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PATHWAY TO DISCOVERY FOR THE PROFESSIONAL CASE MANAGER

Measuring Care Coordination: Tools for today, tools for tomorrow

Ellen Schultz, MS
Stanford University

Patrice Sminkey
Chief Executive Officer
Commission for Case Manager Certification

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Agenda

- Welcome and Introductions
- Learning Objectives
- **Patrice Sminkey**, CEO, the Commission
- Ellen Schultz, MS, Stanford University
- Question and Answer Session

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Audience Notes

- There is no call-in number for today's events. Audio is by streaming only. Please use your computer speakers, or you may prefer to use headphones.

- Please use the "chat" feature on the lower left-hand part of your screen to ask questions throughout the presentations. Questions will be addressed as time permits after both speakers have presented.

- A recording of today's session will be posted within one week to the Commission's website, http://www.ccmcertification.org

- One continuing education credit is available for today's webinar only to those who registered in advance and are participating today.

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Learning Objectives Overview

After the webinar, participants will be able to:

- Identify and summarize what is included in a publicly-available tool to help identify care coordination measures that assess the value and process of case management.
- Explore the landscape of care coordination quality measures available today, with emphasis on measures most relevant to case managers.
- Investigate what's on the horizon for the future of care coordination measurement, and discuss how the case management perspective will be important in shaping that future.

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PATHWAY TO DISCOVERY FOR THE PROFESSIONAL CASE MANAGER

Introduction

Patrice Sminkey
Chief Executive Officer
Commission for Case Manager Certification

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PATHWAY TO DISCOVERY FOR THE PROFESSIONAL CASE MANAGER

- Webinars
- Certification Workshops
- Issue Briefs
- Speaker's Bureau

CareManagement
OFFICIAL JOURNAL OF THE ACADEMY OF CERTIFIED CASE MANAGERS

Case Management Body of Knowledge™
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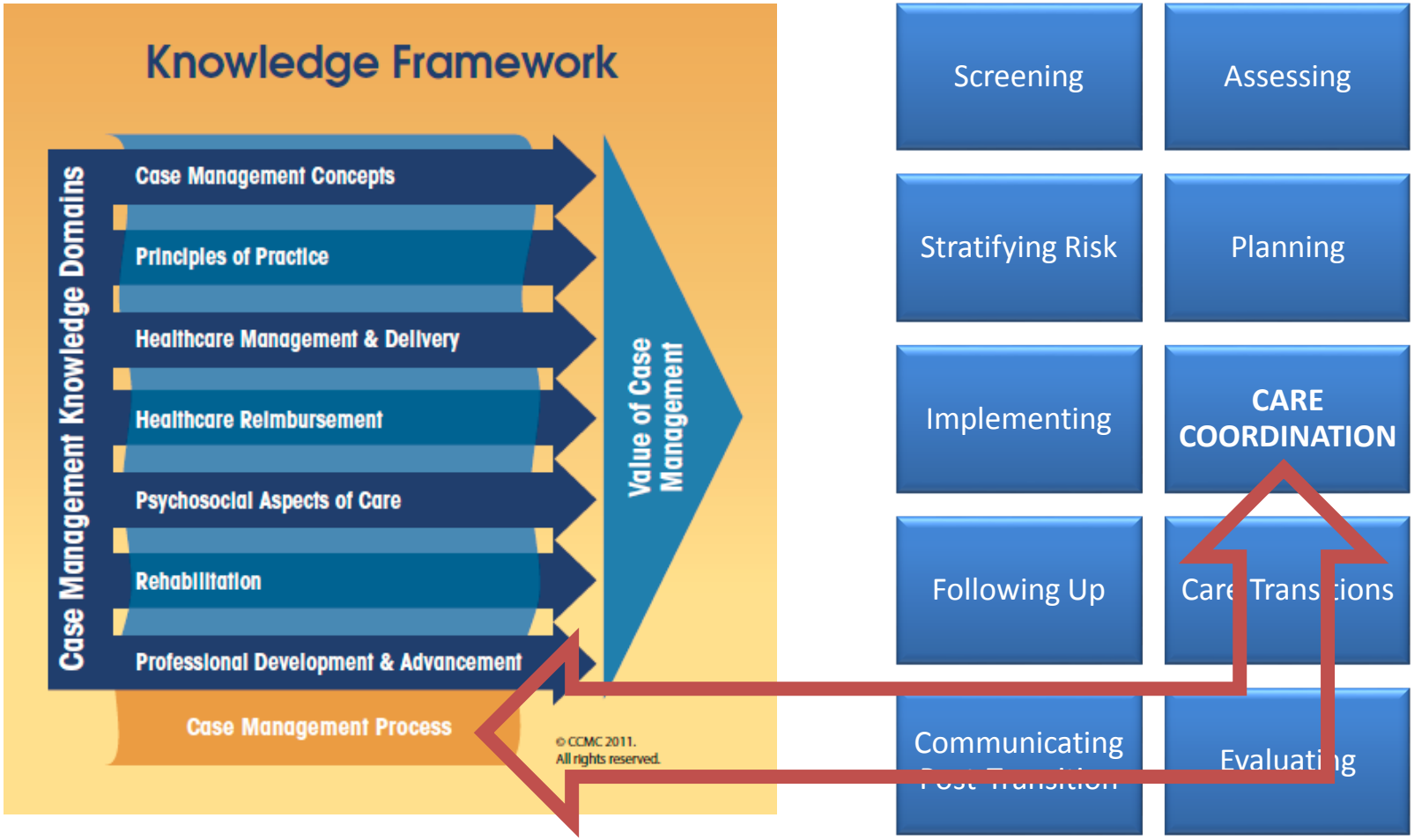
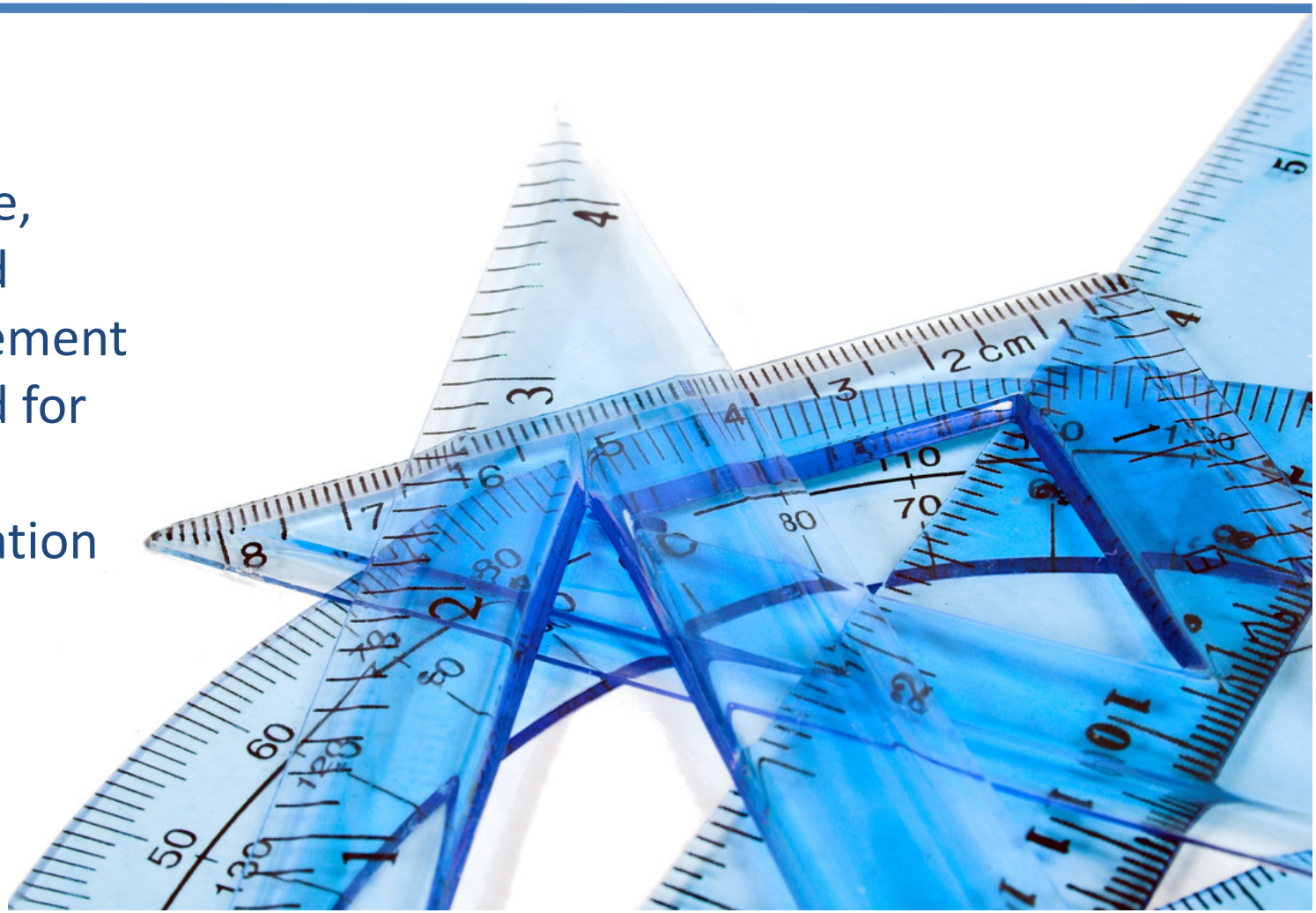
Care coordination:
The promise of connected care



