Care Coordination Measure Development

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Care Coordination Measure Development

Objectives

- Definition of Care Coordination
- CMS 2016 Quality Strategy
  - Mission
  - Goals
- Care Coordination and Medicare Advantage
- Current Measure Development Work
  - NCQA
  - IMPAQ

Polling Question

Care Coordination is:

A. 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.

B. Organizing care that involves the marshalling of personnel and other resources needed to carry out all required patient care activities.

C. Often managed by the exchange of information among participants responsible for different aspects of care.

D. All of the above.

CMS 2016 Quality Strategy Mission

- Optimize health outcomes by leading clinical quality improvement and health system transformation.

1. Make care safer by reducing harm caused in the delivery of care.
2. Strengthen person & family engagement as partners in their care.
3. **Promote effective communication and care coordination of care.**
4. Promote effective prevention and treatment of chronic diseases.
5. Work with communities to promote best practices of healthy living.
6. Make care affordable.

CMS 2016 Quality Strategy Mission (cont.)

- Quality Strategy Goal #3
  - Promote Effective Communication and Coordination of Care—objectives:
    - Reduce admissions and readmissions
    - Embed best practices to enable successful transitions between all settings of care
    - Enable effective health care system navigation

CMS 2016 Quality Strategy Mission (cont.)

- **CMS aims to achieve these objectives by:**
  - Promoting increased care coordination across the healthcare continuum;
  - Promoting a person-centered approach to coordination of care; and
  - Recognizing the positive impact of having critical pieces of information communicated across all providers and settings of care

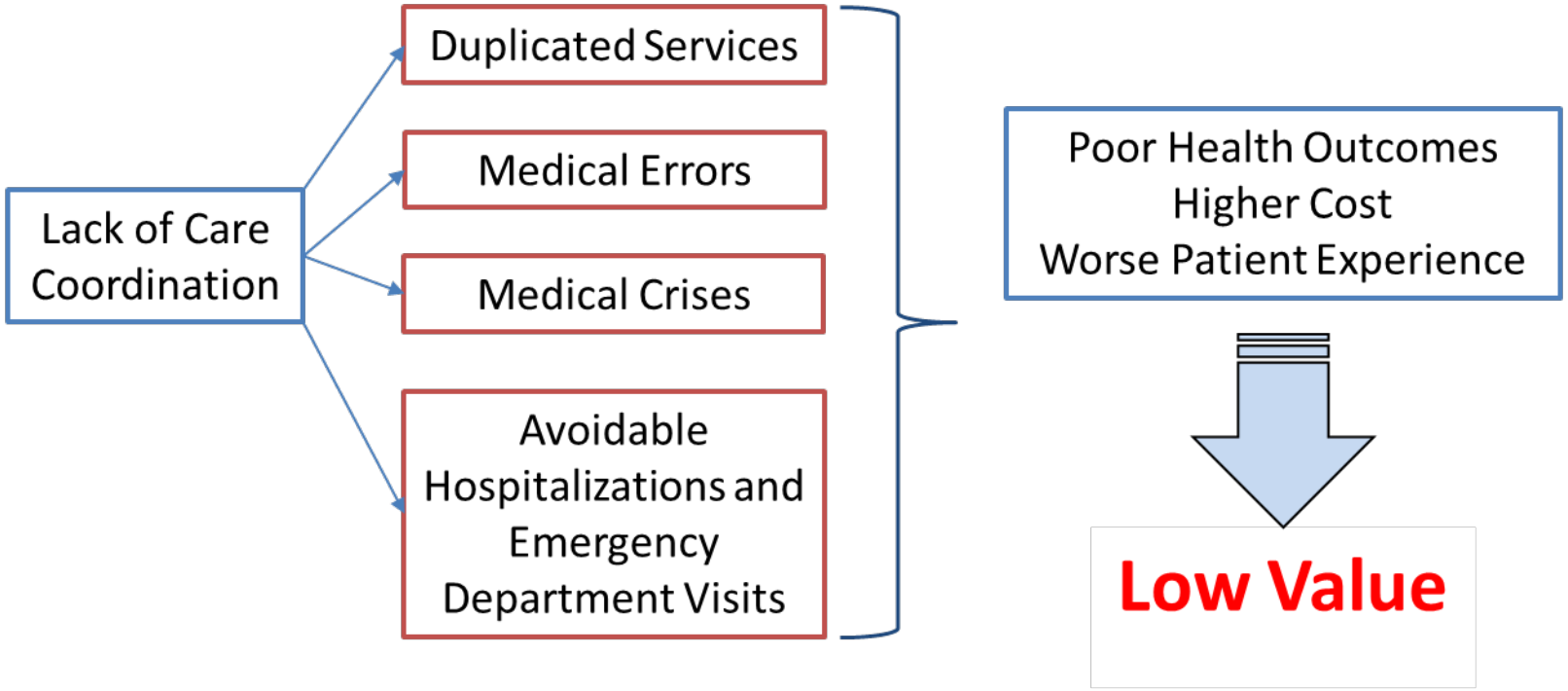
Care Coordination and MA

- 2017 Call Letter
  - Expanding efforts to identify effective care coordination measures
  - Target population
  - Identify relevant activities
  - Various data sources
- Measures will provide comparative information on care coordination services provided to Medicare beneficiaries enrolled in MA plans

