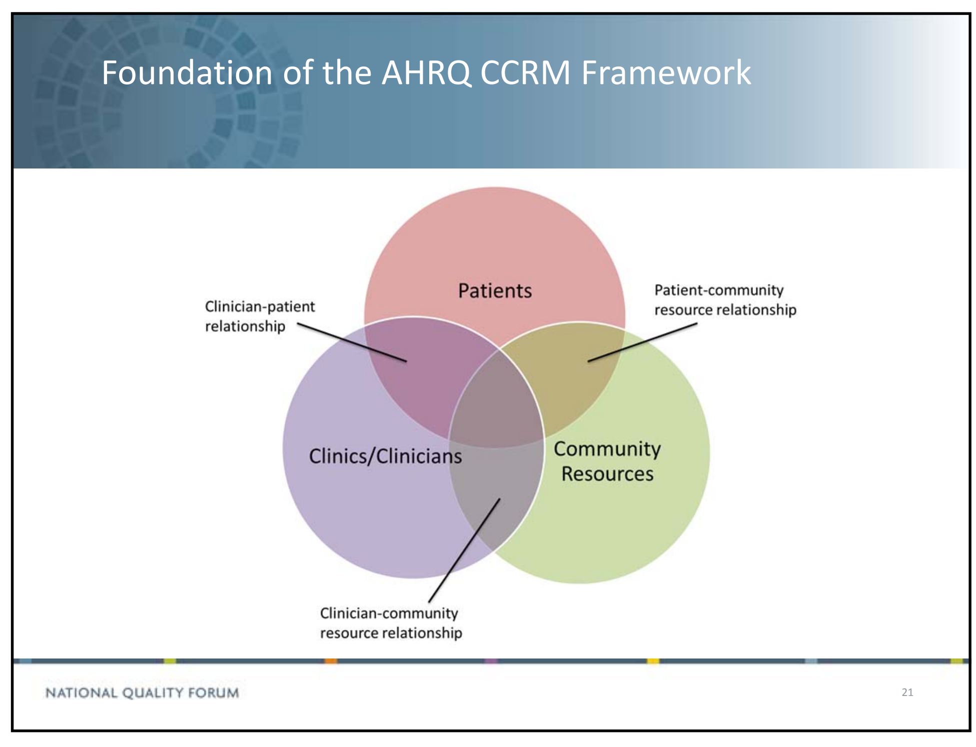
What is Care Coordination?

"Care coordination is the deliberate organization of activities and information to help ensure that patients' and families' needs and preferences for healthcare and community services are met."

- Team developed this hybrid definition based on AHRQ *Care Coordination Measures Atlas* and the NQF *Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination*

Frameworks and Resources Considered

- AHRQ Clinical-Community Relationships Measures Atlas and Evaluation Roadmap
- AHRQ Care Coordination Measures Atlas
- NQF Multiple Chronic Conditions Measurement Framework
- NQF Measure Endorsement Reports
- Other articles, white papers, issue briefs, and regulatory guidance


Foundation of the AHRQ CCRM Framework
Patients
Clinician-patient relationship
Patient-community resource relationship
Clinics/Clinicians
Community Resources
Clinician-community resource relationship
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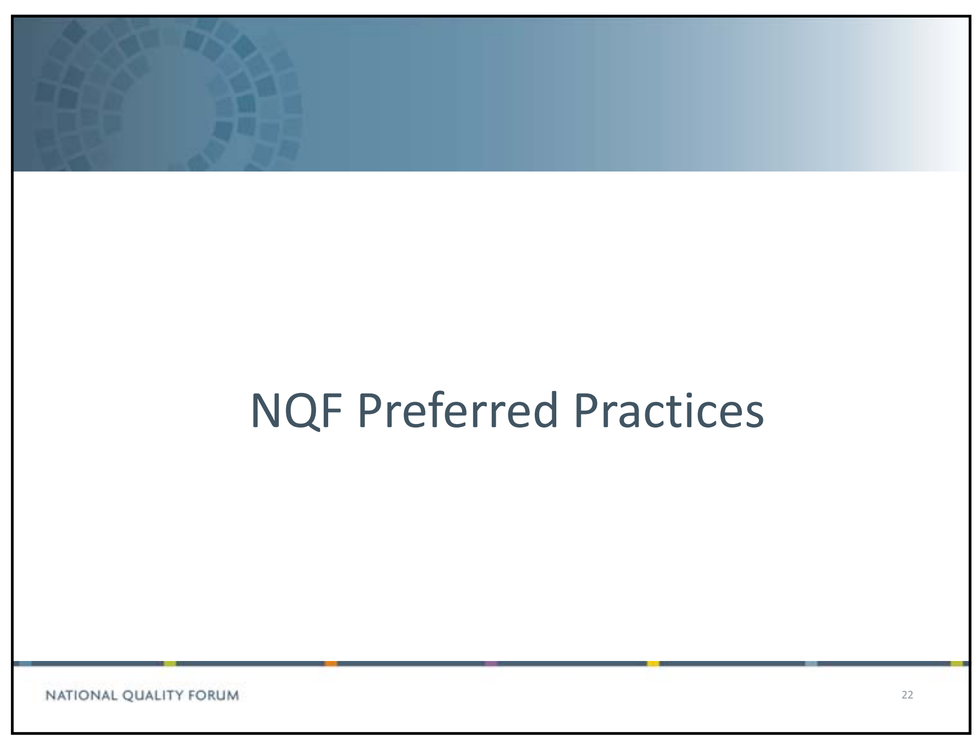
21