Measurement and accountability

No single, standard measurement standard for care coordination



An atlas to guide the measures journey

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PATHWAY TO DISCOVERY FOR THE PROFESSIONAL CASE MANAGER

Measuring Care Coordination: Tools for today, tools for tomorrow

Ellen Schultz, MS
Stanford University

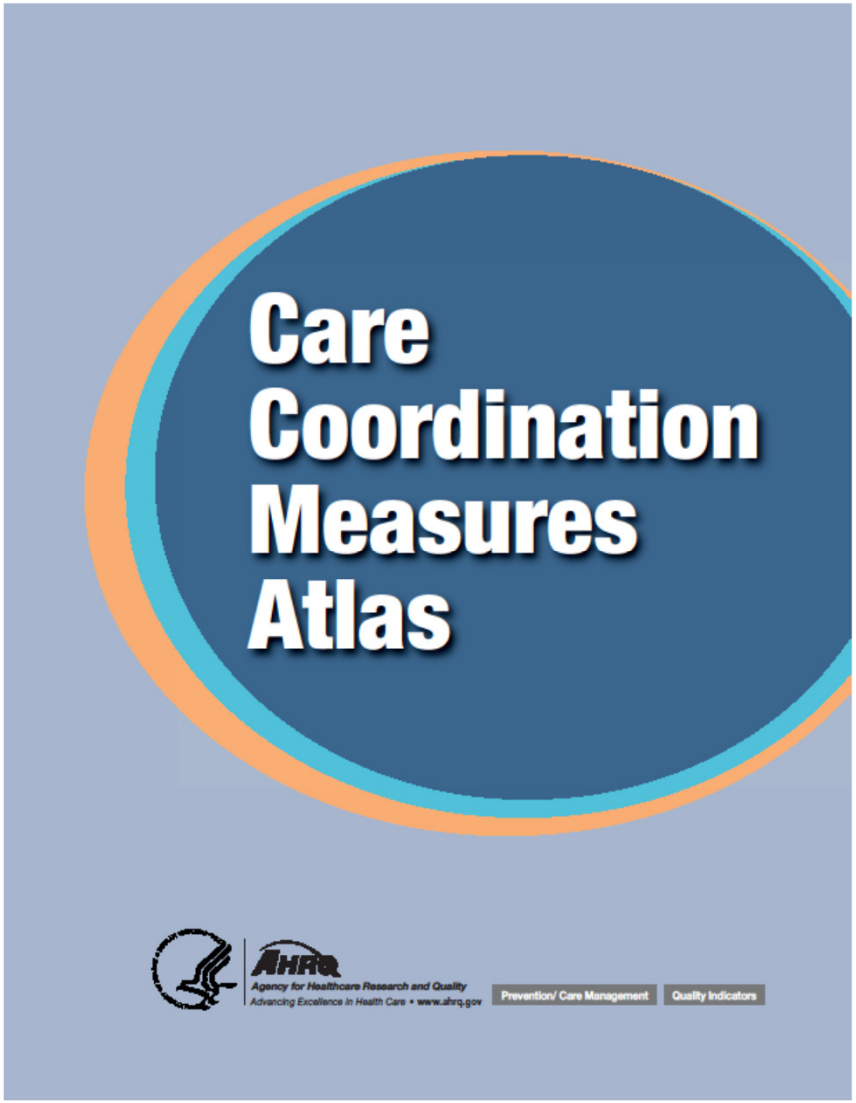
Quality Measurement

Knowledge about how to deliver high-quality, patient-centered care

What might **Quality Measurement** mean for you?

- "Our team gets good feedback on our work, but how can we quantify the quality of our care planning?"
- "Management wants us to improve team communication. But how do we know what to change?"
- "We're trying a new discharge planning process. How will we know if it's working?"

Care Coordination Measures Atlas

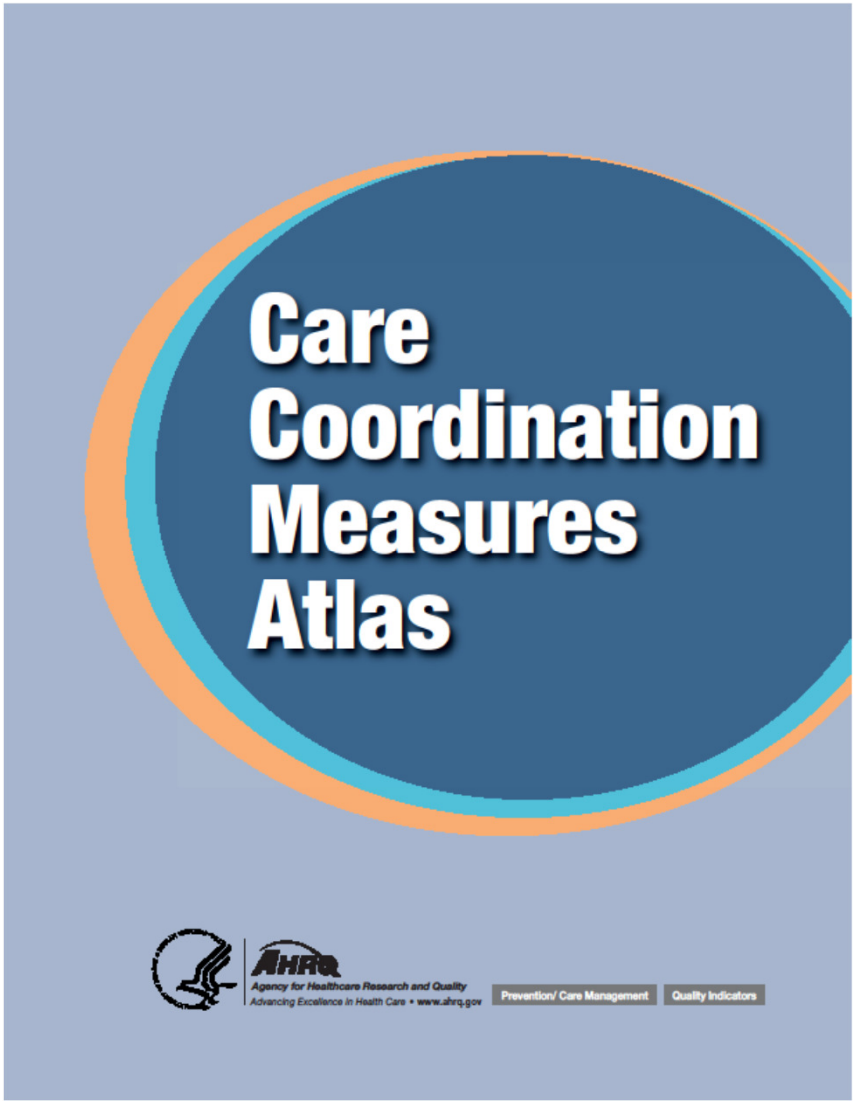


Catalogue of Measures:

- Listed by *what* is measured
- *How* it is measured
- Measure Reviews: testing, reliability, use

Helps users choose measures that work for them

Care Coordination Measures Atlas



- Measures of process
- Applicable to ambulatory care
  - Including transitions to/from hospital or LTC
- Publicly available
  - No license or fee required for use
- Tested

Acknowledgements for *Atlas* Work

Kathryn McDonald

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What is Care Coordination?

Working definition:

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.

Source: McDonald, K., V. Sundaram, D. Bravada, R. Lewis, N. Lin, S. Kraft, M. McKinnon, H. Paguntalan, and D. Owens. June 2007. "Care Coordination." *Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies. Technical Review 9 (Prepared by the Stanford University-UCSF Evidence-based Practice Center under contract 290-02-0017).* K. Shojania, K. McDonald, R. Wachter, and D. Owens. Rockville, MD: Agency for Healthcare Research and Quality.

Schultz, E.M. and McDonald, K.M. *What is Care Coordination?* International Journal of Care Coordination (in press).

