Connecticut Quality Council
2022 Annual Review of the Core Measure Set
February 17, 2022 Meeting
Measure Specifications

Quality ID #374: Closing the Referral Loop: Receipt of Specialist Report
– National Quality Strategy Domain: Communication and Care Coordination
– Meaningful Measure Area: Transfer of Health Information and Interoperability

2022 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Process – High Priority

DESCRIPTION:
Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.

INSTRUCTIONS:
This measure is to be submitted a minimum of **once per performance period** for all patients with a referral during the performance period. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions described in the measure for the patients for whom a referral was made during the performance period based on the services provided and the measure-specific denominator coding. The provider who refers the patient to another provider is the provider who should be held accountable for the performance of this measure. All MIPS eligible professionals or eligible clinicians reporting on this measure should note that all data for the reporting year is to be submitted by the deadline established by CMS. Therefore, all MIPS eligible professionals or eligible clinicians who refer patients towards the end of the performance period (i.e., November - December), should request that providers to whom they referred their patients share their consult reports as soon as possible in order for those patients to be counted in the measure numerator during the performance period. When providers to whom patients are referred communicate the consult report as soon as possible with the referring providers, it ensures that the communication loop is closed in a timely manner and that the data is included in the submission to CMS.

NOTE: *Patient encounters for this measure conducted via telehealth (e.g., encounters coded with GQ, GT, 95, or POS 02 modifiers) are allowable.*

Measure Submission Type:
Measure data may be submitted by individual MIPS eligible clinicians, groups, or third party intermediaries. The listed denominator criteria are used to identify the intended patient population. The numerator options included in this specification are used to submit the quality actions as allowed by the measure. The quality data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this modality for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. For more information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website.

DENOMINATOR:
Number of patients, regardless of age, who had a visit during the measurement period and were referred by one provider to another provider

> ***DENOMINATOR NOTE*:** *If there are multiple referrals for a patient during the performance period, use the first referral.*
>
> **Signifies that this CPT Category I code is a non-covered service under the Medicare Part B Physician Fee Schedule (PFS). These non-covered services should be counted in the denominator population for MIPS CQMs.*
>
> **Denominator Criteria (Eligible Cases):**

Patients regardless of age on the date of the encounter

AND

Patient encounter during the performance period (CPT or HCPCS): 92002, 92004, 92012, 92014, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99381*, 99382*, 99383*, 99384*, 99385*, 99386*, 99387*, 99391*, 99392*, 99393*, 99394*, 99395*, 99396*, 99397*

AND

Patient was referred to another provider or specialist during the performance period: G9968

NUMERATOR:

Number of patients with a referral, for which the referring provider received a report from the provider to whom the patient was referred

Definitions:

Referral – A request from one physician or other eligible provider to another practitioner for evaluation, treatment, or co-management of a patient's condition. This term encompasses "referral" and consultation as defined by Centers for Medicare & Medicaid Services.

Report – A written document prepared by the eligible clinician (and staff) to whom the patient was referred and that accounts for his or her findings, provides summary of care information about findings, diagnostics, assessments and/or plans of care, and is provided to the referring eligible clinician.

NUMERATOR NOTE: *The consultant report that will successfully close the referral loop should be related to the first referral for a patient during the measurement period. If there are multiple consultant reports received by the referring provider which pertain to a particular referral, use the first consultant report to satisfy the measure.*

The provider to whom the patient was referred is responsible for sending the consultant report that will fulfill the communication. Note: this is not the same provider who would report on the measure.