Care Coordination Measure Development Work

- Work by:
  - NCQA
  - IMPAQ International
- Different approaches
- Both utilize the CMS Measures Management System Blueprint (Version 11.1)
  - Recommended processes and decision criteria used to oversee the development, implementation, and maintenance of health care quality measures

Importance


Lack of Care Coordination
Duplicated Services
Medical Errors
Medical Crises
Avoidable Hospitalizations and Emergency Department Visits
Poor Health Outcomes
Higher Cost
Worse Patient Experience
Low Value

Opportunity for Improvement

- Older adults often see multiple providers who operate in silos – Median of 7 providers per year
- Medicare Advantage Plans are in a unique position to see the whole person's care

Identifying New Measure Concepts

- Targeted research
  - Literature review
  - Measure mapping exercise
  - Discussions with high-performing Medicare health plans
- Expert panel and stakeholder feedback
  - Care Coordination Expert Workgroup
  - Geriatric Measurement Advisory Panel (GMAP)
  - Committee on Performance Measurement

Refining Measure Concepts

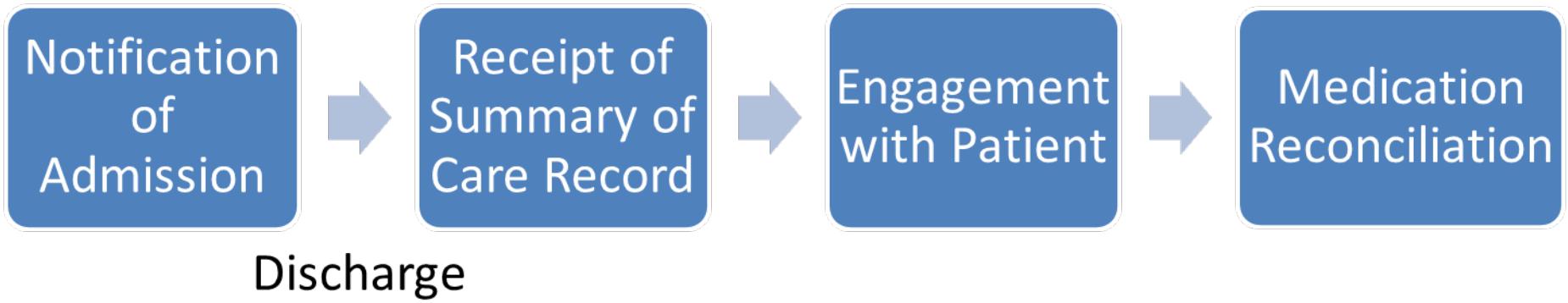
- Narrowed down list of measure concepts with input from expert workgroup and Geriatric Measurement Advisory Panel
  - What can be reliably, validly, and feasibly measured?
  - What are the high-risk populations and settings?
  - How can we minimize data collection burden?

Current Draft Measure Set

- Measures grouped into two care coordination domains based on risk of poor outcomes:
  - Transitions of care from inpatient to outpatient
  - Patients with multiple chronic conditions
- Six proposed measures focused on:
  - Critical elements of evidenced-based transitions model of care
  - Communications between clinicians
  - Assessment and care planning

Transitions of Care

- Assesses critical activities during transition from inpatient setting to community



Polling Question

- Which measure do you think is most reflective of high quality care coordination?
  A. Notification of Inpatient Admission
  B. Receipt of Summary of Care Record
  C. Medication Reconciliation Post-Discharge
  D. Patient Engagement after Inpatient Discharge

Transitions of Care Draft Measures

- Testing Results
  - Notification of Inpatient Admission – 41.4%
  - Receipt of Summary of Care Record – 43.4%
  - Medication Reconciliation Post-Discharge – 23.0%
  - Patient Engagement after Inpatient Discharge – 69.6%
- Next Steps
  - Recommending for inclusion in HEDIS 2018 Public Comment Period