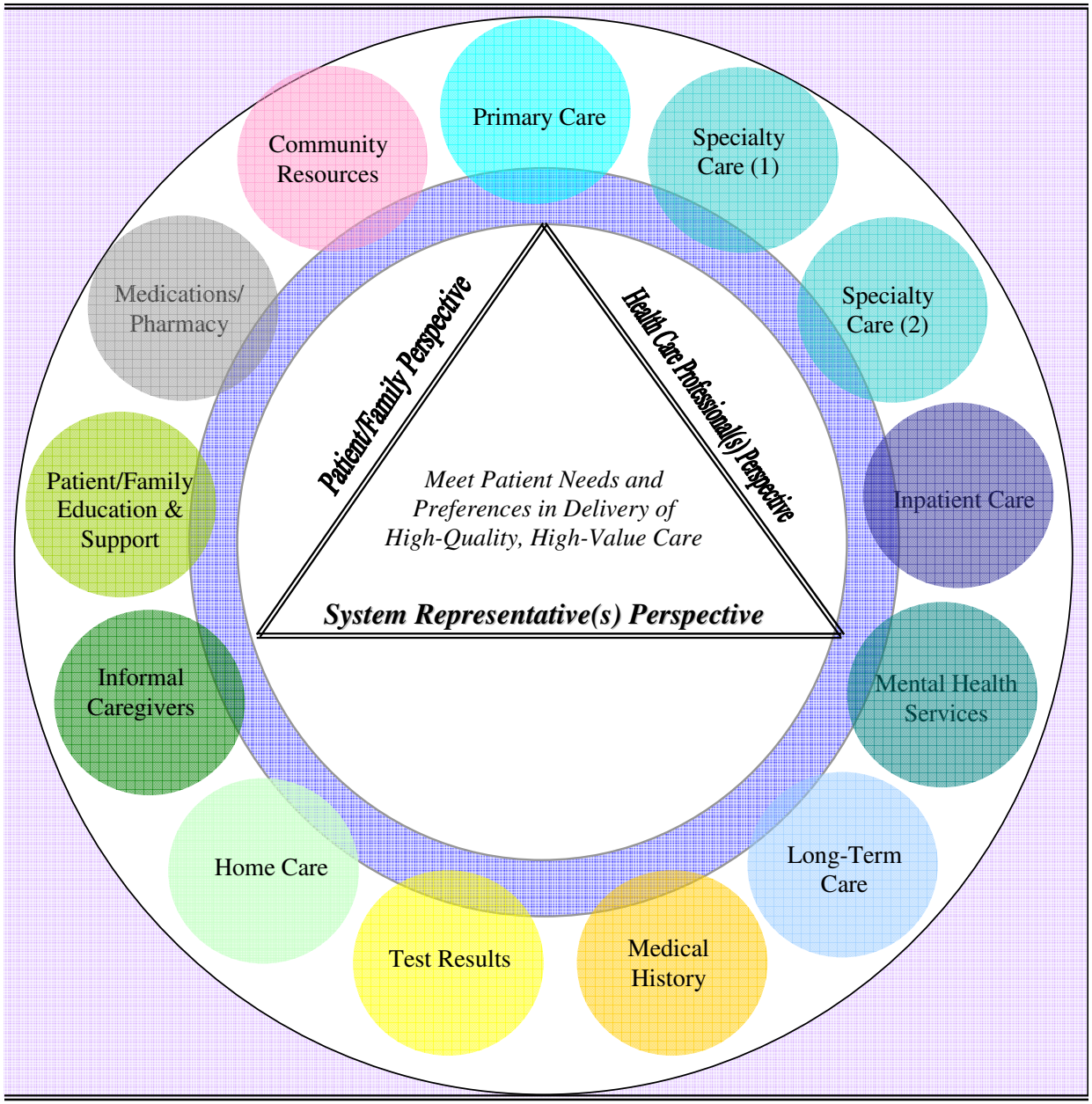
Visual Definition:

Numerous participants along care pathway

Care coordination is anything that ***bridges gaps*** across participants, settings or processes

End goal – deliver high-quality, high-value care that ***meets patients needs***

Care coordination ***looks different*** depending on who you ask



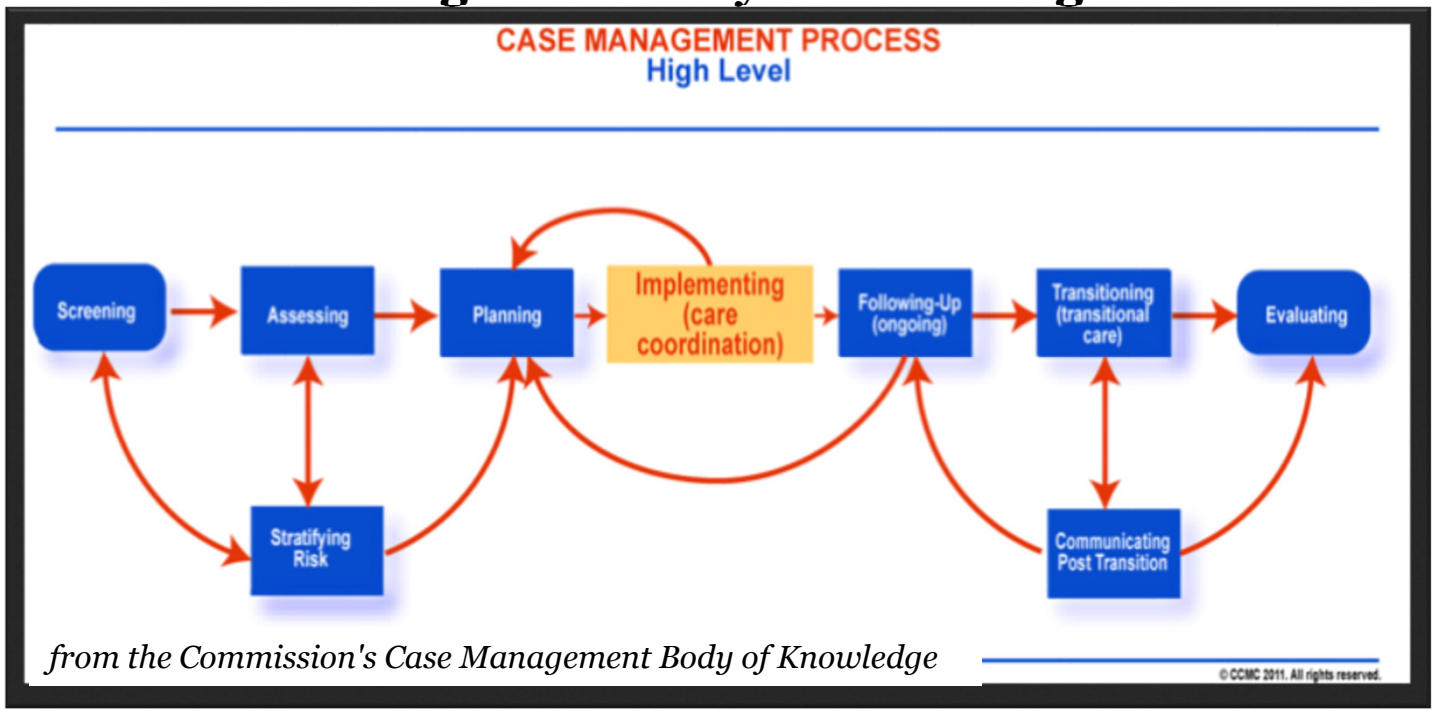
Care Coordination Domains

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

Atlas Activity Domains

Establish accountability or negotiate responsibility	Assess needs & goals	Support self-management goals
Communicate	Create a proactive plan of care	Link to community resources
Facilitate transitions	Monitor, follow-up and respond to change	Align resources with patient & population needs

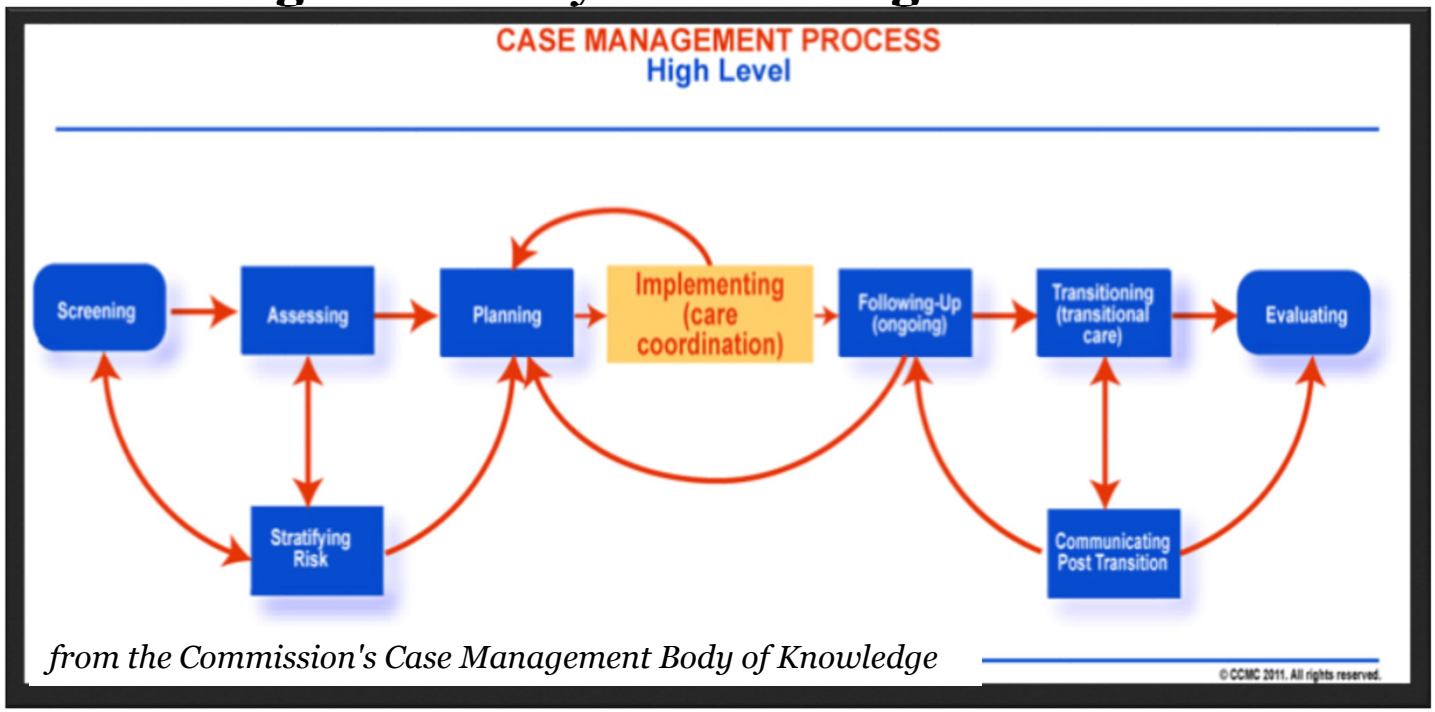
CCMC Case Management Body of Knowledge



Atlas Activity Domains

Establish accountability or negotiate responsibility	**Assess needs & goals**	Support self-management goals
Communicate	**Create a proactive plan of care**	Link to community resources
Facilitate transitions	**Monitor, follow-up and respond to change**	Align resources with patient & population needs

