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Measuring Care Coordination in Medical Homes

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Patient-centered medical homes offer accessible, coordinated, comprehensive care focused on patients' needs. One of the primary activities of the medical home is care coordination, which involves sharing test results with patients and all of their providers, ensuring patients have follow-up appointments, and much more. Effective care coordination results in better outcomes, reduced waste and duplication, and higher patient satisfaction. Through a care team, which includes not only the primary care provider, but also nurses, medical assistants, and other office staff, medical homes are responsible for coordinating care with patients, among providers within a practice, and with providers in other settings. To understand if patients' needs are being met, routine performance measurement and reporting about the effectiveness and quality of care coordination are critical.

In a guide released today by the Patient-Centered Primary Care Collaborative, a chapter by Commonwealth Fund staff outlines seven key strategies to help health systems effectively measure care coordination as a routine part of medical home activities.

The seven strategies are:

1. Work with a broad stakeholder group to reach consensus on measures.
   For health care professionals to believe in and act on the results of a care coordination improvement effort, a broad group of stakeholders—with representation from every level of the organization—needs to be engaged in the design of the intervention, including the selection of measures used to observe both positive and negative effects.
2. Clarify purpose of measurement: quality improvement, accountability, evaluation?
   Be clear about the purpose of assessing your care coordination activities because different objectives will lead to different data collection strategies, reporting requirements, and follow-up. The objectives need not be mutually exclusive, but transparency about the primary purpose—and target audience—will drive key decisions about measure selection, data collection, and reporting. Read a summary of three primary measurement objectives—quality improvement, accountability, and evaluation—and the implications for the medical home.
3. Use standardized measures.
   Whenever possible, it's best to use validated, standardized measures to assess health care quality, and care coordination initiatives are no exception. The Agency for Healthcare Research and Quality (AHRQ) and the National Quality Forum (NQF) recently produced useful frameworks to help organizations select care coordination quality measures (summarized in Table 1 below).
4. Incorporate patient feedback in assessing quality of care coordination.
   A medical home cannot call itself patient- and family-centered if it does not actively engage patients, including obtaining feedback to evaluate the consumer's experience with care coordination. In addition to its value as an independent domain of quality, positive patient experience is associated with improved clinical outcomes, increased medication adherence, reduced medical malpractice risk, and increased physician loyalty and retention.
5. Develop a tracking system that facilitates ongoing monitoring of performance.
   To effectively coordinate care for patients, medical homes need to implement protocols that systematize referrals, transitions, and co-management between the primary care practice and other providers in their "medical neighborhood." To assess practice performance on care coordination, primary care sites need to set up methods and procedures that build on this underlying referral/transition tracking system.
6. Build and nurture relationships with providers outside of your medical home—the "medical neighborhood"—to facilitate data sharing, monitoring, and improvement.
   The success of the technical system of care coordination depends on the strength of the interpersonal relationships between the individual clinicians and organizations. Without familiarity and shared objectives, the administrative transfer of information will not occur or be sustained. Ongoing use of the broad stakeholder group, as well as joint review of performance data at meetings, can help foster a community of continuous quality improvement among multiple providers.
7. Use the data to improve care coordination. Share results at the practice and care-team levels.
   All organizations working on improving care coordination need to regularly review the goals and performance data, collect stories from staff, brainstorm solutions, and test those ideas through quality improvement efforts.

Improving care coordination within and among health care settings is a critical step to achieving high performance in the U.S. health care system. And obtaining information about care coordination performance can help identify weaknesses, stimulate improvement, and track progress. Practice systems that enable routine data collection, standardization of measures, involvement of patients and staff, and systematic processes to respond to poor performance will bring us one step closer to achieving better-coordinated, higher-value care for all patients.

Table 1. Resources to Help Organizations Select Care Coordination Measures	
Tool	Description
AHRQ's Care Coordination Measures Atlas	A framework for care coordination measurement, documenting and mapping more than 60 existing measures to key care coordination activities and different perspectives of key stakeholders.
National Quality Forum's National Priorities Partnership	Measures aimed to 1) improve care and achieve quality by facilitating and carefully considering feedback from all patients regarding coordination of their care, 2) improve communication around medication information, 3) work to reduce 30-day hospital readmission rates, and 4) work to reduce preventable hospital emergency department visits by 50 percent. Highlighted measures focus on coordination in specific areas of clinical care, such as cardiac rehabilitation, stroke, and cancer, as well as transitions from inpatient to other settings.
NCQA Care Coordination Measures	In its 2011 patient-centered medical home (PCMH) standards, NCQA incorporated a number of process measures that indicate care coordination. This table provides summarizes the process measures, or elements, from the NCQA PCMH standards.
The MacColl Institute for Healthcare Innovation, Group Health Research Institute's Care Coordination Questions from Validated Instruments	In this table, MacColl Institute for Healthcare Innovation compares care coordination questions from validated patient experience surveys. The table is an appendix to a larger implementation guide to improve care coordination in medical homes.
Centers for Medicare and Medicaid Services' (CMS) The Physician Quality Reporting System	The goal of this CMS initiative is to provide an incentive payment for eligible professionals who satisfactorily report data on quality measures for professional services furnished to Medicare beneficiaries. One hundred thirty-one searchable quality measures are available from the American Medical Association.
The Care Transitions Program® Care Transitions Measure (CTM®)	This 15-item uni-dimensional measure, developed by Eric Coleman, M.D., assesses the quality of care transitions. The measure is applicable to a variety of settings, including skilled nursing facilities, rehabilitation, and other locations patients are likely to utilize during transition.

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