Patients with Multiple Chronic Conditions

- Assess care coordination for beneficiaries with 3+ chronic conditions
- Proposed measures:
  - Comprehensive Assessment of Needs and Goals
  - Specialist Provides Visit Summary to Primary Care Provider
  - Follow-up after Emergency Department Visit

Polling Question

- Which measure concept do you think is the most reflective of high quality care coordination?
  A. Comprehensive Assessment of Needs and Goals
  B. Specialist Provides Visit Summary to Primary Care Provider
  C. Follow-Up after Emergency Department Visit

Patients with Multiple Chronic Conditions Draft Measures

- Testing Results
  - Follow-Up After Emergency Department Visit (within 7 days) – 34.0%
  - Comprehensive Assessment – Testing 2017
  - Specialist Provides Visit Summary to Primary Care Provider – Testing 2017
- Next Steps
  - Recommending Follow-Up After ED Visit for inclusion in HEDIS 2018 Public Comment Period

Key Encounter Data Elements

- Medicare Advantage Plan Information
  - Data contains nearly all MA plans and their beneficiaries, as validated by external sources
- Beneficiary Information
  - Data appears to be well populated for the calculation of care coordination measures, as validated by external sources and completeness tests
- Encounter Information (ICD, HCPCS)
  - Most encounters contain the required ICD and HCPCS
  - Data allows for longitudinal tracking and inclusion of new and updated value sets

Health Plan Summary Statistics

Number of MA Enrollees (2014)		
# Beneficiaries Enrolled in MA	# Beneficiaries with Encounters	% Beneficiaries with Encounters
17,582,957	16,497,590	93.8%

Number of MA Plans (2014)		
# Plans with Enrollment	# Plans with Encounters	% Plans with Encounters
3,255	3,218	99.0%