Case Management Body of Knowledge



from the Commission's Case Management Body of Knowledge

Atlas Activity Domains

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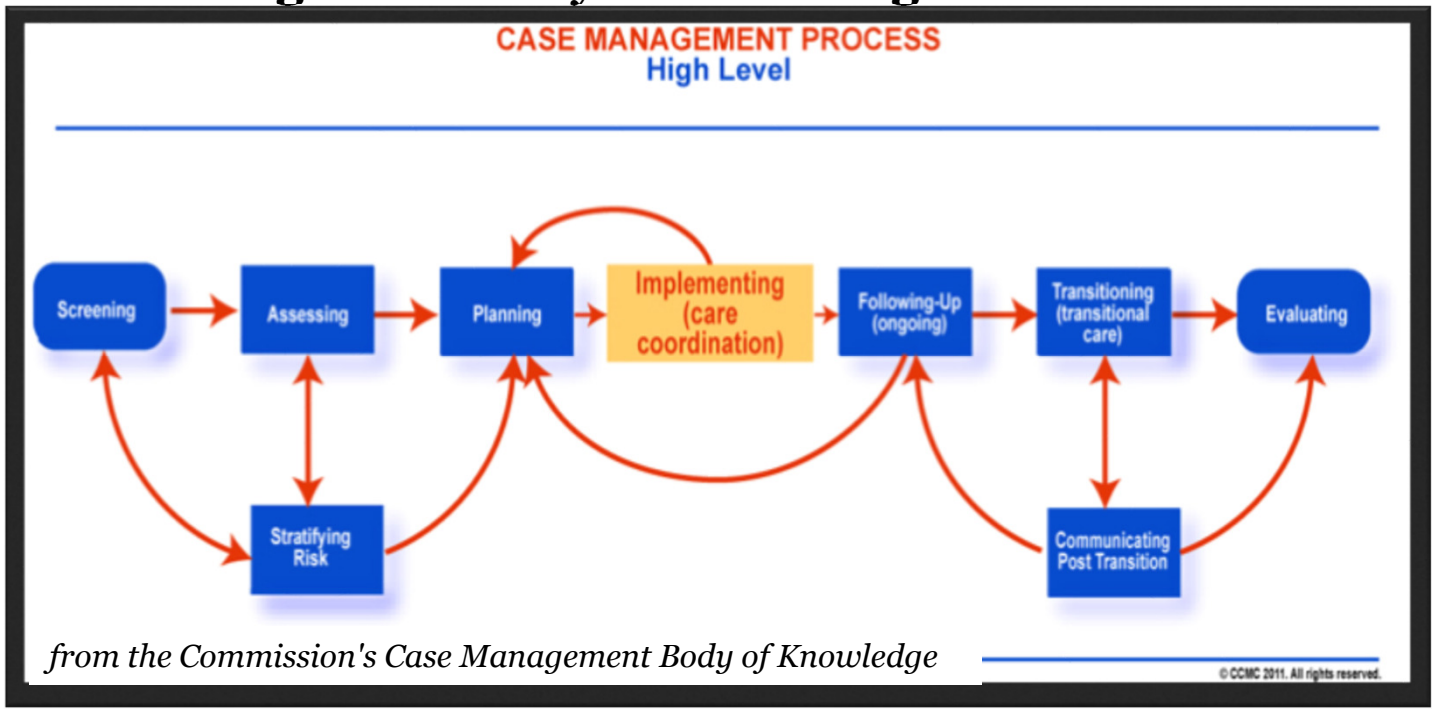
Case Management Body of Knowledge



How can you use the *Atlas* to find measures?

Table 5. Care Coordination Master Measure Mapping Table, Patient/Family Perspective†

	MEASUREMENT PERSPECTIVE: *Patient/Family*
CARE COORDINATION ACTIVITIES	
Establish accountability or negotiate responsibility	3, 4a, 4b, 4c, 6, 9b, 11a, 13, 14, 16c, 17a, 17b, 26, 32, 37, 40, 42, 45, 48
Communicate	3, 4a, 4b, 4c, 6, 9b, 10, 11a, 13, 14, 16c, 17a, 17b, 24, 25, 26, 29, 30, 31, 32, 33, 37, 38a, 45, 48, 51
Interpersonal communication	3, 4a, 4b, 4c, 6, 10, 11a, 13, 14, 16c, 17a, 17b, 21, 33, 35, 36, 37, 38b, 39, 40, 41, 42, 45, 48, 51
Information transfer	3, 4a, 4b, 4c, 6, 9b, 10, 11a, 13, 14, 16c, 17a, 17b, 21, 24, 26, 29, 30, 31, 32, 33, 35, 36, 37, 38a, 38b, 39, 40, 41, 42, 45, 48, 49, 51
Facilitate transitions‡	
Across settings	9a, 9b, 13, 14, 16c, 17a, 17b, 21, 26, 31, 32, 37, 38a, 38b, 40, 42, 51
As coordination needs change	11a, 14, 24
Assess needs and goals	3, 4a, 4b, 4c, 6, 9a, 9b, 10, 11a, 13, 14, 16c, 17a, 17b, 21, 24, 25, 26, 30, 31, 32, 33, 35, 37, 38a, 38b, 40, 41, 42, 45
Create a proactive plan of care	6, 9b, 10, 11a, 16c, 21, 24, 37, 38a, 40
Monitor, follow up, and respond to change	3, 4a, 4b, 4c, 6, 9b, 10, 11a, 13, 16c, 17a, 17b, 21, 24, 25, 26, 29, 31, 32, 33, 36, 37, 39, 40, 41, 45
Support self-management goals	4a, 4b, 4c, 6, 9a, 9b, 10, 11a, 13, 16c, 17a, 17b, 21, 24, 25, 26, 29, 31, 32, 33, 35, 36, 37, 38a, 38b, 40, 41
Link to community resources	10, 11a, 16c, 17b, 21, 24, 31, 33, 38a, 38b
Align resources with patient and population needs	6, 11a, 14, 16c, 17a, 17b, 31, 38a, 38b, 51

How can you use the *Atlas* to find measures?

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Facilitate transitions‡	
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Monitor, follow up, and respond to change	3, 4a, 4b, 4c, 6, 9b, 10, 11a, 13, 16c, 17a, 17b, 21, 24, 25, 26, 29, 31, 32, 33, 36, 37, 39, 40, 41, 45
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Align resources with patient and population needs	6, 11a, 14, 16c, 17a, 17b, 31, 38a, 38b, 51

- Choose perspective
- Choose domain of interest
- Get list of measures…

How can you use the *Atlas* to find measures?

Measure 9b. Care Transitions Measure (CTM-15)

Purpose: To evaluate the essential processes of care involved in successful care transitions from a patient-centered perspective.

Format/Data Source: 15-item survey administered at the time of, or immediately following, hospital discharge. The items span 4 domains: (1) information transfer, (2) patient and caregiver preparation, (3) self-management support, and (4) empowerment to assert preferences. All questions are answered on a 5-point Likert scale.

Date: Measure published in 2002.[1]

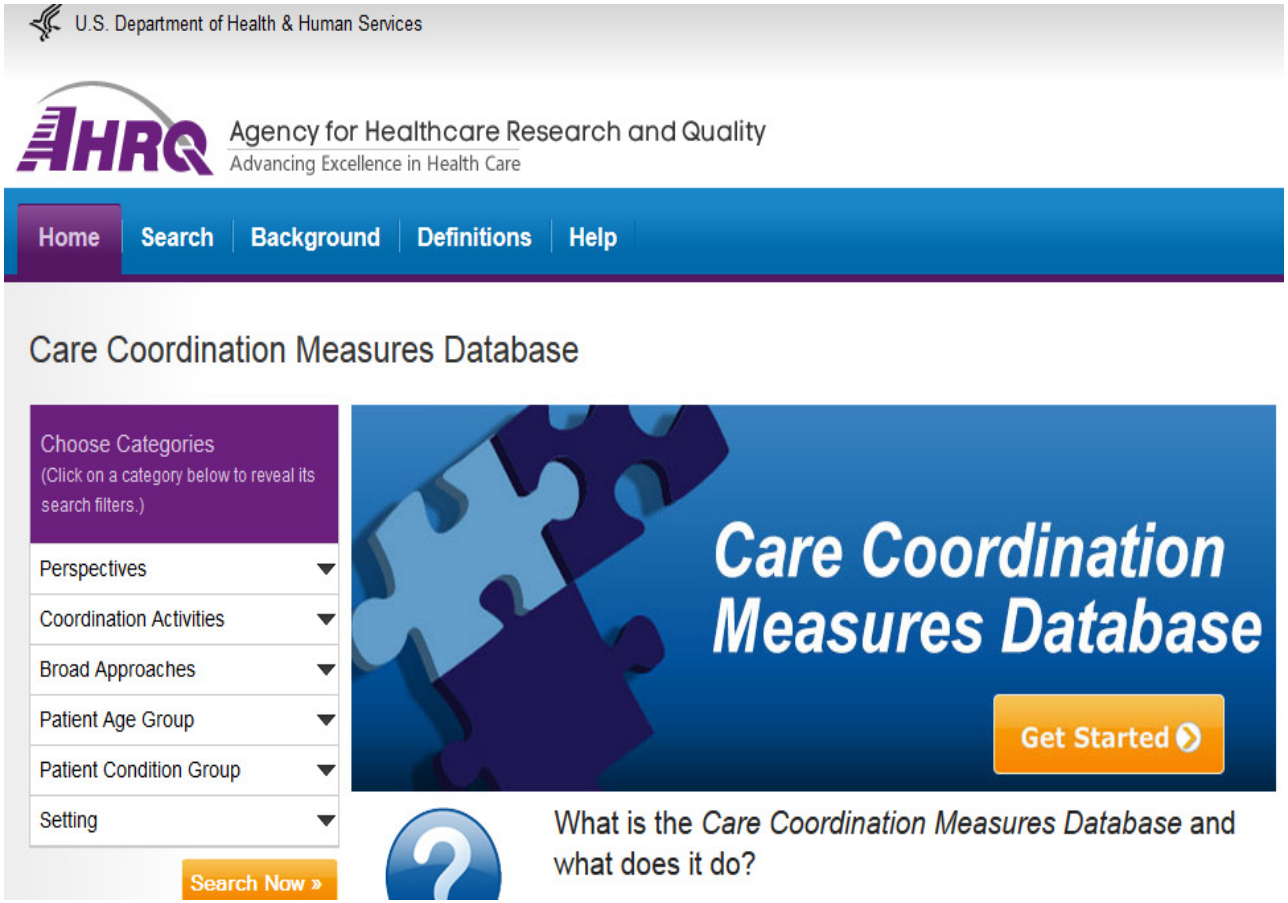
Perspective: Patient/Family

Measure Item Mapping:

