ENDORSEMENT SUMMARY: Care Coordination Measures

AUGUST 2012

Purpose of the Project

Care coordination is a multifaceted concept. Generally, it refers to the need for meaningful communication and cooperation among providers as patients move through the healthcare system's many facilities and care settings – hospitals, doctor's offices, nursing homes, and people's own homes. Such transitions are a routine part of care today, especially for people with complex illnesses or many chronic conditions. Lack of coordination of care can lead to serious complications, including medication errors, preventable hospital readmissions, higher costs, and unnecessary pain and suffering for patients, who often struggle to navigate a complex and fragmented healthcare system. As a result, interest in care coordination has increased steadily in recent years as a path to improving patient outcomes and controlling costs. For example, the U.S. Department of Health and Human Services (HHS) established care coordination as a national priority for improvement in the National Quality Strategy, and the Institute of Medicine has estimated that care coordination initiatives could result in $240 billion in healthcare savings.[1]

In 2006, NQF endorsed a definition and measurement framework for care coordination, establishing five domains essential to measurement: the need for a healthcare home; a proactive plan of care and follow-up; communication between patients, families, and caregivers; information systems; and adequate care transitions. Since that time, NQF has endorsed more than 10 performance measures and 25 preferred practices of care intended for use across multiple care settings.

In July 2011, HHS tasked NQF to lead a two-phased project on care coordination across episodes of care and care transitions. The first phase of the project sought to address the lack of cross-cutting measures in the NQF measure portfolio by developing a path forward for meaningful measures of care coordination leveraging health information technology. This work was strengthened by the development of a commissioned paper examining electronic capabilities to support care coordination measurement as well as the findings of an environmental scan. The second phase consisted of the evaluation of 15 endorsed measures undergoing maintenance review. Despite extensive targeted outreach to solicit new measures – especially those that address cross-cutting components of care coordination – NQF did not receive any new measures for review.

What Was Endorsed

Summary of Care Coordination Endorsement Maintenance Project

Measure under consideration	15 (15 maintenance)
Measures recommended for endorsement	12
Measures not recommended for endorsement	3

Under the care coordination endorsement project, NQF endorsed 12 measures suitable for accountability and quality improvement. Of the 12 measures, all were previously endorsed and underwent endorsement maintenance review; three measures did not maintain endorsement.

Measure stewards included the National Committee for Quality Assurance, the Centers for Medicare & Medicaid Services, the American Academy of Dermatology, and the Physician Consortium for Performance Improvement, convened by the American Medical Association. A full list of measures is at the end of this report.

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The Need these Measures Fill

This project sought to identify and endorse care coordination measures for accountability and quality improvement. The endorsed measures focus on a wide range of care concerns, including medication reconciliation for older patients being discharged from inpatient facilities; emergency room visits and hospitalization rates for patients on home health stays; and whether older patients have documented advance care plans or surrogate decision-makers in place.

Care coordination is an especially important part of managing patients with multiple chronic conditions, who often receive care from many providers. With estimates showing that nearly half of the U.S. population will have one or more chronic conditions by 2030, the need for coordinated care – and more importantly, the tools to evaluate such care – is evident.[2] These measures will help the healthcare community better align treatment and communication efforts, and ensure patients receive high-quality, coordinated, and safer care.

Potential Use

These measures are applicable for use in a variety of settings, including ambulatory care, in-patient facilities, home health, emergency departments, and nursing homes.

Project Perspectives

Despite this set of endorsed measures and existing set of preferred practices, significant measurement gaps exist within the NQF portfolio. Measures addressing care coordination that span types of providers and episodes of illness are still very much needed. Such measures have the potential to be more person-centric, more useful for those with multiple chronic conditions, and more appropriate for efficiency and patient-reported outcomes measures.

Three sets of measures – dealing with medication review and documentation, medication reconciliation, and transition records – were identified as competing and/or related; as a result, the Steering Committee urged developers to work collaboratively on harmonization. Given that harmonized measures often have the broadest possible applicability, many developers agreed to make specific modifications pending approval from their internal advisory panels.

The Steering Committee also made several recommendations for future measure development that could help improve care coordination. The committee prioritized five concepts they believed could have the most impact in moving such efforts forward, including:

- **Patient-reported outcomes.** Did a patient get necessary follow-up care? Were the patient's needs met? Was care effectively coordinated?
- **Capturing data and documenting linkages.** Patient needs and preferences must align with relevant interventions in a standardized way and then link to relevant outcomes. For example, if a patient's goal is to die at home, how do we document the relevant interventions to ensure this goal is met?
- **Established continuity within the plan of care.** There must be an initiation of a care plan, a transmission between patients and providers, and a receipt and acknowledgement of acceptance of such a plan.
- **Accessibility and functionality of a plan of care.**
- **Measurement of adverse events that could be markers of poor care coordination.**

The committee also proposed potential future uses for the 25 Care Coordination Preferred Practices endorsed in 2010, suggesting that the practices could:

- Serve as the foundation for a self-assessment tool for health professionals and institutions wanting to know how they are doing in the care coordination field;
- Operate as a tool for public reporting;
- Function as an accreditation tool, similar to the NCQA Medical Home System Survey;
- Be further publicized as a mechanism for other organizations to improve their care coordination practices; and
- Signal to measure developers the key elements involved in effective care coordination.

Endorsed Measures

0097: Medication Reconciliation (NCQA)

Description: Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.

0171: Acute care hospitalization (risk-adjusted) (CMS)

Description: Percentage of home health stays in which patients were admitted to an acute care hospital during the 60 days following the start of the home health stay.

0173: Emergency Department Use without Hospitalization (CMS)

Description: Percentage of home health stays in which patients used the emergency department but were not admitted to the hospital during the 60 days following the start of the home health stay.

0326: Advance Care Plan (NCQA)

Description: Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.

0494: Medical Home System Survey (NCQA)

Description: The following 6 composites are generated from the Medical Home System Survey (MHSS). Each measure is used to assess a particular domain of the patient-centered medical home.

- Measure 1: Improved access and communication
- Measure 2: Care management using evidence-based guidelines
- Measure 3: Patient tracking and registry functions
- Measure 4: Support for patient self-management
- Measure 5: Test and referral tracking
- Measure 6: Practice performance and improvement functions

0526: Timely Initiation of Care (CMS)

Description: Percentage of home health episodes of care in which the start or resumption of care date was either on the physician-specified date or within 2 days of the referral date or inpatient discharge date, whichever is later.

0553: Care for Older Adults – Medication Review (NCQA)

Description: Percentage of adults 66 years and older who had a medication review; a review of all a member's medications, including prescription medications, over-the-counter (OTC) medications and herbal or supplemental therapies by a prescribing practitioner or clinical pharmacist.

0554: Medication Reconciliation Post-Discharge (NCQA)

Description: The percentage of discharges from January 1–December 1 of the measurement year for members 66 years of age and older for whom medications were reconciled on or within 30 days of discharge.

0646: Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (AMA-PCPI)

Description: Percentage of patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a reconciled medication list at the time of discharge including, at a minimum, medications in the specified categories.

0647: Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (AMA-PCPI)

Description: Percentage of patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the specified elements.

0648: Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care) (AMA-PCPI)

Description: Percentage of patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.

0649: Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care) (AMA-PCPI)

Description: Percentage of patients, regardless of age, discharged from an emergency department (ED) to ambulatory care or home health care, or their caregiver(s), who received a transition record at the time of ED discharge including, at a minimum, all of the specified elements.

Endnotes

1. IOM, *Roundtable on Value & Science-Driven Health Care: The Healthcare Imperative: Lowering Costs and Improving Outcomes:* Workshop Serious Summary, Washington, DC: National Academies Press, 2010.

2. Anderson, G, *Chronic Care: Making the Case for Ongoing Care*. Princeton, NJ: Robert Wood Johnson Foundation; 2010. Available at http://www.rwjf.org/pr/product.jsp?id=50968. Last accessed June 2011.

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