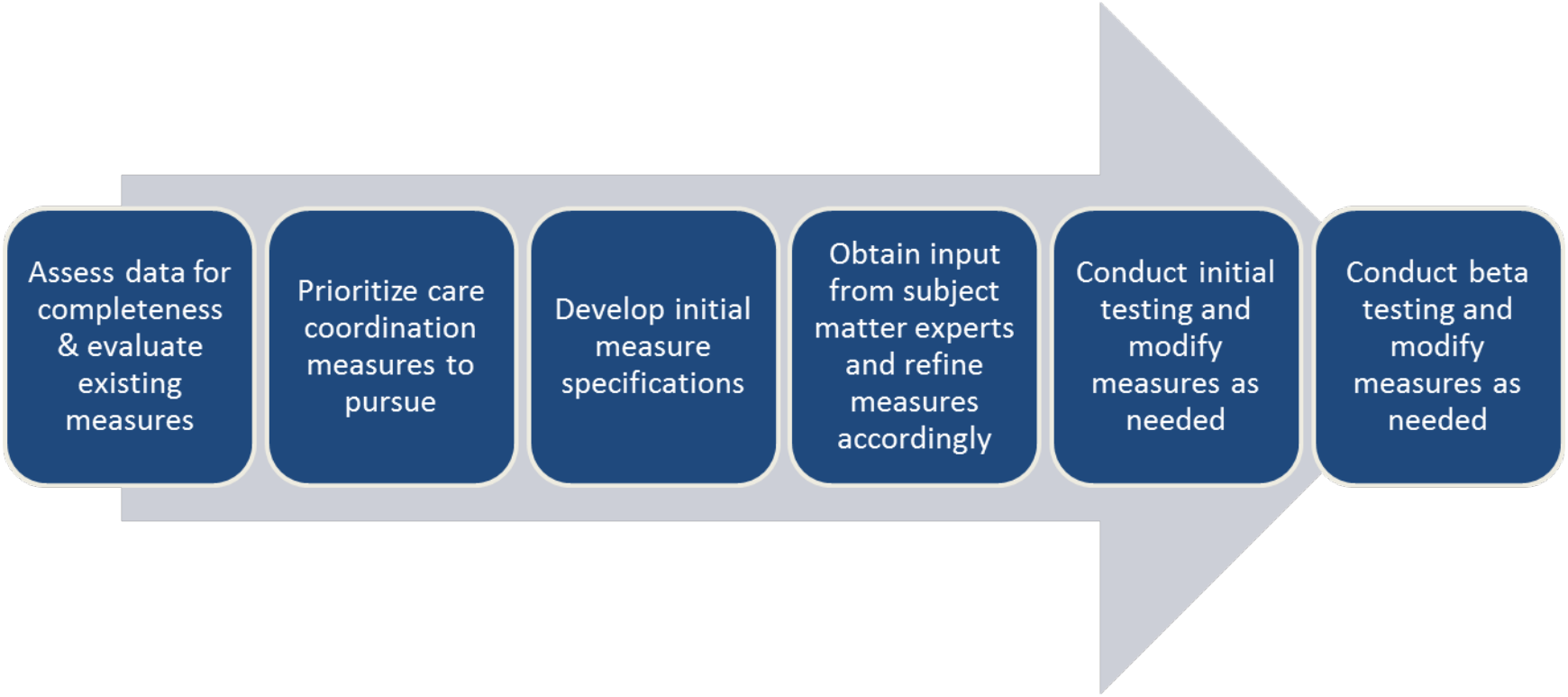
Beneficiary Summary Statistics

Characteristic (2014)	# of Encounters	% of Encounters	# of Beneficiaries	% of Beneficiaries
18 to 64 years old	67,481,071	15.5%	2,238,152	13.6%
65 to 74 years old	180,462,216	41.4%	7,818,953	47.4%
≥ 75 years old	187,570,045	43.1%	6,440,467	39.0%
Female	252,947,799	58.1%	9,411,353	57.0%
White	345,560,205	79.3%	13,018,581	78.9%
Black	53,973,792	12.4%	1,920,211	11.6%
Other	33,235,343	7.6%	1,419,014	8.6%

Chronic Condition Summary Statistics

Chronic Condition (2014)	# of Encounters	% of Encounters	# of Beneficiaries	% of Beneficiaries
Asthma	7,912,901	1.80%	1,459,621	8.80%
Heart Failure	20,225,644	4.60%	1,776,464	10.80%
COPD	29,705,383	6.80%	2,849,893	17.30%
Diabetes	82,908,498	19.00%	5,456,760	33.10%
Hypertension	96,673,793	22.20%	11,756,423	71.30%
Mental Health	33,518,483	7.70%	4,535,399	27.50%
Substance Abuse	2,674,486	0.60%	507,456	3.10%

Measure Development Milestones



Conceptual Framework

- Quantifiable evidence for the deliberate organization of patient care activities between two or more participants involved in a patient's care:
  - Process measures on practices that enable successful transitions between all settings of care
  - Proxy outcome measures that could be indicative of good or poor care coordination

Literature Review

- Conducted literature review to identify:
  - Care coordination measure topics
  - Essential components of successful care coordination
  - Current mechanisms to measure coordination
- Based on results, identified care coordination measurement domains

Evaluation of Proposed Measures Identified in Literature Review

- Identified several potential unique measures for care coordination
- Evaluated each measure based on:
  - Relevance to care coordination
  - Feasibility for implementation
  - Measure type
- Identified set of measures that are highly relevant to care coordination and feasible to construct with encounter data

Care Coordination Measure Set

- Adapt 4 existing measures
  - Closely align with CMS' objectives to enable successful transitions between all settings of care and to reduce (re)admissions
  - Focus on vulnerable populations for whom care coordination is critical
- Develop 5 de novo measures
  - Address current gaps in coordination measurement
  - Focus on high-prevalence and high-cost chronic conditions (heart failure and diabetes) and events (duplication of testing)

Existing Measures

1) Proportion of Patients with a Chronic Condition that have a Potentially Avoidable Complication (PAC) during a Calendar Year (NQF #0709)
2) Follow-Up after Discharge from the Emergency Department for Mental Health (NQF #2605)
3) Follow-Up after Discharge from the Emergency Department for Alcohol or Other Drug Dependence (NQF #2605)
4) Follow-Up after Hospitalization for Mental Illness (NQF #0576)

De Novo Measures

1) Follow-Up after Discharge from the Emergency Department for Diabetes
2) Follow-Up after Discharge from the Emergency Department for Heart Failure
3) Follow-Up after Hospitalization for Diabetes
4) Follow-Up after Hospitalization for Heart Failure
5) Duplication of HbA1c Tests

Adaption of Existing Measures and Development of De Novo Measures

- Conducted extensive search on relevant literature to establish relevance and significance within MA context
- Modified numerator, denominator, and exclusion rules to align with data source and context
- Developed value sets needed to construct measures
- Consulted with SMEs and TEP members
- Conducting initial testing and modifying measures as needed

Next Steps

- Comprehensive and rigorous beta testing and validation of the measures, including:
  - Assessment of meaningful differences
  - Exclusions testing
  - Risk adjustment testing
  - Measure score reliability testing
  - Validity testing

Resources

Questions?

- Contact the MA Policy Mailbox Portal at https://dpap.lmi.org

Resources:

- Agency for Healthcare Research and Quality Care Coordination Measures Atlas, Updated June 2014
- CMS 2016 Quality Strategy
- A Blueprint for the CMS Measures Management System Version 11.1 August 2015