- **Establish accountability or negotiate responsibility:** 9
- **Communicate:**
  - *Between health care professional(s) and patient/family:* 1
  - Information transfer:
    - *Between health care professional(s) and patient/family:* 4
- **Facilitate transitions:**
  - Across settings: 1-15
- **Assess needs and goals:** 1-3, 7
- **Create a proactive plan of care:** 7, 12
- **Monitor, follow up, and respond to change:** 12
- **Support self-management goals:** 1, 4-6, 8-11
- **Medication management:** 13-15

- Review profiles of relevant measures
- Ask: does this look useful?

Coming Soon…
Care Coordination Measures Database

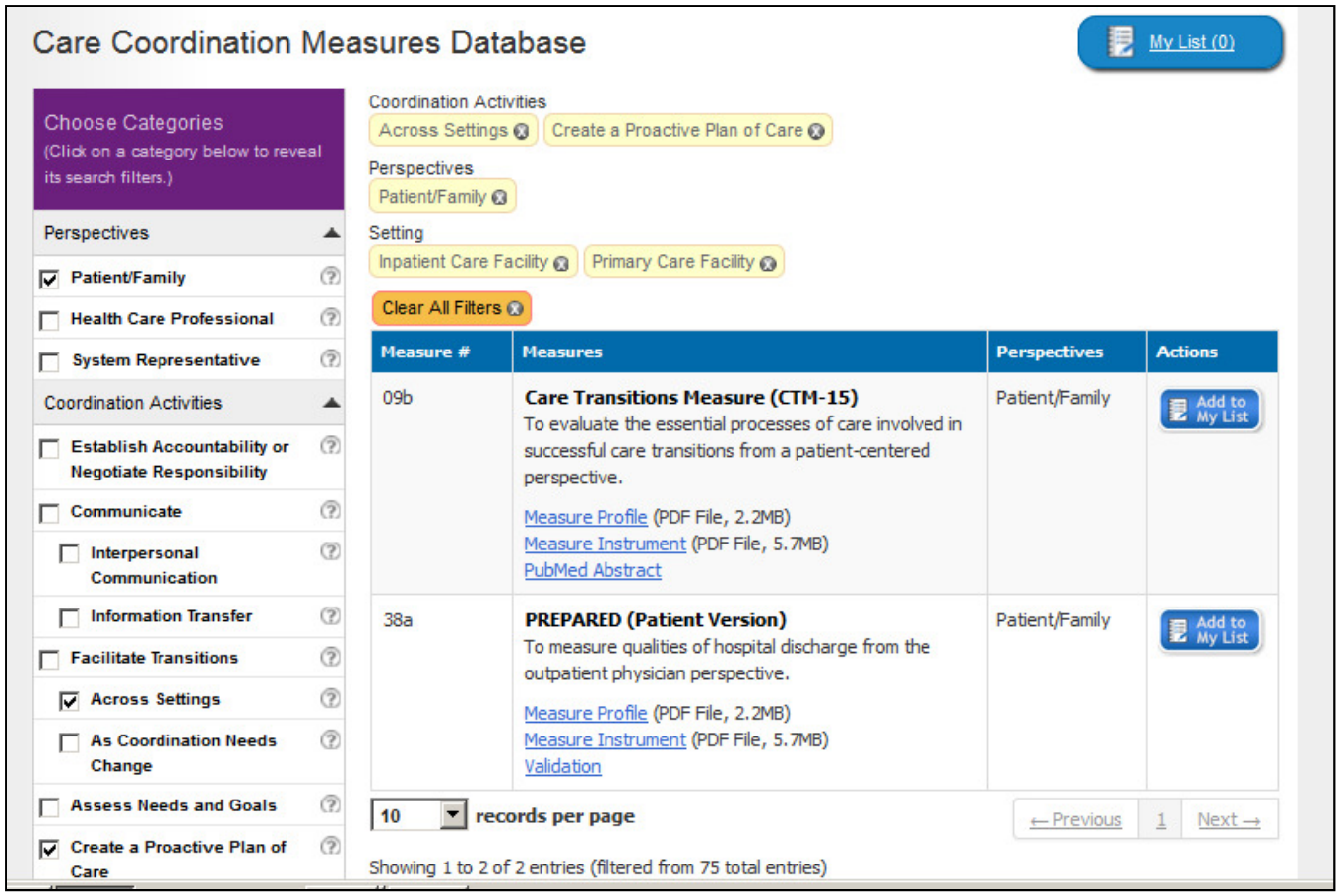


Online "shopping" for measures:

Filter by:
- Perspective
- Domain
- Patient groups
- Settings

Link to additional info about each measure:
- Overview
- Instrument
- Related publications

Database Search Example



Perspective:

- Patient/family

AND

Domains:

- Transitions - across settings
- Plan of Care

AND

Settings:

- Inpatient
- Primary Care

Combining *Facilitate Transitions Across Settings* domain with *Inpatient* and *Primary Care* settings in search criteria = Measures of hospital discharge

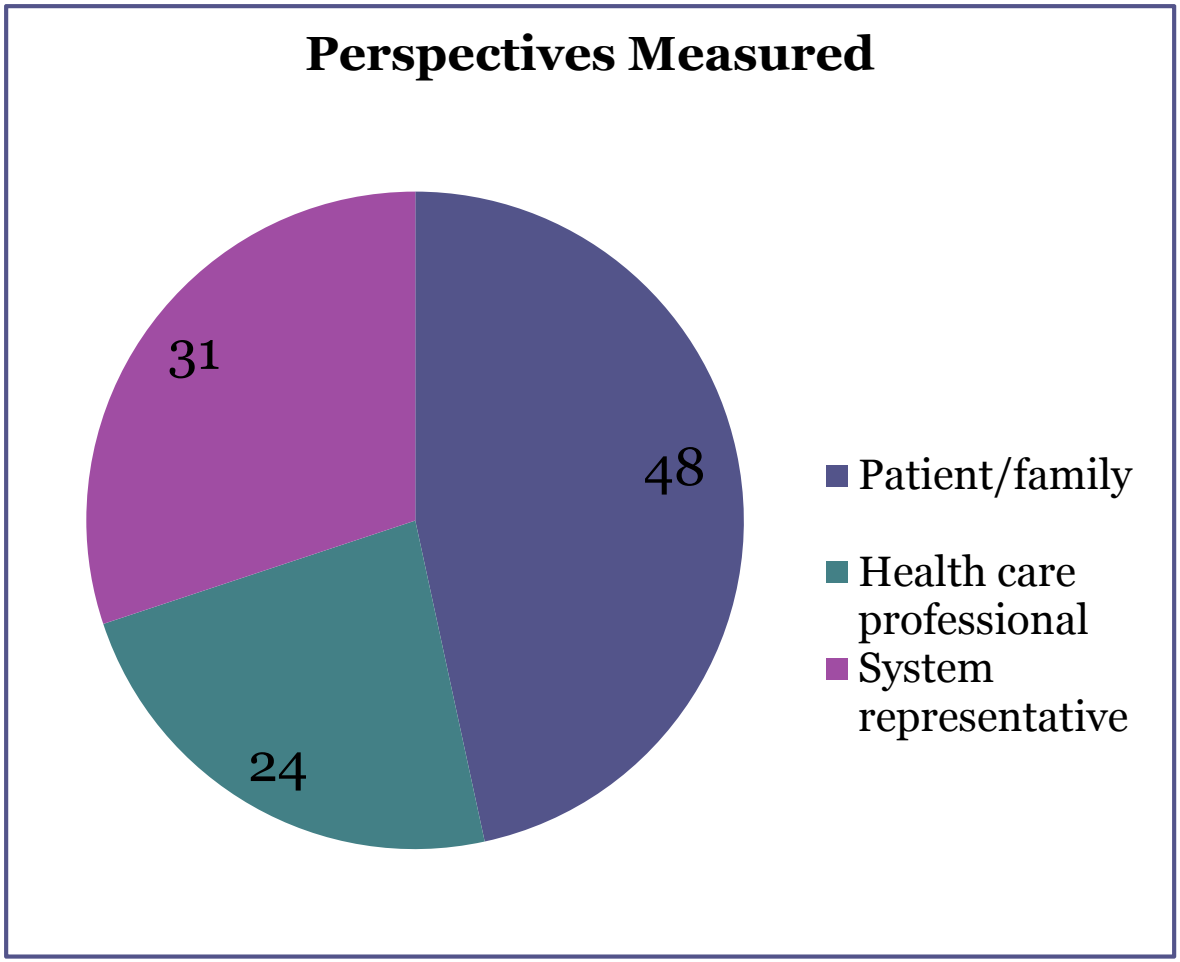
What does the care coordination measures landscape look like today?

