Measuring Care Coordination:
Tools for today, tools for tomorrow

Ellen Schultz, MS
Stanford University

Patrice Sminkey
Chief Executive Officer
Commission for Case Manager Certification
Agenda

• Welcome and Introductions

• Learning Objectives

• Patrice Sminkey, CEO, the Commission

• Ellen Schultz, MS, Stanford University

• Question and Answer Session
• 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.
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.
Introduction

Patrice Sminkey
Chief Executive Officer
Commission for Case Manager Certification
• Webinars
• Certification Workshops
• Issue Briefs
• Speaker’s Bureau
Care coordination: The promise of connected care

Knowledge Framework

Case Management Knowledge Domains
- Case Management Concepts
- Principles of Practice
- Healthcare Management & Delivery
- Healthcare Reimbursement
- Psychosocial Aspects of Care
- Rehabilitation
- Professional Development & Advancement

Case Management Process

Value of Case Management

Screening
Assessing
Stratifying Risk
Planning
Implementing
CARE COORDINATION
Following Up
Care Transitions
Communicating
Post Transition
Evaluating
Measurement and accountability

No single, standard measurement standard for care coordination
An atlas to guide the measures journey
Measuring Care Coordination:
Tools for today, tools for tomorrow

Ellen Schultz, MS
Stanford University
Quality Measurement

- Quality of Care
- Quality Improvement
- Performance Evaluation

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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Lauren Albin
Sheryl Davies
Vandana Sundaram
Crystal Smith-Spangler

Jennifer Brustrom
Elizabeth Malcolm
Kathan Volrath
Chris Stave
Lauren Rohn
Jodie Ha

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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.


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

<table>
<thead>
<tr>
<th>COORDINATION ACTIVITIES</th>
</tr>
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<tbody>
<tr>
<td>Establish Accountability or Negotiate Responsibility</td>
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<th>BROAD APPROACHES</th>
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<tr>
<td>Health Care Home</td>
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<td>Medication Management</td>
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<td>Health IT-Enabled Coordination</td>
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**Atlas Activity Domains**

<table>
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<tr>
<th>Establish accountability or negotiate responsibility</th>
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**CCMC Case Management Body of Knowledge**

*from the Commission's Case Management Body of Knowledge*
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### Case Management Body of Knowledge

*from the Commission's Case Management Body of Knowledge*
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**Case Management Body of Knowledge**

*from the Commission's Case Management Body of Knowledge*
How can you use the *Atlas* to find measures?

<table>
<thead>
<tr>
<th>CARE COORDINATION ACTIVITIES</th>
<th>MEASUREMENT PERSPECTIVE: Patient/Family Perspective¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish accountability or negotiate</td>
<td>3, 4a, 4b, 4c, 6, 9b, 11a, 13, 14, 16c, 17a, 17b, 26, 32, 37, 40, 42, 45, 48</td>
</tr>
<tr>
<td>Communicate</td>
<td>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</td>
</tr>
<tr>
<td><em>Interpersonal communication</em></td>
<td>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</td>
</tr>
<tr>
<td><em>Information transfer</em></td>
<td>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, 51</td>
</tr>
<tr>
<td>Facilitate transitions²</td>
<td></td>
</tr>
<tr>
<td><em>Across settings</em></td>
<td>9a, 9b, 13, 14, 16c, 17a, 17b, 21, 26, 31, 32, 37, 38a, 38b, 40, 42, 51</td>
</tr>
<tr>
<td><em>As coordination needs change</em></td>
<td>11a, 14, 24</td>
</tr>
<tr>
<td>Assess needs and goals</td>
<td>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</td>
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</table>
How can you use the *Atlas* to find measures?

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

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

<table>
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</table>
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?

Total Number of Measure Instruments, by Domain

- Establish Accountability or Negotiate Responsibility
- Communication
- Facilitate Transitions Across Settings
- Facilitate Transitions As Coordination Needs Change
- Assess Needs & Goals
- Create Proactive Plan of Care
- Monitor, Follow-Up & Respond to Change
- Support Self-management Goals
- Link to Community Resources
- Align Resources with Patient & Pop. Needs
- Teamwork Focused on Coordination
- Health Care Home
- Care Management
- Medication Management
- Health IT-enabled Coordination

Note: 101 measure instruments; most assess multiple domains
Close-up: Types of Communication

Measure Instruments, by Types of Communication

- Any Communication
- Communicate
- Interpersonal Communication
- Information Transfer

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

<table>
<thead>
<tr>
<th>Survey Item</th>
<th>Measure Instrument</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Is there a staff person or <strong>care coordinator</strong> that helps families coordinate care?</td>
<td>Family-Centered Care Self-Assessment Tool (Family Version and Provider Version)</td>
</tr>
<tr>
<td></td>
<td>Family Voices</td>
</tr>
<tr>
<td>• Does anyone <strong>help you arrange or coordinate</strong> your child’s care among the different doctors or services that he/she uses?</td>
<td>National Survey of Children with Special Health Care Needs (CSHCN)</td>
</tr>
<tr>
<td></td>
<td><em>Child and Adolescent Health Measurement Initiative (CAHMI)</em></td>
</tr>
<tr>
<td>• A designated <strong>care coordinator</strong> ensures the availability of these activities including written care plans with ongoing monitoring</td>
<td>Medical Home Index</td>
</tr>
<tr>
<td></td>
<td><em>Center for Medical Home Improvement</em></td>
</tr>
<tr>
<td>• Will most of this patient’s aftercare be provided in your program by the same person who served as the patient’s primary <strong>counselor/case manager</strong> during intensive substance use disorder treatment?</td>
<td>Continuity of Care Practices Survey - Individual Level</td>
</tr>
</tbody>
</table>
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

EHR-based Care Coordination Measures Today

- Establish Accountability or...
- Communicate
- Facilitate Transitions
- Assess Needs and Goals
- Create a Proactive Plan of Care
- Monitor, Follow Up &...
- Support Self-Management...
- Link to Community Resources
- Align Resources with Patient...
- Teamwork Focused on...
- Health Care Home
- Care Management
- Medication Management
- Health IT-Enabled...

