 Breakout Room Worksheet

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

# Web Meeting 5

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 is building on this work to develop 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 are being provided for:

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

These recommendations are conveyed in two Final Recommendations Reports (a long, technical version and a shortened, non-technical version).

## Overview of Previous Committee Meetings

The Base Year themes discussed at *Web Meeting 1* were streamlined into themes related to how to effectively facilitate care communication and care coordination with EHRs. These themes came from the environmental scan and updates based on Committee feedback, Web Meeting 1 discussions, and responses to surveys sent after the meeting. *Web Meeting 2* focused on obtaining feedback on recommendations for the specific EHR functions, capabilities, and capacities for effective care communication and care coordination from the Committee. *Web Meeting 3* focused on how EHR data on SDOH can be used to improve care communication and care coordination. The Committee reviewed the work of the Gravity Project which aims to standardized EHR data for SDOH and provided recommendations for how SDOH data can be used to improve care communication and care coordination and in quality measurement. In *Web Meeting 4*, the Committee began to discuss how existing and future development of EHR-sourced measures can be leveraged to improve care communication and care coordination and to develop possible measure concepts (an idea for a measure, novel or re-specified from already developed measures).

NQF synthesized these previous discussions to develop recommendations that were incorporated into the early drafts of both versions of the Final Recommendations Reports. These reports were sent to the Committee for their review on May 13. **NQF requests the Committee’s written feedback by May 27.** Additional discussion about these recommendations will also occur during Web Meeting 5.

## Web Meeting 5 Discussion and Breakout Groups

The intent of **Web Meeting 5 (May 24)** is to further refine the recommendations for approaches to using detailed EHR data to improve measurement of care communication and care coordination by:

* Prioritizing possible EHR-sourced measure concepts to improve care communication and care coordination.
* Identifying specific EHR data elements needed to measure care communication and care coordination.

### Part 1: Prioritizing Possible EHR-Sourced Measure Concepts *(30 minutes)*

*Directions: Please review the possible EHR-source measure concepts to improve care communication and care coordination. During the Web Meeting 5 Breakout Group, the Committee will discuss these possible measure concepts in terms of* ***importance and feasibility*** *in the short, intermediate, and long term. Before the meeting, please review the measure possible measure concepts and place them in the chart below.*

1. **Hospital readmissions within 30 days of discharge:** Readmissions are a common measure of quality in claims data. These measures could be respecified to include more detailed data about why the readmission occurred, using structured fields completed by the treating clinician and/or patients. Because many causes for readmissions are unrelated to care communication and care coordination (e.g., clinical progression, patient choice, or emergency care unrelated to an original diagnosis), this would allow the measure to be more specific to modifiable processes associated with the measurement of care communication or care coordination.
2. **Unexpected return ED visits within 72 hours of discharge with hospital admission:** After emergency care, gaps in care communication and care communication may result in another hospital admission within a short period of time. Similar to the readmissions measure, clinicians and non-clinicians could provide information on why these returns to the hospital occurred and if the returns were associated with a care communication or care coordination process.
3. **Frequency of duplicate, unnecessary testing (i.e., repeat imaging or laboratory tests):** Duplicate, unnecessary testing is common. This novel measure concept would assess the rate of duplicate testing within specific periods of time (e.g., normal laboratory tests on the same day across settings or repeated imaging such as a computed tomography (CT) or magnetic resonance imaging (MRI) within the same day or week without a clear indication for repeat imaging).
4. **Frequency of follow-up care that was not completed within the recommended time frame:** Several existing measures identify specific follow-up periods based on expert opinion. For example, for patients with new antipsychotic medications, a 28-day follow-up appointment is used to assess quality. EHRs give more detail on specific follow-up dates recommended within clinician encounters that could more precisely assess whether an individual patient’s recommended follow-up occurred.
5. **Frequency of specific medical errors related to care communication and care coordination:** Existing measures of medication appropriateness rely on linking pharmacy claims data to claims or recommend that specific actions (e.g., medication reconciliation) be performed within settings. Outcome measures related to medications could be created, such as the presence of medications with high-risk interactions (e.g., where there is no clinical justification) or duplicative medication orders (e.g., multiple prescriptions from different providers for similar medications).
6. **Patient engagement with care coordination / clinician communication / care integration:** Using standardized data, novel measures could assess patient and caregiver engagement with their care communication and care coordination (e.g., did the patient perceive that care delivery is aligned with the care plan).
7. **Utilization of patient portals, responsiveness of clinicians:** EHRs are configured to measure processes related to patient and caregiver engagement with the patient portal. The Committee recommend assessing specific clinician actions in response to patient queries, such as response to emails. This could also be included in the patient engagement with their care data.
8. **Assessing whether care goals are met:** A measure could utilize standardized data from patients to assess whether specific care goals are being met. The types of goals measures could include function and symptom-related goals (e.g., adequate pain control, functional status, activities of daily living) or quality of life-related specific goals (e.g., being able to attend a wedding or walk around the home).
9. **Improving outcomes related to SDOH:** EHRs can be portals for patients to enter data on SDOH, and outcome measures can utilize these data to assess whether care needs are being met. For example, patients could self-report their food insecurity or other needs, and those reports could be captured as standardized data (e.g., as defined by the Gravity Project).
10. **Closing the loop: communication of critical test findings to the care team and patient:** A measure for closing the loop could be developed as a standardized process measure that assesses specific high-risk communications (e.g., lab or radiology results).
11. **Appropriate handoff/communication performed between clinicians for high-risk transitions:** EHR data can support a standardized process measure of appropriate handoffs (e.g., all relevant information is shared using closed-loop communication) at transitions in care. However, the measure should not increase clinician documentation burden.
12. **Care plan creation, availability, and use:** Care plans currently exist as claims-based measures. Detailed EHR-based measures of care plans could include specific information about who created the care plan, availability of the care plan within EHRs, the assessment of use and access of the care plan by clinicians, and the achievement of care goals.
13. **Interventions to address SDOH problems:** When patients present with social risk factors that put them at risk for poor health outcomes (such as food or housing insecurity), measures could evaluate whether the care team implemented appropriate interventions to address identified issues.

