



# NATIONAL QUALITY FORUM

Driving measurable health  
improvements together

## Leveraging Electronic Health Record (EHR) Sourced Measures to Improve Care Communication and Coordination

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The Base Year of the Leveraging Electronic Health Record (EHR) Sourced Measure to Improve Care Communication and Coordination project described the current state of using EHRs to measure and improve care communication and care coordination. The Option Year One will build on this work to develop consensus-based recommendations for facilitating and improving EHR-based care communication and care coordination measurement in an all-payer, cross-setting, and fully electronic manner to drive quality improvement and outcomes. Recommendations will be provided for:

1. How EHRs could better facilitate care communication and care coordination
2. How existing and future development of EHR-sourced measures can be leveraged to improve care communication and care coordination
3. Addressing social determinants of health (SDOH) data collected by EHRs as it relates to care communication and care coordination
4. Possible EHR-sourced measure concepts related to care communication and care coordination

These recommendations will be conveyed in a Final Recommendations Report.

Below, themes and related examples identified during the Base Year from Committee discussions and the development of the Environmental Scan Report. Web Meeting One will involve a discussion around these themes and examples to support the development of recommendations in Web Meetings Two, Three, and Four. Web Meeting Five will center on providing feedback and refining the early draft of the Final Recommendations Report. Web Meeting Six will be after the public comment period and will be used to adjudicate comments received.

### Themes and Examples from the Base Year

- Availability of Data in EHRs
  - How to incorporate data from clinicians, mobile devices, wearables, and other sources
  - How to capture activities for those who do not document in an EHR
  - How to capture community-based activities
  - How to identify all team members in the EHR involved in patient care, both healthcare providers and non-healthcare providers – for communication/coordination and accountability/attribution
  - Standard data set for all care transitions
  - Training for how to use the EHR
- Sharing EHR Data
  - Lack of interoperability to share and access data (e.g., across different health systems, with independent organizations, etc. and with different EHR vendors)
  - Impact of health information exchanges (HIEs), especially for non-hospital settings
  - Democratized data
  - Integrating with rapid innovation in health information technology (IT)

- Connecting data with social service providers and tracking with the EHR
- Barriers in Using and Sharing EHR Data
  - Lack of interoperability
  - Lack of standards for structured data
  - Use of unstructured data
  - Use of inconsistent coding
  - Competition in the EHR market
- Equity Considerations
  - Advancing equity as a lens for all recommendations
  - Provider access to EHRs (some EHRs are more advanced than others)
  - Digital divide/issues related to high-speed internet infrastructure and patient access to technology
  - Enabling standardized SDOH data collection within EHRs
  - Availability of SDOH data within EHRs for measure stratification
- Need for a Single/Overall Care Plan
  - Example: skilled nursing facilities Comprehensive Minimum Data Set
  - Identified care communication and care coordination activities:
    - Improving patient and caregiver engagement
    - Developing and implementing care plans including the patient's goals
    - Enhancing transitions in care
    - Promoting cross-disciplinary coordination to integrate care
    - Using closed-loop communication
    - Deploying risk assessments and stratifications
    - Participating in case management
    - Encouraging patients and caregivers to use navigation resources
    - Using shared decision making
    - Delivering team-based care
- Role of EHR-Based Tools (e.g., patient portals, decision support/electronic triggers)
  - Patient portal considerations
    - Must be used and usable
    - Need alternatives for patients who do not find portals to be feasible or practical
- Measurement Considerations
  - Prioritization of specific types of measures (e.g., outcome, structural, process, utilization)
  - How to have measures beyond using a "check-box" to indicate an activity occurred
  - How can EHR data be used to improve current measures
    - More detailed data/more precise specifications
    - Measure outcomes that are not as directly observable in claims data
    - Use of EHR-based tools to improve care communication and care coordination
  - Measuring patient/family experience from the EHR
  - Measuring provider experience from the EHR
- Measure Endorsement Barriers
  - Care communication and care coordination processes lack sufficient evidence to link them to outcomes
  - Limited uptake of process measures resulting in limited or no data for analysis to demonstrate usability or feasibility
- Need for Standardizing SDOH Data Collection
  - SDOH assessment not routinely part of the medical evaluation

- Data not captured in the EHR (not built into the system)
- Inconsistent and/or inaccurate language used in unstructured notes
- Identifying responsibility for who should collect, assess, and address the data
- Collection of race, ethnicity, language, and disability (R/E/L/D) data
- Reimbursement for collecting this data, where to store it
- Ability to share SDOH data across systems
- Considerations for Machine-Learning Algorithms
  - How the algorithms are created
  - What data might be missing from the algorithm
  - Concern algorithm may amplify disparities by preferentially assessing risk or targeting interventions
- Possible measure concepts (novel or re-specified from already developed measures):
  - Pair provider experience with patient experience – Quadruple Aim
  - Improving existing readmission measures
  - Stratifying existing utilization measures
  - Long-Term Services and Supports Comprehensive Care Plan (LTSS-CPU) as a model
  - Potential concepts for portals (from public comment):
    - Data as to the use of patient portals, including whether patients sign up for the portal
    - Whether patients who are signed up for the portal access important items (e.g., the patient plan of care)
    - Whether messages entered by the patient are responded to within a particular period
    - Experience of patients in using portals to improve usability and use
    - Pushing information to patients who so opt via email or text rather than require patients to pull the information
    - Whether there are alternative, easily used, and accessible methods of communication, particularly telephone, available to patients who do not sign up for the portal or who cannot effectively use IT systems. This applies particularly to the very elderly for whom telephone communication options would often be much more suitable.

## Discussion Questions

1. What are the gaps in the themes included above?
2. Which themes should be prioritized for recommendation development?
3. Which themes or topics are overarching and should be applied across all recommendations (e.g., equity, patient centeredness)?
4. What additional topics should be included for recommendation development?