Total Measures
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

**Coming Soon from AHRQ**
- Updated *Care Coordination Measures Atlas*
- Care Coordination Measures Database (interactive search)

**Other Atlas Resources from AHRQ**
- *Clinical Community Relationships Atlas*

- *Atlas of Integrated Behavioral Health Care Quality Measures*
  - [http://integrationacademy.ahrq.gov/atlas](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](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](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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1-856-380-6836 • Email: ccmchq@ccmcertification.org

www.ccmcertification.org
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](http://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

<table>
<thead>
<tr>
<th>Item description</th>
<th>Domain mapping</th>
</tr>
</thead>
</table>
| 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 |

### Additional Database Search Example:

<table>
<thead>
<tr>
<th>Measure #</th>
<th>Measures</th>
<th>Perspectives</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>11a</td>
<td>Family-Centered Care Self-Assessment Tool - Family Version</td>
<td>Patient/Family</td>
<td><img src="#" alt="Add to My List" /></td>
</tr>
<tr>
<td></td>
<td>To discern areas for improvement from evaluation of family satisfaction in intensive care units.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Measure Profile (PDF File, 2.2MB)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Measure Instrument (PDF File, 5.7MB)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>User’s Guide</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>National Survey of Children with Special Health Care Needs (CSHCN)</td>
<td>Patient/Family</td>
<td><img src="#" alt="Add to My List" /></td>
</tr>
<tr>
<td></td>
<td>To collect a broad range of information about children’s health and well-being in order to allow for comparisons among States as well as nationally.</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
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<tr>
<td></td>
<td>Validation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>51</td>
<td>National Survey for Children’s Health (NSCH)</td>
<td>Patient/Family</td>
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<tr>
<td></td>
<td>To assess multiple aspects of system integration within the mental health facility, and system integration between mental health, primary care, and case management for the HIV-infected patient.</td>
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</table>

- 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

| Measure                                                                 | Domains                                                                 |  | Measure                                                                 | Domains                                                                 |  | Measure                                                                 | Domains                                                                 |
|------------------------------------------------------------------------|-------------------------------------------------------------------------|  |------------------------------------------------------------------------|-------------------------------------------------------------------------|  |------------------------------------------------------------------------|-------------------------------------------------------------------------|
| Prenatal record present at the time of delivery                        | **Domains:** Info Transfer, Transitions across Settings                  |  | Communication with the physician managing ongoing care post fracture of hip, spine, or distal radius | **Domains:** Communicate, Transitions across Settings and As Needs Change |  | Communication with the physician managing ongoing care post fracture of hip, spine, or distal radius | **Domains:** Communicate, Transitions across Settings and As Needs Change |
| Critical info communicated (and received) with request for referral to specialist | **Domains:** Info transfer, Transitions across Settings, HIT-enabled coordination |  | Ability to receive lab data electronically into EHR                      | **Domains:** Info Transfer, HIT-enabled coordination                      |  | Ability to receive lab data electronically into EHR                      | **Domains:** Info Transfer, HIT-enabled coordination                      |
| 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                   |  | 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 |  | Medication Reconciliation                                               | **Domains:** Accountability, Info Transfer, Monitor & f/u, Medication Mgt |  | 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                                               |  | Specialist communicates results to patient/family                        | **Domains:** Info Transfer                                               |
| Dementia: Caregiver Education and Support                               | **Domains:** Support self-management, Link to Community Resources        |  | Dementia: Caregiver Education and Support                               | **Domains:** Support self-management, Link to Community Resources        |  | Dementia: Caregiver Education and Support                               | **Domains:** Support self-management, Link to Community Resources        |
## Sample Stage 1&2 MU Measures

<table>
<thead>
<tr>
<th>Provide patients the ability to view online, download and transmit their health information</th>
<th>Use clinically relevant information to identify and provide patient-specific education resources to the patient</th>
<th>Closing the Referral Loop: Receipt of Specialist Report</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Domain:</strong> Info transfer</td>
<td><strong>Domain:</strong> Support self-mgt</td>
<td><strong>Domains:</strong> Info Transfer, Transitions across Settings</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provide clinical summaries for patients for each office visit</th>
<th>The EP/EH who receives a patient from another setting/provider should perform med reconciliation</th>
<th>Home management plan of care document given to patient/caregiver</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Domain:</strong> Info transfer</td>
<td><strong>Domains:</strong> Med Mgt, Transitions across Settings</td>
<td><strong>Domains:</strong> Info Transfer, Plan of Care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care</th>
<th>The EP/EH who transitions or refers their patient to another setting/provider should provide a summary care record</th>
<th>Use secure electronic messaging to communicate with patients on relevant health information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Domains:</strong> Monitor &amp; f/u, Align resources</td>
<td><strong>Domain:</strong> Transitions across Settings</td>
<td><strong>Domain:</strong> Info Transfer</td>
</tr>
</tbody>
</table>
## Case Management Activities Increasingly Captured in Proposed Stage 3 MU Measures

### Sample of Current and Proposed Meaningful Use Measures

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

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