| Level of Importance | Feasible in the Short Term (0-12 months) | Feasible in the Intermediate Term (1-4 years) | Feasible in the Long Term (5 years or more) |
| --- | --- | --- | --- |
| High | *Please indicate which measure concepts, if any, meet this selection.* | *Please indicate which measure concepts, if any, meet this selection.* | *Please indicate which measure concepts, if any, meet this selection.* |
| Medium | *Please indicate which measure concepts, if any, meet this selection.* | *Please indicate which measure concepts, if any, meet this selection.* | *Please indicate which measure concepts, if any, meet this selection.* |
| Low | *Please indicate which measure concepts, if any, meet this selection.* | *Please indicate which measure concepts, if any, meet this selection.* | *Please indicate which measure concepts, if any, meet this selection.* |

### Part 2: Additional EHR Data Elements Entered by Patients, Family, and/or Caregivers Needed to Measure Care Communication and Care Coordination *(20 minutes)*

The Committee identified the lack of standardized feedback from patients and caregivers as a major data gap within the EHR. This gap could be addressed through the development of standardized data elements entered by patients, family members, and/or caregivers.

*Directions: Please review the topic areas and examples of potential EHR data elements below.* ***Please list your ideas for additional potential EHR data elements (new or existing) that relate to these topic areas.***

| Topic Area | Examples of Potential EHR Data Elements | Additional Potential EHR Data Elements |
| --- | --- | --- |
| Engagement with care communication and care coordination (e.g., whether shared decision-making occurred and was effective, problems with care navigation) | A standardized question about if shared decision making occurred and was understood; A standardized question about if problems occurred with care navigation | *Please list your ideas here for additional EHR data elements* |
| Perceived correctness of clinical notes | A standardized patient assessment about if clinical notes are accurate | *Please list your ideas here for additional EHR data elements* |
| Perceived alignment of care or patient participation in developing care plans | A standardized patient assessment of care alignment with goals; A standardized patient assessment of involvement in care planning | *Please list your ideas here for additional EHR data elements* |
| Self-management and activation | A standardized form that would collect data on a Patient Activation Measure (PAM) | *Please list your ideas here for additional EHR data elements* |
| Perceived equity of care received from clinicians | A standardized question that would assess perceived equity in care received | *Please list your ideas here for additional EHR data elements* |
| Perceived trust in clinicians | A standardized question that would assess perceived trust in clinicians |  |
| Perspectives on specific goals of care | A standardized question to assess whether goals of care are assessed and being met | *Please list your ideas here for additional EHR data elements* |
| Desires for specific care (e.g., advanced directives, no blood transfusions for Jehovah’s Witnesses, details related to how blood is drawn such as with topical anesthetic or through ultrasound guidance | Standardized questions around common patient preferences | *Please list your ideas here for additional EHR data elements* |

### Part 3: Feedback on Final Recommendations Reports *(10 minutes)*

If possible, please review the Final Recommendations Report and the Shortened Final Recommendations Report sent to the Committee via email on May 13. As a reminder, the content of both reports is similar, but the audiences and purposes are different. The **Final Recommendations Report** is targeted to measure developers, EHR vendors, healthcare providers, and other quality measurement stakeholders. The purpose of this recommendations report is to support the evolution of EHR-based care communication and care coordination and performance measurement to drive quality improvement and equitable health outcomes. The **Shortened Final Recommendations Report** is targeted to changemakers, policy and legislative professionals, and nontechnical individuals. The purpose of this non-technical report is to educate a broad audience of individuals who are interested in the topic may or may not have healthcare expertise in the topic area.

Please consider the following discussion questions:

1. Do the recommendations in the Final Recommendations Report resonate with you? Are any recommendations missing or should be clarified?
2. Do you feel that the Shortened Final Recommendations Reports includes sufficient information regarding the recommendations, is accessible to its respective intended audience, and has an educational tone? If not, what suggestions do you have to improve the report?