Overview of Current Measures

- Original *Atlas* contained 61 measures
- Updated version (coming soon)
  - 80 measures (101 unique instruments)
  - Additional information on EHR-based measures

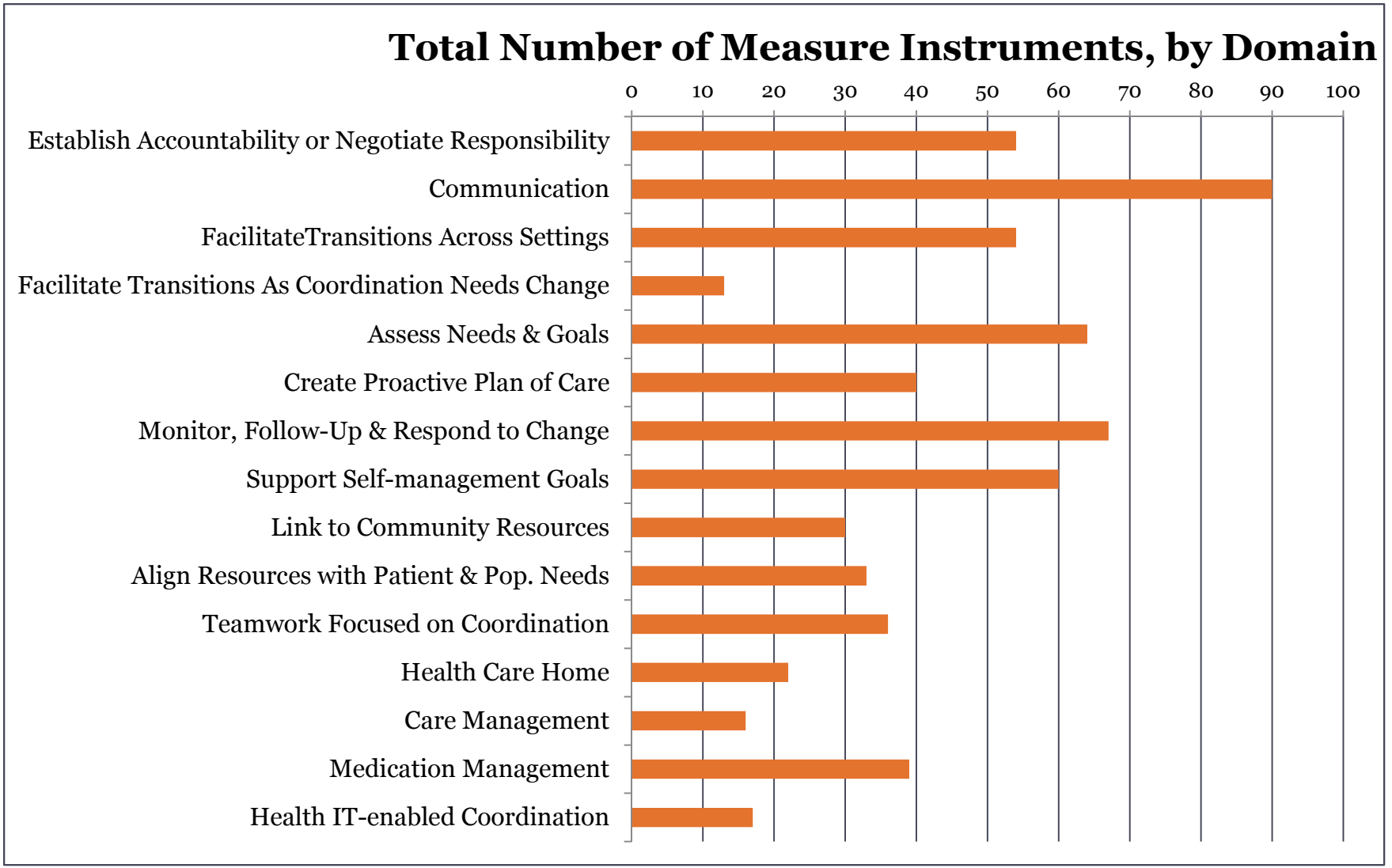
Whose View of Care Coordination?

- ***Patient/family*** perspective most frequently measured
- ***Health care professional*** least often measured
- 3 instruments measured multiple perspectives (*Patient/family* and *System*)



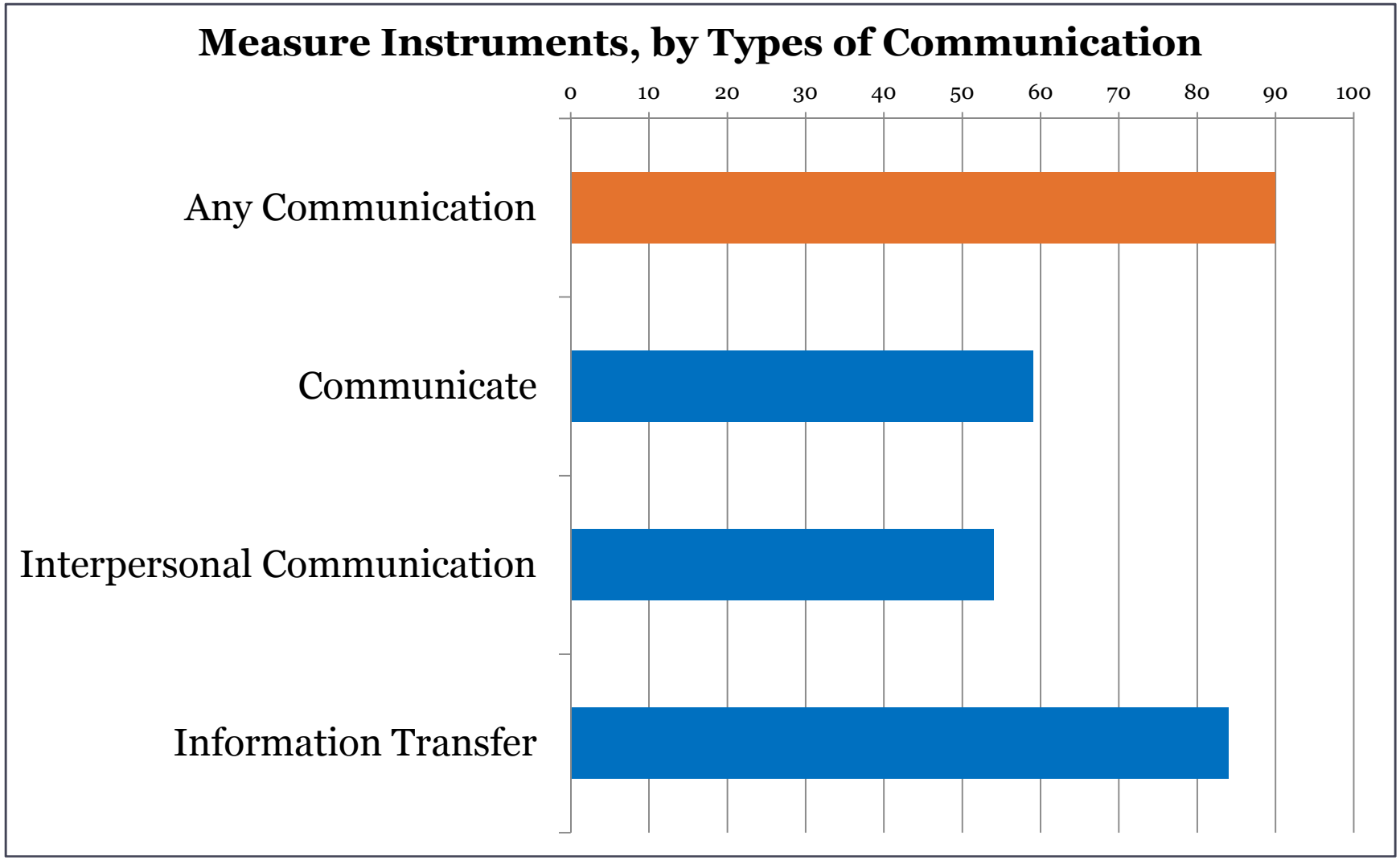
Note: 101 measure instruments; some measure multiple perspectives

What Care Coordination Domains Measured?



Note: 101 measure instruments; most assess multiple domains

Close-up: Types of Communication



Note: 101 measure instruments; most assess multiple domains

Care Management Domain

"A process designed to assist patients and their support systems in managing their medical, social or mental health conditions more efficiently and effectively."

- Case management
- Disease management

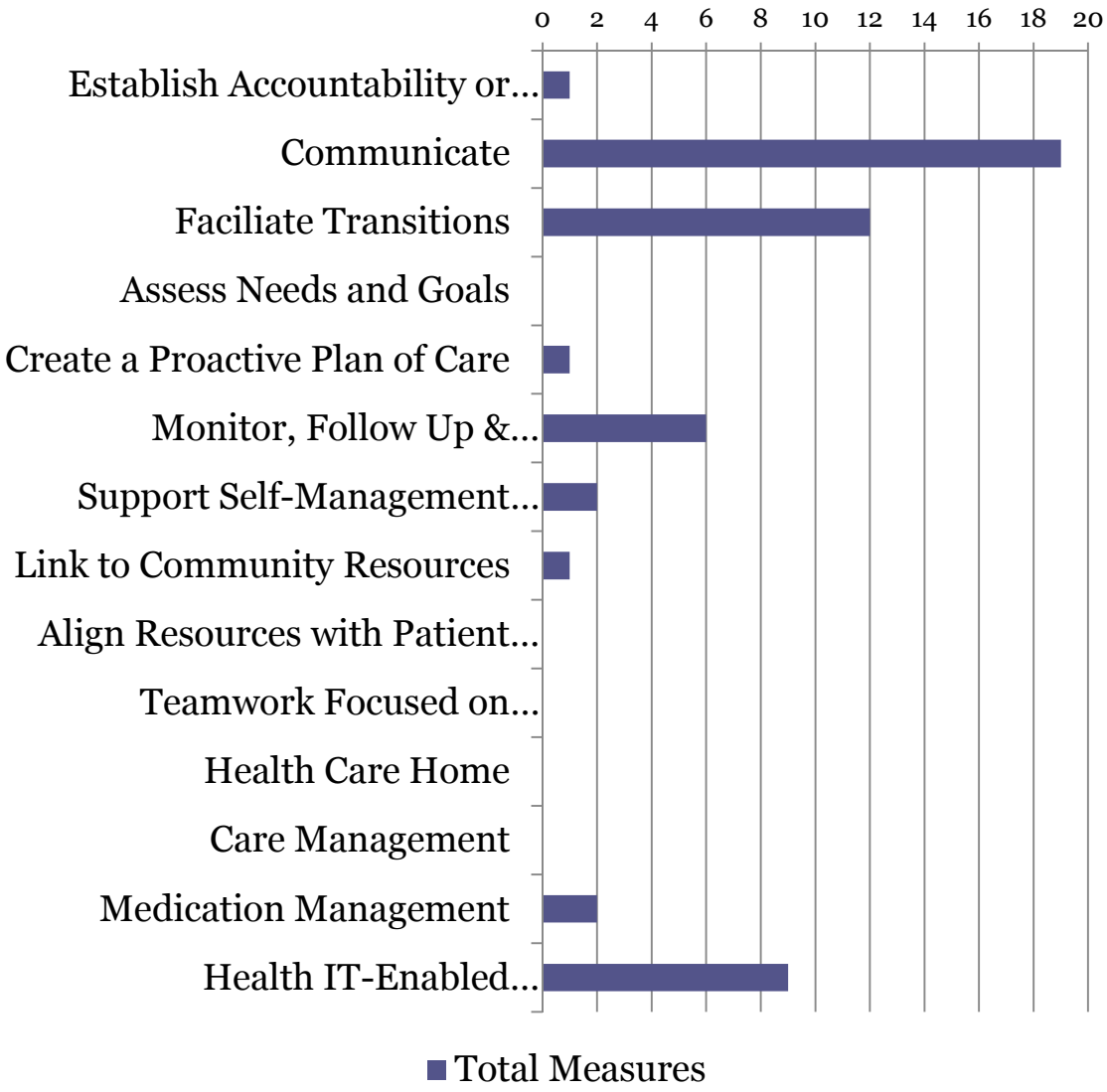
Examples: *Care Management* domain items

Survey Item	Measure Instrument
• Is there a staff person or **care coordinator** that helps families coordinate care?	Family-Centered Care Self-Assessment Tool (Family Version and Provider Version) *Family Voices*
• Does anyone **help you arrange or coordinate** your child's care among the different doctors or services that he/she uses?	National Survey of Children with Special Health Care Needs (CSHCN) *Child and Adolescent Health Measurement Initiative (CAHMI)*
• A designated **care coordinator** ensures the availability of these activities including written care plans with ongoing monitoring	Medical Home Index *Center for Medical Home Improvement*
• Will most of this patient's aftercare be provided in your program by the same person who served as the patient's primary **counselor/case manager** during intensive substance use disorder treatment?	Continuity of Care Practices Survey - Individual Level *Schaefer, JA, Cronkite, RC, and Ingudomnukul, E. (2004). Journal of Studies on Alcohol, 65, 513-520.*

EHR-based Care Coordination Measures Today

Review in 2013 found:

- 26 current measures
- Most focus on *Communication*, especially exchanging information
- Measure transactions, but don't (yet) capture dynamic care coordination process
- Interpersonal processes not captured



Future Directions

Where are we headed?

- Expect much more growth in EHR-based measurement
  - Near-term: transactional, single processes
  - Long-term: more complex, dynamic processes
- Increased focus on **patient engagement** and **person-focused care**
  - Importance of family, social, financial, community factors

On-going NQF work

What should we measure in the future?

- Revised framework (in progress) recognizes:
  - Whole-person approach to care
  - Importance of clinical-community relationships (health neighborhood)
  - Value of goal-setting and comprehensive care planning
  - Shared accountability

On-going NQF work

- Key issues raised:
  - What should the **care coordinator** role be when community services are **unavailable?**
  - Performing some care coordination **activities does not** guarantee patients **experience** coordinated care
  - Who participates in and leads **care teams**? How is this **documented**?
  - Must **match** care coordination services to **patient/family needs** – needs are dynamic, periodic re-assessment necessary

What does this mean for Case Managers?

What gets measured gets attention, so…

- How case management work is documented in EHRs will matter for measurement
  - Expect more EHR-based measures
- What parts of your work are being measured? →What's not?
- Who is setting the agenda?
  - Need to include more voices in discussions – nurses, case managers, social workers, etc.

Find Opportunities to Speak Up

- Public Comment Periods
  - NQF work – comment period mid- to late-June
  - CMS also holds public comment periods
- Give feedback on EHR design, implementation
  - Impact on care and measurement
- Get involved in measurement
  - Volunteer for local/organizational committees
  - Start discussions with co-workers, managers
  - Make suggestions for what's important to measure

Make sure case managers are part of the conversation about what we measure, and how, going forward!

Additional Resources

Current *Care Coordination Measures Atlas*

- Original version available online and as PDF
- http://www.ahrq.gov/professionals/systems/long-term-care/resources/coordination/atlas/index.html

Coming Soon from AHRQ

- Updated *Care Coordination Measures Atlas*
- Care Coordination Measures Database (interactive search)

Other Atlas Resources from AHRQ

- *Clinical Community Relationships Atlas*
  - http://www.ahrq.gov/professionals/prevention-chronic-care/resources/clinical-community-relationships-measures-atlas/

- *Atlas of Integrated Behavioral Health Care Quality Measures*
  - http://integrationacademy.ahrq.gov/atlas

Related Reports

- *Care Coordination Accountability Measures for Primary Care Practice*
  - http://www.ahrq.gov/research/findings/final-reports/pcpaccountability/index.html
- *Prospects for Care Coordination Measurement Using Electronic Data Sources*
  - http://www.ahrq.gov/research/findings/final-reports/prospectscare/index.html

Find Opportunities to Speak Up

NQF Care Coordination Projects

- Prioritizing Measure Gaps
  - **Watch for public comment period mid-late June**
  - http://www.qualityforum.org/Prioritizing_Measure_Gaps_-_Care_Coordination.aspx
- Care Coordination Measures
  - **Public comment open through May 28**
  - http://www.qualityforum.org/Care_Coordination_Measures.aspx

And everyday through the work that you do!

Question and Answer Session

Ellen Schultz, MS
Stanford University

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Thank you!

- Please fill out the survey after today's session
- Those who signed up for Continuing Education will receive an evaluation from the Commission.
- A recording of today's webinar and slides will be available in one week at www.ccmcertification.org

Bonus Material

Example Measure Mapping: Care Transition Measure (CTM) – 3

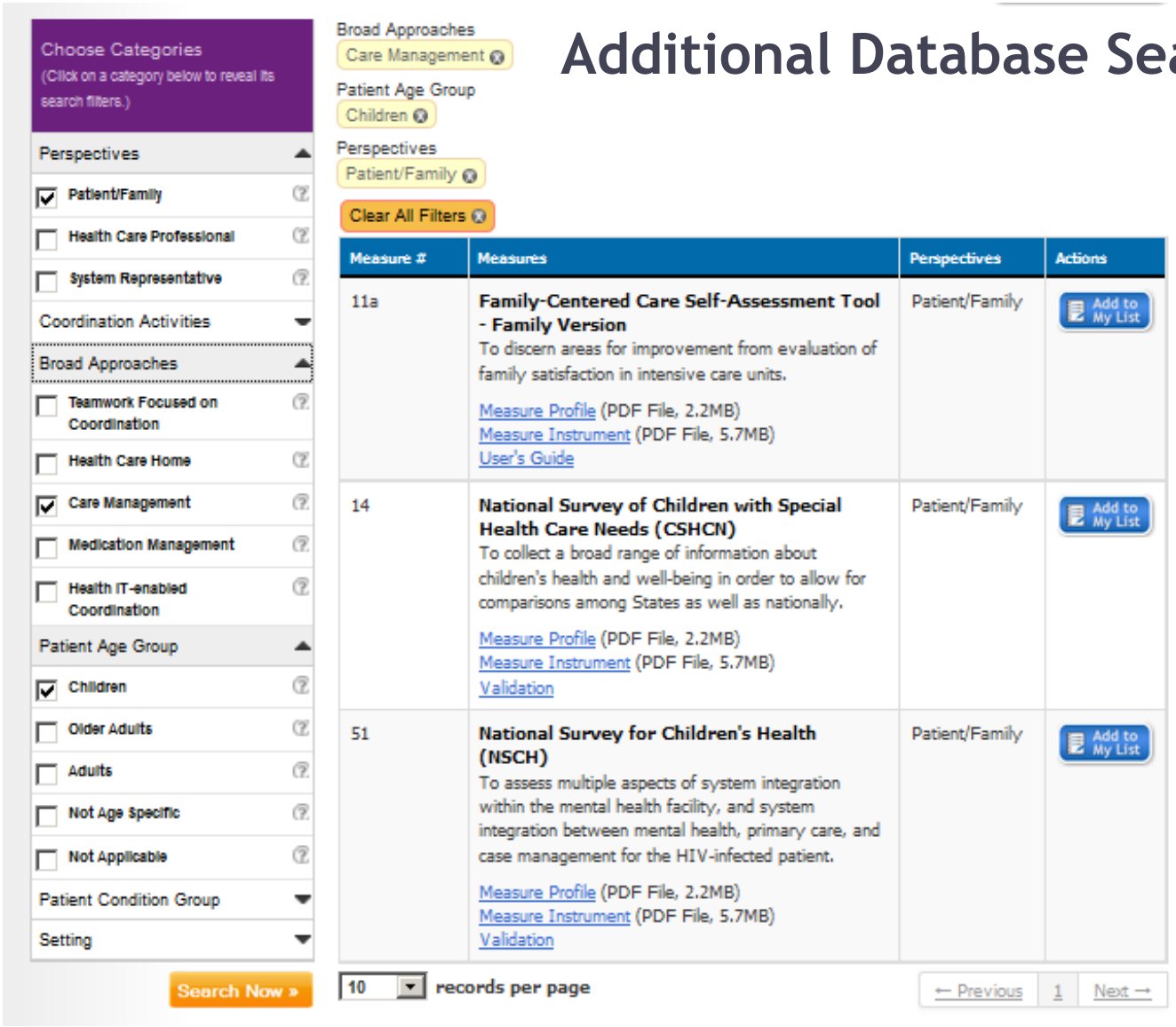
3-item survey completed by patients about preparation for hospital discharge