Numerator Options:

Performance Met:	Provider who referred the patient to another provider received a report from the provider to whom the patient was referred **(G9969)**
OR	
Performance Not Met:	Provider who referred the patient to another provider did not receive a report from the provider to whom the patient was referred **(G9970)**

RATIONALE:

Problems in the outpatient referral and consultation process have been documented, including lack of timeliness of information and inadequate provision of information between the specialist and the requesting physician (Gandhi et al., 2000; Forrest et al., 2000; Stille et al., 2005). In a study of physician satisfaction with the outpatient referral process, Gandhi et al. (2000) found that 68% of specialists reported receiving no information from the primary care provider prior to referral visits, and 25% of primary care providers had still not received any information from specialists 4 weeks after referral visits. In another study of 963 referrals (Forrest et al., 2000), pediatricians scheduled appointments with specialists for only 39% and sent patient information to the specialists in only 51% of the time.

In a 2006 report to Congress, the Medicare Payment Advisory Commission (MedPAC) found that care coordination programs improved quality of care for patients, reduced hospitalizations, and improved adherence to evidence-based care guidelines, especially among patients with diabetes and CHD. Associations with cost-savings were less clear; this was attributed to how well the intervention group was chosen and defined, as well as the intervention put in place. Additionally, cost-savings were usually calculated in the short-term, while some argue that the greatest cost-savings accrue over time (MedPAC, 2006).

Improved mechanisms for information exchange could facilitate communication between providers, whether for time-limited referrals or consultations, on-going co-management, or during care transitions. For example, a study by Branger, van't Hooft, van der Wouden, Moorman & van Bemmel (1999) found that an electronic communication network that linked the computer-based patient records of physicians who had shared care of patients with diabetes significantly increased frequency of communications between physicians and availability of important clinical data. There was a 3-fold increase in the likelihood that the specialist provided written communication of results if the primary care physician scheduled appointments and sent patient information to the specialist (Forrest et al., 2000).

Care coordination is a focal point in the current health care reform and our nation's ambulatory health information technology (HIT) framework. The National Priorities Partnership (2008) recently highlighted care coordination as one of the most critical areas for development of quality measurement and improvement.

CLINICAL RECOMMENDATION STATEMENTS:
None

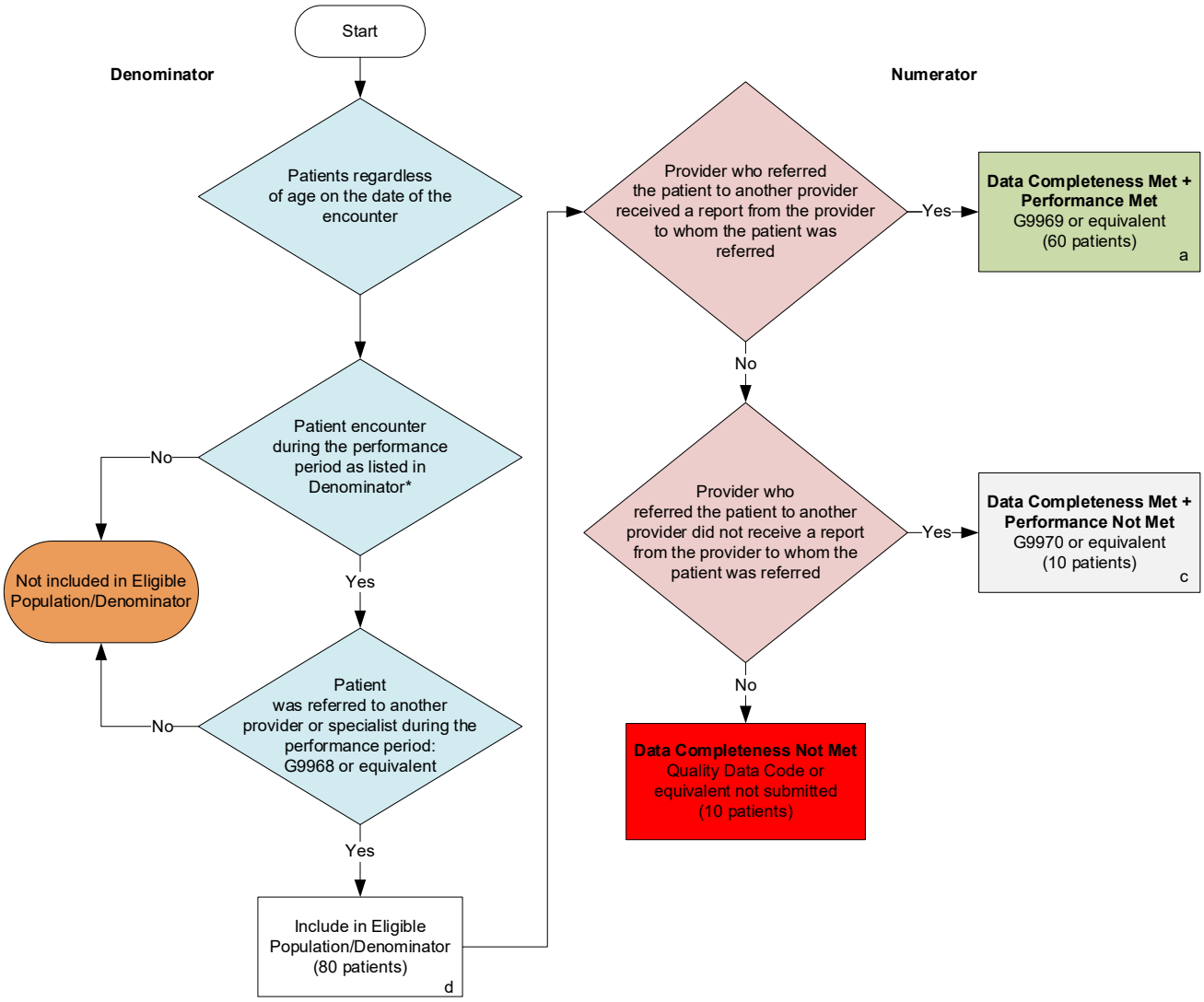
COPYRIGHT:
These performance measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications.

THE MEASURES AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.

Limited proprietary coding is contained in the measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets.

2022 Clinical Quality Measure Flow for Quality ID #374: Closing the Referral Loop: Receipt of Specialist Report

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*



SAMPLE CALCULATIONS

Data Completeness=
Performance Met (a=60 patients) + Performance Not Met (c=10 patients) = 70 patients = **87.50%**
Eligible Population / Denominator (d=80 patients) = 80 patients

Performance Rate=
Performance Met (a=60 patients) = 60 patients = **85.71%**
Data Completeness Numerator (70 patients) = 70 patients

*See the posted measure specification for specific coding and instructions to submit this measure.
NOTE: Submission Frequency: Patient-Process

v6

2022 Clinical Quality Measure Flow Narrative for Quality ID #374: Closing the Referral Loop: Receipt of Specialist Report

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*

1. Start with Denominator
2. *Patients regardless of age on the date of the encounter*
3. Check *Patient encounter during the performance period as listed in Denominator*:*
    a. If *Patient encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient encounter during the performance period as listed in Denominator** equals Yes, proceed to check *Patient was referred to another provider or specialist during the performance period.*
4. Check *Patient was referred to another provider or specialist during the performance period*:
    a. If *Patient was referred to another provider or specialist during the performance period* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient was referred to another provider or specialist during the performance period* equals Yes, include in *Eligible Population/Denominator*.
5. Denominator Population
    a. Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 patients in the Sample Calculation.
6. Start Numerator
7. Check *Provider who referred the patient to another provider received a report from the provider to whom the patient was referred*:
    a. If *Provider who referred the patient to another provider received a report from the provider to whom the patient was referred* equals Yes, include in *Data Completeness Met and Performance Met*.
        - *Data Completeness Met and Performance Met* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a equals 60 patients in the Sample Calculation.
    b. If *Provider who referred the patient to another provider received a report from the provider to whom the patient was referred* equals No, proceed to check *Provider who referred the patient to another provider did not receive a report from the provider to whom the patient was referred.*
8. Check *Provider who referred the patient to another provider did not receive a report from the provider to whom the patient was referred:*
    a. If *Provider who referred the patient to another provider did not receive a report from the provider to whom the patient was referred* equals Yes, include in *Data Completeness Met and Performance Not Met.*
        - *Data Completeness Met and Performance Not Met* letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c equals 10 patients in the Sample Calculation.

b. If *Provider who referred the patient to another provider did not receive a report from the provider to whom the patient was referred* equals No, proceed to *Data Completeness Not Met.*

9. Check *Data Completeness Not Met:*

    - If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations:

Data Completeness equals Performance Met (a equals 60 patients) plus Performance Not Met (c equals 10 patients) divided by Eligible Population/Denominator (d equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate equals Performance Met (a equals 60 patients) divided by Data Completeness Numerator (70 patients). All equals 60 patients divided by 70 patients. All equals 85.71 percent.

* See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Process

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

Interviewer: _____ Date:_____

Client Perceptions of Coordination Questionnaire (CPCQ)

<u>Health Service (General):</u> Questions 1-11 relate to the care you received for your health from any doctor or service provider in the last 3 months

1. How often did you get the services you thought you needed?

☐	☐	☐	☐	☐	☐
Never	Rarely	Sometimes	Mostly	Always	Prefer Not to Say

2. How often did you have to wait too long to obtain a service/appointment?

☐	☐	☐	☐	☐	☐
Never	Rarely	Sometimes	Mostly	Always	Prefer Not to Say

3. In the past 3 months, how often did you seem to receive the medicines you thought you needed?

☐	☐	☐	☐	☐	☐	☐
Never	Rarely	Sometimes	Mostly	Always	Not Applicable	Prefer Not to Say

4. How often were the results of tests discussed with you (e.g. blood tests)?

☐	☐	☐	☐	☐	☐	☐
Never	Rarely	Sometimes	Mostly	Always	Not Applicable	Prefer Not to Say

5. In the past 3 months, how often did you feel the care you received was well coordinated?

☐	☐	☐	☐	☐	☐
Never	Rarely	Sometimes	Mostly	Always	Prefer Not to Say

6. How often were you happy with the quality of care you received?

☐	☐	☐	☐	☐	☐
Never	Rarely	Sometimes	Mostly	Always	Prefer Not to Say

7. In the past 3 months, how often have service providers responded appropriately to changes in your needs?

☐	☐	☐	☐	☐	☐	☐
Never	Rarely	Sometimes	Mostly	Always	Not Applicable	Prefer Not to Say

8. How often did you seem to get conflicting advice from service providers?

☐	☐	☐	☐	☐	☐
Never	Rarely	Sometimes	Mostly	Always	Prefer Not to Say

9. In the past 3 months, how often have you felt like complaining about any of your care?

☐	☐	☐	☐	☐	☐
Never	Rarely	Sometimes	Mostly	Always	Prefer Not to Say

10. How well did you feel you understood your conditions?

☐	☐	☐	☐
Not at all well	Fairly well	Very well	Prefer Not to Say

11. Overall, how satisfied are you with the care you have received in the past 3 months?

☐	☐	☐	☐	☐	☐
Very dissatisfied	Moderately dissatisfied	Neutral	Moderately satisfied	Very satisfied	Prefer Not to Say

<u>Primary Care Practitioner:</u> Questions 12-15 relate to the care you have received from your Primary Care Provider (PCP) in the last 3 months

12. How often did you and your PCP agree about your care needs?

☐	☐	☐	☐	☐	☐	☐
Never	Rarely	Sometimes	Mostly	Always	Not Applicable	Prefer Not to Say

13. How often did your PCP seem to be communicating with your other providers?

☐	☐	☐	☐	☐	☐	☐
Never	Rarely	Sometimes	Mostly	Always	Not Applicable	Prefer Not to Say

14. How often did your PCP involve you when making decisions about your care?

☐	☐	☐	☐	☐	☐	☐
Never	Rarely	Sometimes	Mostly	Always	Not Applicable	Prefer Not to Say

15. How often did your PCP talk with you about your future care?

☐	☐	☐	☐	☐	☐	☐
Never	Rarely	Sometimes	Mostly	Always	Not Applicable	Prefer Not to Say

<u>Main Carer:</u> Questions 16-17 relate to the care you have received from your main carer (the individual primarily responsible for your care at home)

16. Who is your main carer?

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
No carer	Spouse	Parent	Daughter	Son	Other relative	Friend	Neighbor	Other: _____	Prefer Not to Say

17. In the last 3 months, how often do you think your main carer was satisfied with the care you received?

☐	☐	☐	☐	☐	☐	☐
Never	Rarely	Sometimes	Mostly	Always	Not Applicable	Prefer Not to Say

Care Coordination Quality Measure for Primary Care (CCQM-PC)

Your Care Coordination Experience

Survey Instructions

Answer each question by marking the box to the left of your answer. You are sometimes told to skip over some questions in this survey. When this happens, you will see an arrow with a note that tells you what question to answer next, like this:

[1] ☐ Yes
[2] ☒ No → **If No, go to #1**

Introduction

This survey asks questions about your experience with care coordination. Care coordination refers to health care that is provided in a planned way that meets the needs and preferences of the patient. When care is coordinated well, the patient and his or her doctors, nurses, other health care providers, family, and other caregivers all know who is responsible for different parts of the patient's care, and they communicate with each other so that everyone has the information they need.

Your answers to this survey will help us learn more about people's experiences with care coordination.

Definitions

Below are several definitions of terms that are used throughout the survey. Some of these definitions are relevant to specific sections of the survey and are also included at the beginning of that section.

Your primary care provider: The doctor or other provider who cares for most of your usual health care needs and who you normally see when you need care for a new illness or injury, to maintain or control a health issue, or to prevent health problems so you can stay healthy.

Other primary care professionals in this office: doctors, nurse practitioners, physician assistants, nurses, and others who work in the same office or group as your primary care provider and also help people get better, maintain their health, and prevent problems to stay healthy.

Primary care office: A group of primary care professionals and the staff who work with them in an office. The primary care professionals and other staff in the office all work for the same organization or business that shares a common goal of caring for the health needs of patients and keeping patients healthy. A primary care office is designed to be the first place patients go to get their health needs met.

Other health care professionals: Specific or specialized care from doctors, nurse practitioners, physician assistants, nurses, and others who work outside of your primary care practice.

Health care team: this includes your primary care provider, other primary care professionals, and other health care professionals who care for you. It also includes people who are not primary care professionals; for example, the people in your life such as yourself, family members, or friends that help you get the care you need to feel better or stay healthy.

Care plan: Sometimes, in order to coordinate care, the patient and/or family creates a care plan, together with one or more health care providers. It can be created for people with any health condition. The care plan covers the patient's needs and goals for health care and identifies any gaps in care coordination. The plan may set goals for the patient and the patient's providers. Ideally, it anticipates routine needs and tracks current progress toward a patient's goals. This plan is often called a care plan or a plan of action.

Seeking care in the last 12 months

1. In the last 12 months, how many times did you visit your primary care provider's office to get care for yourself from your primary care provider or other primary care professionals?

1 ☐ None
2 ☐ 1
3 ☐ 2
4 ☐ 3
5 ☐ 4
6 ☐ 5 to 9
7 ☐ 10 or more times

2. In the last 12 months, apart from scheduling appointments, how many times did you contact your primary care provider or other primary care professionals in this office about your health—for example, by email or phone call?

1 ☐ None
2 ☐ 1
3 ☐ 2
4 ☐ 3
5 ☐ 4
6 ☐ 5 to 9
7 ☐ 10 or more times

3. In the last 12 months, including your primary care provider, how many different primary care professionals at your primary care provider's office have you seen for a health reason?

1 ☐ 1
2 ☐ 2
3 ☐ 3 or more
4 ☐ I did not get care from this primary care provider's office in the last 12 months.

4. In the last 12 months, how many health care professionals outside of your primary care provider's office have you seen for a health reason?

1 ☐ None
2 ☐ 1
3 ☐ 2
4 ☐ 3 or more

Knowing Who Does What

Care coordination: this refers to health care that is provided in a planned way that meets the needs and preferences of the patient. When care is coordinated well, the patient and his or her doctors, nurses, other health care providers, family, and other caregivers all know who is responsible for different parts of the patient's care, and they communicate with each other so that everyone has the information they need.

Health care team: this includes your primary care provider, other primary care professionals, and other health care professionals who care for you. It also includes people who are not primary care professionals—for example, the people in your life such as yourself, family members, or friends that help you get the care you need to feel better or stay healthy.

5. In the last 12 months, how often did you know what aspects of your care you were responsible for?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

6. In the last 12 months, if you had health problems, how often did your primary care provider or other primary care professionals in this office talk with you about what to do if your condition got worse or came back?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ I did not have a health problem in the last 12 months.

7. In the last 12 months, if you saw more than one health care professional for your health care needs, how often did you know which one to get in touch with when you needed medical care?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ I did not see more than one health care professional for my health care needs in the last 12 months.

Communicating with your health care providers

8. In the last 12 months, if you called your primary care provider's office with a medical question during regular office hours, how often did you get an answer that same day?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ I did not call my primary care provider's office with a medical question during regular office hours in the last 12 months.

9. In the last 12 months, if you called your primary care provider's office **after regular office hours,** how often did you get the help or advice you needed?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ I did not call my primary care provider's office after regular office hours in the last 12 months.

10. In the last 12 months, if you emailed your primary care provider's office with a question, how often did you get an answer as soon as you needed it?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ I did not email my primary care provider's office with a question in the last 12 months.

11. In the last 12 months, how often did the primary care professionals in your primary care provider's office make it easy for you to discuss your care in your preferred language?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

12. In the last 12 months, if you needed to talk to your primary care provider or another primary care professional in this office, how often did you get to talk to the primary care professional who knows you best?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ I did not need to talk to my primary care provider or another primary care professional in this office in the last 12 months.

13. In the last 12 months, how often did your primary care provider or other primary care professionals in this office explain things in a way that was easy to understand?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

14. In the last 12 months, how often did your primary care provider or other primary care professionals in this office listen carefully to you?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

15. In the last 12 months, how often did your primary care provider or other primary care professionals in this office encourage you to ask all the questions you had?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

16. In the last 12 months, how often did your primary care provider or other primary care professional in this office ask you if you understood all of the information he or she gave you?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

17. In the last 12 months, how often have you felt comfortable asking questions of your primary care provider or other primary care professionals you saw in this office?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

Sharing health information

Care plan: Sometimes, in order to coordinate care, the patient and/or family creates a care plan, together with one or more health care providers. It can be created for people with any health condition. The care plan covers the patient's needs and goals for health care and identifies any gaps in care coordination. The plan may set goals for the patient and the patient's providers. Ideally, it anticipates routine needs and tracks current progress toward a patient's goals. This plan is often called a **care plan** or a **plan of action**.

18. In the last 12 months, how often did your primary care provider or other primary care professionals in this office know about your past health problems or past treatments?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

19. In the last 12 months, if you saw a health care professional outside of your primary care provider's office, how often did your primary care provider know about any tests or results from these visits?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ I did not see a health care professional outside of my primary care provider's office in the last 12 months.

20. In the last 12 months, how often has it seemed like your primary care provider's office keeps health information about you complete and up-to-date?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

21. In the last 12 months, if you asked someone at your primary care provider's office for your medical records, how often did you get them as soon as you needed?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ I did not ask my primary care provider's office for my medical records in the last 12 months.

Develop and execute a plan of action for your care: *Assessing your needs and goals*

22. In the last 12 months, if you had a health insurance plan, how often did your primary care provider or other primary care professionals in this office talk with you about what is and is not covered by your insurance plan?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ I did not have health insurance in the last 12 months.

23. In the last 12 months, how often did your primary care provider or other primary care professionals in this office talk to you about any support you might need to take care of your health?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

24. In the last 12 months, how often did your primary care provider or other primary care professionals at this office ask about your goals for taking care of your health?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

25. In the last 12 months, how often has your primary care provider or other primary care professional at this office helped you in setting goals for taking care of your health?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

Develop and execute a plan of action for your care: *Collaboration on the design of care*

26. In the last 12 months, how often did your primary care provider or other primary care professionals at this office consider your preferences for where you wanted to receive your care?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

27. Choices for your treatment or health care can include choices about tests and screenings, preventive health care (e.g., flu shot), medicine, surgery, or other treatment.

In the last 12 months, how often did your primary care provider or other primary care professionals in this office tell you there was more than one choice for your health care or treatment?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

28. In the last 12 months, if you talked about different options for your health care or treatment with your primary care provider or other primary care professionals in this office, how often did they talk with you about the reasons for choosing an option?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ I did not talk to my primary care provider or other primary care professionals in this office about different options for my health care or treatment.

29. In the last 12 months, if you talked about different options for your health care or treatment with your primary care provider or other primary care professionals in this office, how often did they talk about the reasons for **not** choosing an option?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ I did not talk to my primary care provider or other primary care professional in this office about different options for my health care or treatment.

Develop and execute a plan of action for your care: *Creating a health care plan of action*

Care plan: Sometimes, in order to coordinate care, the patient and/or family creates a care plan, together with one or more health care providers. It can be created for people with any health condition. The care plan covers the patient's needs and goals for health care and identifies any gaps in care coordination. The plan may set goals for the patient and the patient's providers. Ideally, it anticipates routine needs and tracks current progress toward a patient's goals. This plan is often called a **care plan** or a **plan of action**.

30. In the last 12 months, how often did your primary care provider or other primary care professionals in this office help you create a plan of action that you use every day to help you take care of your health?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

31. In the last 12 months, if you and a primary care professional in this office had a plan of action to take care of your health, how often did the plan **include different ways to communicate with your primary care practice**?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ I did not have a health care plan of action with primary care professionals in this office in the last 12 months.

32. In the last 12 months, if you and a primary care professional in this office had a plan of action to take care of your health, how often did the plan **include specific outcomes that would tell you when you met your goals**? Outcomes can include functional goals, such as being able to walk a flight of stairs without losing your breath, or target rates—for example, a blood pressure reading below 120/80 mmHg?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ I did not have a health care plan of action with primary care professionals in this office in the last 12 months.

33. In the last 12 months, if you and a primary care professional in this office had a plan of action to take care of your health, how often did the **plan include what to do if there is a problem or a change in your health**?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ I did not have a health care plan of action with primary care professionals in this office in the last 12 months.

34. During stressful times, some people find it harder to take care of their health. In the last 12 months, how often did your primary care provider or other primary care professionals in this office help you to plan ahead so that you could take care of your health even during difficult or stressful times?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

Develop and execute a plan of action for your care: *Following up, identifying problems, and making adjustments*

35. In the last 12 months, if you had a health problem, how often did your primary care provider or other primary care professional in this office follow up on a health problem you had, either at the next visit or by phone?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ I did not have a health problem in the last 12 months.

36. In the last 12 months, how often did your primary care provider or other primary care professionals in this office ask you how your health or treatment affected your daily life?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

37. In the last 12 months, if you had treatment, how often did your primary care provider or other primary care professionals in this office follow up with you to find out what was working well with your treatment?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ I did not have treatment in the last 12 months.

38. In the last 12 months, how often did your primary care provider or other primary care professionals in this office discuss with you whether you were getting the health care you needed?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

Connecting you to other sources of care

39. In the last 12 months, if you needed a referral from your primary care provider to see another health care professional, how often did you get one as soon as you needed it?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ I did not need a referral to another health care professional in the last 12 months.

40. In the last 12 months, if you needed to visit another health care professional outside of your primary care provider's office, how often did someone in your primary care provider's office help you make the appointment?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ I did not need to visit a health care professional outside of my primary care provider's office in the last 12 months.
6 ☐ When I needed to visit a health care professional outside of my primary care provider's office in the last 12 months, I did not seek help from anyone in my primary care provider's office.

41. In the last 12 months, how often did your primary care provider or other primary care professionals in this office give you information about available community-based services to support your health such as support groups, classes, counselors, community recreation programs, or faith-based activities?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

42. In the last 12 months, if your primary care provider or another primary care professional in this office told you about resources available in the community that could help you take care of yourself or your family, how often did someone in your primary care provider's office follow up with you about your use of these resources?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ Community-based services were not recommended to me in the last 12 months.

43. In the last 12 months, if you had health problems, how often did your primary care provider or other primary care professionals in this office help you connect with other people with similar health problems?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ I did not have health problems in the last 12 months.

Helping you take care of yourself

44. In the last 12 months, if you had an illness or injury, how often did your primary care provider or other primary care professionals in this office ask whether you had enough services to help you take care of this illness or injury at home?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ I did not have an illness or injury in the last 12 months.

45. In the last 12 months, if you needed help at home to manage your health, how often did someone in your primary care provider's office arrange services for you at home to help manage your health condition?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ I did not need help at home to manage my health in the last 12 months.

46. In the last 12 months, how often did you feel like the activities that primary care professionals in this office recommended for your care took into account the responsibilities you have at work or home?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

47. In the last 12 months, how often did a primary care professional in this office give you health information such as booklets or videos about what you can do for your health?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

About You

48. In general, how would you rate your overall **physical** health?

1 ☐ Excellent
2 ☐ Very good
3 ☐ Good
4 ☐ Fair
5 ☐ Poor

49. In general, how would you rate your overall **mental or emotional** health?

1 ☐ Excellent
2 ☐ Very good
3 ☐ Good
4 ☐ Fair
5 ☐ Poor

50. In the last 12 months, did you get health care 3 or more times for the same condition or problem?

1 ☐ Yes
2 ☐ No → **If No, go to #52**

51. Is this a condition or problem that has lasted for at least 3 months? Do <u>not</u> include pregnancy or menopause.

1 ☐ Yes
2 ☐ No

52. Do you now need or take medicine prescribed by a doctor? Do **not** include birth control.

1 ☐ Yes
2 ☐ No → **If No, go to #54**

53. Is this medicine to treat a condition that has lasted for at least 3 months? Do **not** include pregnancy or menopause.

1 ☐ Yes
2 ☐ No

54. In the last 12 months, did you have to stay in the hospital for at least one night?

1 ☐ Yes
2 ☐ No

55. In the last 12 months, were you admitted to or discharged from a nursing home or rehabilitation facility?

1 ☐ Yes
2 ☐ No

56. In the last 12 months, did you have health insurance?

1 ☐ Yes
2 ☐ No

57. What is your age?

1 ☐ 18 to 24 years
2 ☐ 25 to 34
3 ☐ 35 to 44
4 ☐ 45 to 54
5 ☐ 55 to 64
6 ☐ 65 to 74
7 ☐ 75 or older

58. Are you male or female?

1 ☐ Male
2 ☐ Female

59. What is the highest grade or level of school that you have completed?

1 ☐ 8th grade or less
2 ☐ Some high school, but did not graduate
3 ☐ High school graduate or GED
4 ☐ Some college or 2-year degree
5 ☐ 4-year college graduate
6 ☐ More than 4-year college degree

60. Are you Hispanic, