NQF
THE NATIONAL QUALITY FORUM

Endorsing Preferred Practices & Performance Measures for Measuring & Reporting Care Coordination

Nicole W. McElveen, MPH
Program Director, Performance Measures
National Quality Forum

Discussion Points

- NQF-endorsed Care Coordination Framework
- Endorsing Practices and Measures
- Purpose/Scope of Project
- Identifying Gaps
- Next Steps, Phase II

Development of the Framework

NQF
THE NATIONAL QUALITY FORUM

- 2005 Ambulatory Care project – no care coordination measures were identified
- Need to encourage measure development:
  - What are measures of care coordination?
- Not setting specific
- Patient-centered

Framework

- Definition of care coordination
- Five domains
  - Healthcare "home"
  - Proactive plan of care and follow-up
  - Communication
  - Information systems
  - Transitions and "hand-offs"
- Four Principles
- Endorsed through NQF's Consensus Development Process

Definition

Care coordination is a function that helps ensure the patient's needs and preferences for health services and information sharing across people, functions, and sites over time. Coordination maximizes the value of services delivered to patients by facilitating beneficial, efficient, safe, and high-quality patient experiences and improved healthcare outcomes.

Domain 1: Healthcare "home"

- Usual source of care selected by the patient
- Central point for coordinating care around patient's needs or preferences
- Coordinates between all team members, including patient, family members, other caregivers, providers, specialists, health care services (public and private) and non-clinical services as needed

Domain 1: Healthcare "home" (cont.)

NQF
THE NATIONAL QUALITY FORUM

- Enduring relationship
- Point of access
- Information about the patient and origins of interpretation of information from many sources
- Routine, acute, and chronic care coordination

Domain 2: Proactive Plan of Care

NQF
THE NATIONAL QUALITY FORUM

Established and current plan of care that anticipates routine needs and tracks up-to-date progress toward patient goals:

- System for developing a plan of care
- Goal setting with patients and joint management of the plan of care
- Assessment of progress toward goals
- Evidence-based referrals
- Follow-up tests, referrals, treatments, or other services
- Self-management support
- Community services and resources

Domain 3: Communication

Available to all team members, including patients and family

- Shared plan of care
- Tests and services
- Patient safety– avoid errors in diagnosis and treatment
- Shared decision-making with patient and family
- Not limited to office visits
- Privacy and information access

Domain 4: Information Systems

NQF
THE NATIONAL QUALITY FORUM

Standardized, integrated electronic information systems with functionalities essential to care coordination:

- Seamless interoperability
- Evidence-based plan of care management
- Efficient and effective integration of patient information, labs, imaging, referrals, medications, social and community services, self-management support
- Patient registries and population-based data
- Supports quality improvement and safety
- Case/disease management
- Decision support tools
- Provider alerts
- Patient reminders

Domain 5: Transitions/ "hand-offs"

NQF
THE NATIONAL QUALITY FORUM

Care processes between settings of care deserve special attention:

- Medication reconciliation
- Follow-up tests and services
- Changes in plan of care
- Involvement of team during hospitalization, nursing home stay, etc
- Communication with non-English speakers
- Transfer of all information when healthcare home changes

Principles

1. Care coordination is important for everyone
2. Some populations are particularly vulnerable
3. Care coordination measures may be appropriate at the clinician-level; others may be appropriate at the group, practice or organizational-level
4. Patient/family surveys are essential to measure care coordination; performed within close proximity to the healthcare event

NPP Care Coordination Goals

- Healthcare organizations and their staff will continually strive to improve care by **soliciting and carefully considering feedback from all patients and their families** regarding coordination of their care during transitions.

- **Medication information will be clearly communicated** to patients, family members, and the next healthcare professional and/or organization of care, and medications will be reconfirmed at each transition.

- All healthcare organizations and their staff will work collaboratively with patients to **reduce 30-day readmission rates**.

- All healthcare organizations and their staff will work collaboratively with patients to **reduce preventable emergency department visits**.

Project Goal:

- To endorse a set of preferred practices and performance measures in care coordination that are applicable across all settings of care.
- Identify high-priority research areas to advance the evaluation of care coordination as a quality improvement tool.

Work Completed to Date

NQF
THE NATIONAL QUALITY FORUM

- Issued *Call for Practices*, Dec. 2008 – Jan. 2009
  - 30 practices
- Issued *Call for Measures*, March 19 – April 17, 2009
  - Yielded 77 measures
- Steering Committee in-person meetings
  - Jan. 27 – 28, 2009 & June 23 – 24, 2009
- Steering Committee conference calls, February- ongoing.