NQF Preferred Practices
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22

NQF Domains of Care Coordination Measurement

- Healthcare Home
- Proactive Plan of Care and Follow-Up
- Communication
- Information Systems
- Transitions or Handoffs

Healthcare Home Domain

- **Preferred Practice 2 – Original Language:** The healthcare home or sponsoring organizations shall be the central point for incorporating strategies for continuity of care.
  - ***Preferred Practice 2 – Revised:*** 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.
- **Preferred Practice 3 – Original Language:** 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 3 – Revised:*** The healthcare home shall develop infrastructure for managing plans of care and ensuring that those plans of care are delivered and received by all relevant entities. The infrastructure should incorporate systems for registering, tracking, measuring, reporting, and improving essential coordinated services.

Proactive Plan of Care and Follow-up Domain

- **Preferred Practice 6 – Original Language:** 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 6 – Revised:*** Healthcare providers and other entities involved with providing care and supports to an individual should have structured and effective systems, policies, procedures, and practices to create, document, execute, and update that person's plan of care.
- **Preferred Practice 7 – Original Language:** A systematic process of follow-up tests, treatments, or services should be established and be informed by the plan of care.
  - ***Preferred Practice 7 – Revised:*** A systematic process of preventive and follow-up tests, treatments, assessments, or services should be established and informed by the plan of care.

Proactive Plan of Care and Follow-up Domain cont'd.

- **Preferred Practice 8 – Original Language:** The joint plan of care should be developed and include patient education and support for self-management and resources.
  - ***Preferred Practice 8 – Revised*:** The development of the comprehensive plan of care should include education of the care recipient and support for self-management as appropriate. The plan of care should also consider natural supports such as family caregivers and other resources.
- **Preferred Practice 9 – Original Language:** 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 9 – Revised:*** The plan of care should include the entire array of community, nonclinical, behavioral, and healthcare services that respond to a person's needs and preferences and contribute to achieving the person's goals.

Communication Domain

- **Preferred Practice 12 – Original Language:** All healthcare home team members, including the person 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 12 - Revised:*** All members of the healthcare home team, including the care recipient and his or her designees, should work within the same plan of care and share responsibility for their contributions to achieving the care recipient's goals.

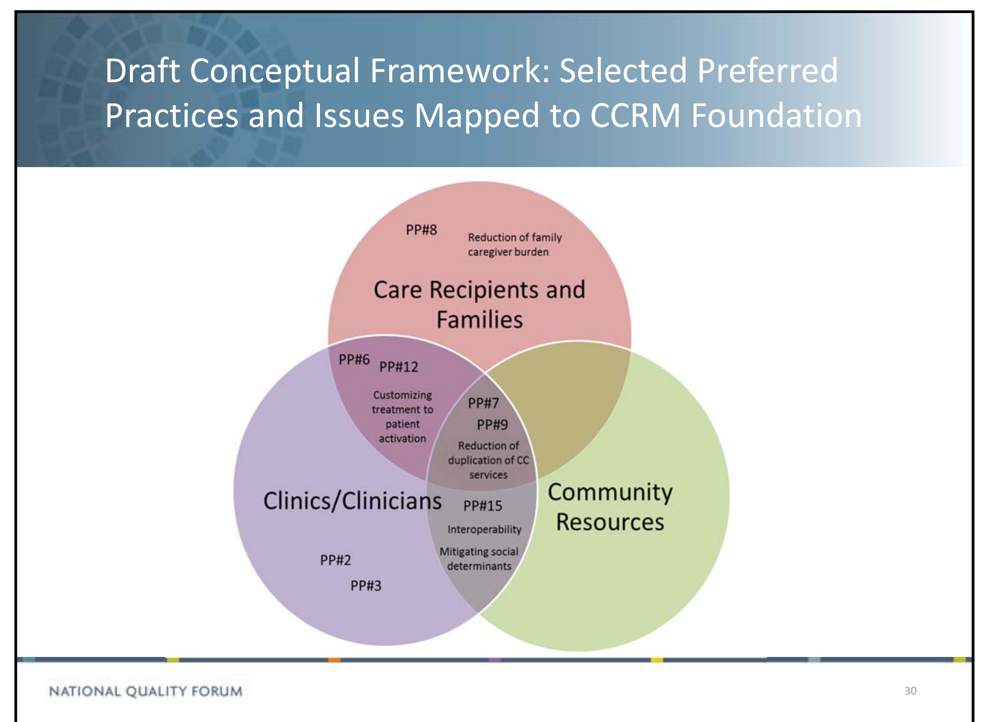
Information Systems Domain

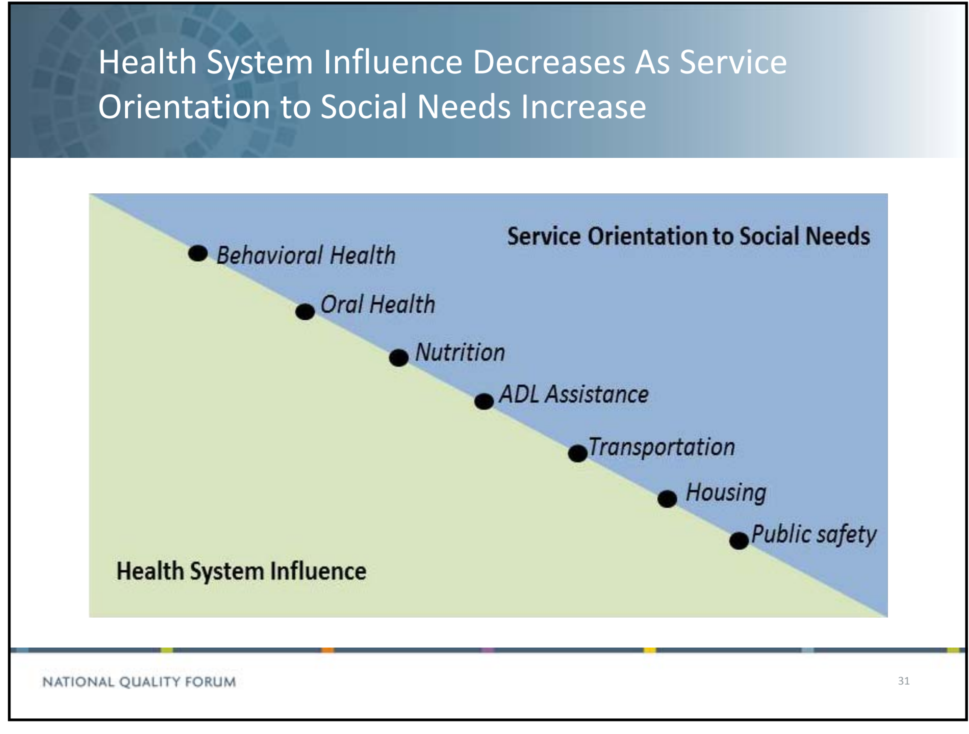
- **Preferred Practice 15:** Standardized, integrated, interoperable, electronic, information systems with functionalities that are essential to care coordination, decision support, and quality measurement and practice improvement should be used.

Additional Concepts Suggested

- System and data interoperability to support integration of non-medical human services information into person-centered plans of care
- Evaluating the care recipient's level of activation or engagement in care and customizing treatment accordingly
- Acknowledging role of social determinants in health outcomes and working in partnership to mitigate them
- Reduction of caregiver burden
- Reduction of duplication of care coordination services

Draft Conceptual Framework: Selected Preferred Practices and Issues Mapped to CCRM Foundation





Questions and Comments from Committee

- Is the conceptual framework sufficiently easy to understand?
- Is the conceptual framework sufficiently complete?
- Should other information sources be considered and incorporated?

Preliminary Environmental Scan of Measures

Preliminary Measure Scan Results

- Scan included a review of 5,962 measures
- 363 measures identified as potential care coordination measures
- Available measures are either too narrowly or too broadly designed to be actionable by providers of primary care
- 180 measures calculated at a broad population level and would need significant modification before being applied to clinics, clinicians, and/or community-based providers

Types of Measures Revealed by Scan

- Measures clustered into several distinct types, each with its own strengths and weaknesses. These included:
  - Condition-Specific Measures
  - Age-Specific Measures
  - International Measures
  - One-Way Referral Measures
  - Measures Derived from Surveys and/or Research Evaluations
  - Population-Level Measures

Condition-Specific Measures

Example Measure: Major depression in adults in primary care: percentage of patients who have a depression follow-up contact within three months of initiating treatment.

Measure Description:	This measure is used to assess the percentage of patients 18 years and older with a new primary care diagnosis of major depression who have a depression-related office visit or phone contact with a physician or other care clinician within three months of initiating treatment.
Measure Type:	Process
Measure Steward:	Institute for Clinical Systems Improvement (ICSI)
Data Source:	Administrative clinical data, paper medical records

Age-Specific Measures

Example Measure: Plan of care includes at least one public and/or private community service/resource.

Measure Description:	
Measure Type:	Process
Measure Developer:	PD Nordness, MH Epstein
Data Source:	Wrap-Around Observation Manual—Second Version (Item 2)

International Measures

Example Measure: Care planning: percentage of consumers with current completed care plans (including consumer involvement and signature) in the file, during the 6 month time period.

Measure Description:	This measure is used to assess the percentage of consumers with current completed care plans (including consumer involvement and signature) in the file, during the 6 month time period.
Measure Type:	Process
Measure Steward:	Australian Council on Healthcare Standards
Data Source:	Administrative clinical data, paper medical record

One-Way Referral Measures

Example Measure: Domestic violence: percent of adult and adolescent patients who screened positive for current or past intimate partner violence (IPV) for whom records indicate that intervention and treatment plans were offered.

Measure Description:	The percent of patients who screened positive for IPV for whom records indicate that intervention and treatment plans were offered including: - Verbal and/or written information about safety planning - An option to talk with an advocate in person or on the phone - Verbal and/or written information about abuse and its impact on health - Referrals to culturally and linguistically appropriate services - A review of discharge instructions and a scheduled follow-up appointment or care plan with a mental health, social worker or community based service provider.
Measure Type:	Process
Measure Steward:	Futures Without Violence
Data Source:	Paper medical record

Measures Derived from Surveys or Evaluations

Example Measure: Changes in clinicians' knowledge of available services in the local community.

Measure Description:	Clinicians in the area who have at least six dementia patients and who referred family caregivers diagnosed with dementia to a service coordinator and responded "yes" to question (Q7) on survey.
Measure Type:	Outcome
Measure Developer:	RH Fortinsky, CG Unson, RI Garcia
Data Source:	ASCP Physician Survey

Population-Level Measures

Example Measure: Increase in the proportion of children, adolescents, and adults who used the oral health care system in the past 12 months.

Measure Description:	Number of persons aged 2 years or older who report having had a dental visit in the past 12 months
Measure Type:	Outcome
Measure Steward:	Centers for Disease Control and Prevention
Data Source:	Medical Expenditure Panel Survey (MEPS)

Questions and Comments from Committee

- What do the available measures tell us about the state of care coordination measurement?
- Should other measure sources be incorporated into the scan?

Discussion of Key Questions Raised by Conceptual Framework

Discussion Questions

- What are direct outcomes of care coordination?
  - To what other outcomes does care coordination contribute?
  - How can these be measured?
- How can shared-decision making and care planning be captured in measures of care coordination?
- How much reliance is appropriate to place on care recipients and caregivers to serve as the coordinators between the medical and non-medical community?
- Given the proliferation of care coordination activities, is there a role for measurement in "coordinating the coordinators?"

Opportunity for Public Comment
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45

Next Steps
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46

Post-Meeting Assignment

- Purpose of post-meeting assignment is to prioritize domains and subdomains of measurement for care coordination.
- NQF staff will send a document immediately following this web meeting.
- Send questions and responses to ldorian@qualityforum.org
- Assignment due by next Friday, **January 24**.

Next Steps

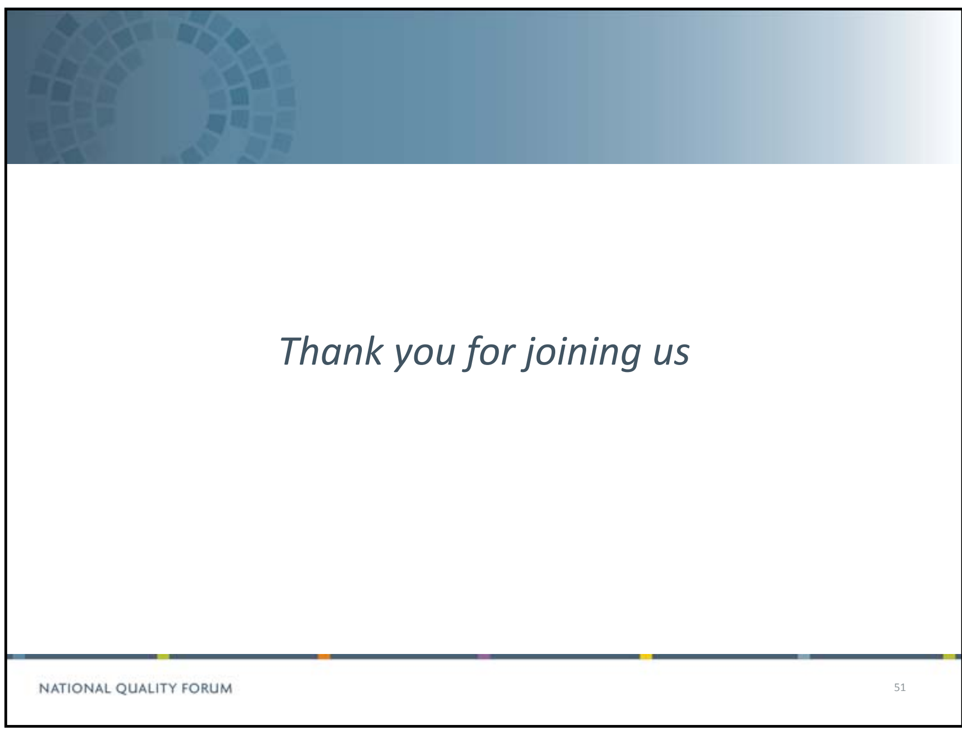
- Send additional thoughts or resources to NQF
- Continuation of Scan for Measures and Measure Concepts
- Care Coordinating Committee in-person meeting April 3-4, 2014
- Draft final report will be available for public comment in June/July 2014
- Final report due to HHS in August 2014

AHRQ Atlas: Mechanisms for Achieving Care Coordination (i.e., Domains)

- Coordination Activities
  - Establish Accountability or Negotiate Responsibility
  - Communicate
  - Facilitate Transitions
  - Assess Needs and Goals
  - Create a Proactive Plan of Care
  - Monitor, Follow Up, and Respond to Change
  - Support Self-Management Goals
  - Link to Community Resources
  - Align Resources with Patient and Population Needs
- Broad Approaches
  - Teamwork Focused on Coordination
  - Health Care Home
  - Care Management
  - Medication Management
  - Health IT-Enabled Coordination

For More Information

Content Area	Name and Title	Contact Information
Adult Immunization	Juliet Feldman, Project Manager Reva Winkler, Senior Director	jfeldman@qualityforum.org rwinkler@qualityforum.org
Alzheimer's Disease	Juliet Feldman, Project Manager Karen Johnson, Senior Director	jfeldman@qualityforum.org kjohnson@qualityforum.org
Care Coordination	Lauralei Dorian, Project Manager Sarah Lash, Senior Director	ldorian@qualityforum.org slash@qualityforum.org
Health Workforce	Allison Ludwig, Project Manager Angela Franklin, Senior Director	aludwig@qualityforum.org afranklin@qualityforum.org
Person-Centered Care and Outcomes	Mitra Ghazinour, Project Manager Karen Pace, Senior Director	mghazinour@qualityforum.org kpace@qualityforum.org
Overall Project Management and Oversight	Camille Smith, Senior Project Manager Wendy Prins, Senior Director	csmith@qualityforum.org wprins@qualityforum.org



Thank you for joining us
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51