→ ***Patient/family perspective***

Item description	Domain mapping
Planning for health care needs at the time of discharge included patient and family preferences	➢ Assess Needs and Goals ➢ Facilitate Transitions Across Settings
Patient understands self-management responsibilities at the time of discharge	➢ Support Self-management Goals ➢ Facilitate Transitions Across Settings
Patient understands purpose of medications at the time of discharge	➢ Support Self-management Goals ➢ Medication Management ➢ Facilitate Transitions Across Settings

Source: Coleman EA, Smith JD, Frank JC, et al. Int J Integr Care 2002;2(1):1-9.

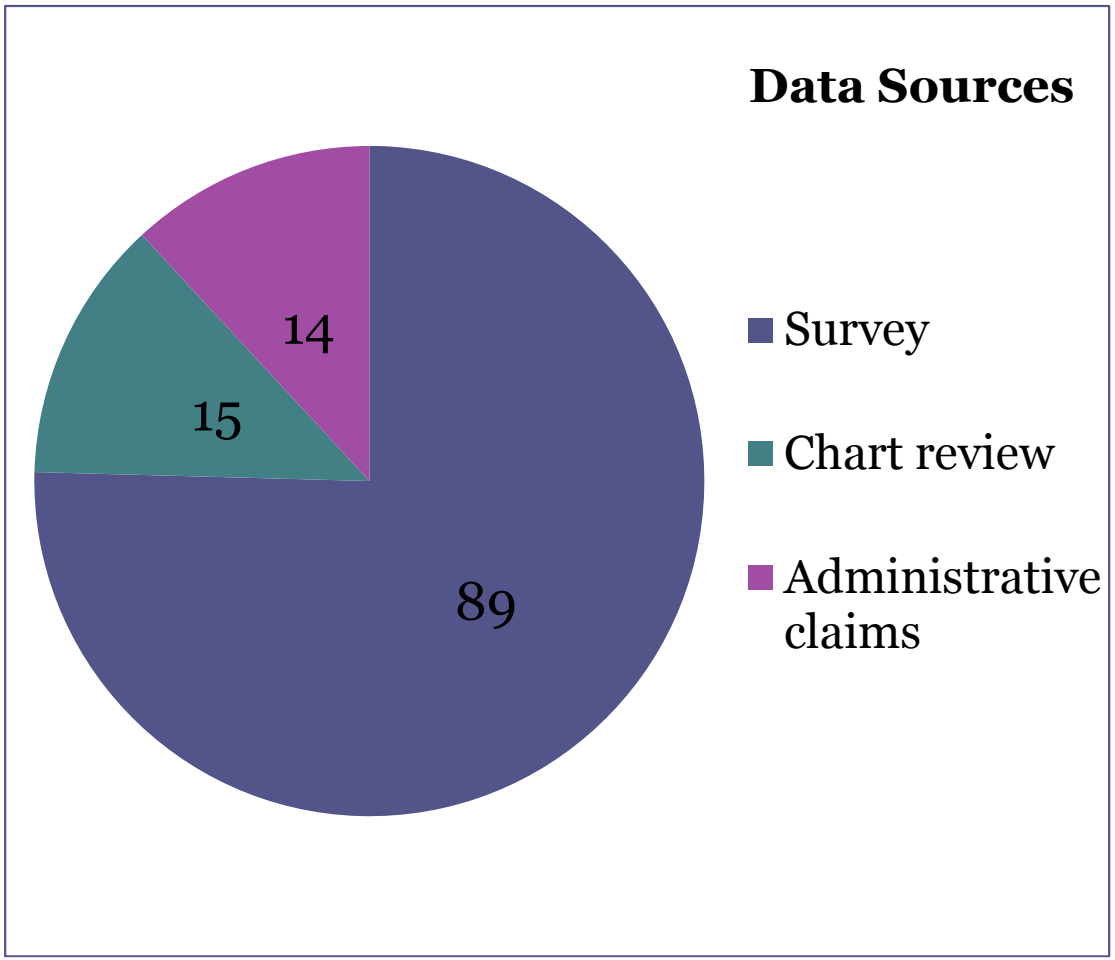
Additional Database Search Example:



- Patient/family perspective
- Care Management domain
- Children

What data used for measurement?

- Vast majority of current measures are surveys
- Some measures combine multiple data sources
- Very few rely exclusively on chart review or administrative claims (one each)



Note: 101 measure instruments; some use multiple types of data

EHR-based Measurement

- HITECH Act allocated $48B for EHR-adoption and incentives
  - Improving **care coordination** a key motivation
- **Meaningful Use** program requires demonstrated *information exchange*, *care planning*, *risk stratification*, *follow-up* using EHRs
- As of 2013, 44% of hospitals and 78% of office-based physicians used EHRs, and growing

Sample: EHR-based Care Coordination Measures Today

Prenatal record present at the time of delivery **Domains:** Info Transfer, Transitions across Settings	Critical info communicated (and received) with request for referral to specialist **Domains:** Info transfer, Transitions across Settings, HIT-enabled coordination	Communication with the physician managing on-going care post fracture of hip, spine, or distal radius **Domains:** Communicate, Transitions across Settings and As Needs Change
Ability to receive lab data electronically into EHR **Domains:** Info Transfer, HIT-enabled coordination	PCP communicates to patient the reason for referral **Domains:** Info Transfer, Transitions across Settings	Medication Reconciliation **Domains:** Accountability, Info Transfer, Monitor & f/u, Medication Mgt
Tracking of clinical results between visits **Domains:** Monitor & f/u, HIT-enabled coordination	Specialist communicates results to patient/family **Domains:** Info Transfer	Dementia: Caregiver Education and Support **Domains:** Support self-management, Link to Community Resources

Sample Stage 1&2 MU Measures

Provide patients the ability to view online, download and transmit their health information **Domain:** Info transfer	Use clinically relevant information to identify and provide patient-specific education resources to the patient **Domain:** Support self-mgt	Closing the Referral Loop: Receipt of Specialist Report **Domains:** Info Transfer, Transitions across Settings
Provide clinical summaries for patients for each office visit **Domain:** Info transfer	The EP/EH who receives a patient from another setting/provider should perform med reconciliation **Domains:** Med Mgt, Transitions across Settings	Home management plan of care document given to patient/caregiver **Domains:** Info Transfer, Plan of Care
Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care **Domains:** Monitor & f/u, Align resources	The EP/EH who transitions or refers their patient to another setting/provider should provide a summary care record **Domain:** Transitions across Settings	Use secure electronic messaging to communicate with patients on relevant health information **Domain:** Info Transfer

Case Management Activities Increasingly Captured in Proposed Stage 3 MU Measures

Sample of Current and Proposed Meaningful Use Measures

Stage 1 & 2 MU (in use today)	Proposed Stage 3 (to be finalized in 2015)
Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care	Use clinical, **social**, or **family history** information (**beyond demographics**) to identify patients who should receive reminders for preventive/follow-up care
Provide clinical summaries to patient for each office visit	Office visit summary is provided to patient/patient representative with **relevant and actionable information** and **instructions pertaining to the visit** in the **format requested as indicated by the patient**
None	Provider/hospital will send electronic **notification of significant healthcare event** (e.g., ED visit, hospitalization) in timely manner to key members of patient's care team, such as PCP, **care coordinator**, referring provider

Case Management Activities Increasingly Captured in Proposed Stage 3 Measures

Example: Provider/hospital who transfers/refers patient should provide **Summary of Care Record** that includes:

Item for Inclusion	Transfer across sites	Consult Request	Consult Result Note
Concise **narrative in support of transition** (e.g., current care synopsis, expectations)	Required	Required	Required
Contact info for **professional care team members**, including PCP, role and contact info	Required	Required	Optional
Indication of whether there is a **designed family or informal caregiver** who is playing significant role in patient's care	Required	Required	Optional
Over-arching **patient goals** and **problem-specific goals**	Required	Optional	Optional
Patient instructions and/or suggested and/or planned interventions for **care during transition** and/or 48 hours afterwards	Required	Optional	Optional