Practices

NQF
THE NATIONAL QUALITY FORUM

- Specifically address the framework domains:
  - Establishing an infrastructure of a healthcare "home"
  - Identifying components that should included within the plan of care
  - Importance of communicating and partnering with patient and family during care
  - Appropriate components of an electronic information system necessary for care coordination
  - Transitions: preparing the patient, essential data elements, accountability, consistent methods, evaluation/feedback

Measures

- Submitted measures: condition-specific, addressed office visits, consultation/referrals, case management

- Committee's recommendations for measures
  - Most measures were viewed as not relevant to care coordination
  - 9 measures recommended with conditions
  - Examples of recommended measures
    - Transitions Record
    - CTM-3 (continued endorsement)

Gap Areas for Care Coordination

NQF
THE NATIONAL QUALITY FORUM

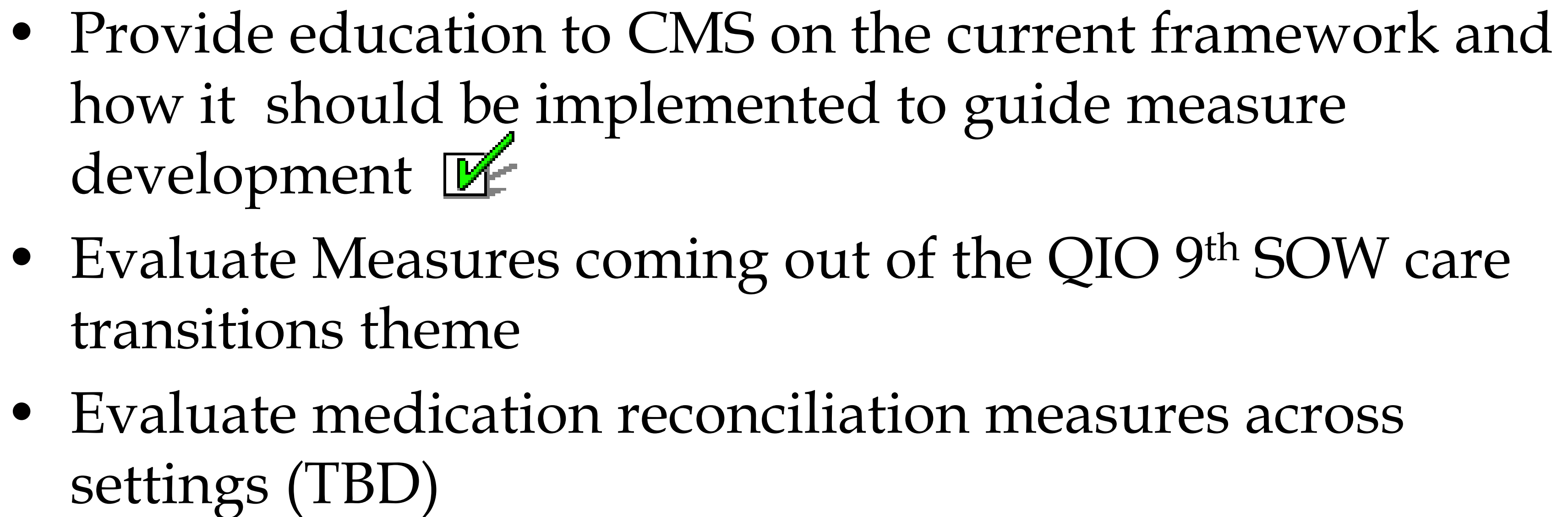
Addressing gaps within measures for care coordination:

- Measuring the processes or factors for care coordination/receiving care:
  - The activities that happen during an encounter with a care provider
  - Showing documentation of hand-offs and /or information was passed onto the healthcare home and incorporated in the care plan
  - Closing the loop of communication between a specialty care provider and the PCP and patient
- Measures associated with addressing high-risk populations or those who usually require more care coordination.

Next Steps – Phase II
HHS Contract Deliverable

NQF
THE NATIONAL QUALITY FORUM

Proposal sub-tasks (1):



- Provide education to CMS on the current framework and how it should be implemented to guide measure development ☑
- Evaluate Measures coming out of the QIO 9th SOW care transitions theme
- Evaluate medication reconciliation measures across settings (TBD)

For more information, visit our web site at www.qualityforum.org.

Next Steps – Phase II HHS Contract Deliverable

NQF

THE NATIONAL QUALITY FORUM

Proposal sub-tasks (2)

- Evaluate registry and EHR-based outcome and process measures across settings
    - Particularly stroke and cancer outcome and process measures across settings through existing CMS-NQF measures and outreach to guide the developers through what is needed to make them interoperable (TBD)
  - Evaluate cancer care measures across settings (TBD)

Contact Information

NQF
THE NATIONAL QUALITY FORUM

- National Quality Forum
  601 13th Street, NW
  Suite 500 North
  Washington, DC 20003
  Tel: 202.783.1300
  Fax: 202.783.3434
  www.qualityforum.org

- Nicole McElveen nmcelveen@qualityforum.org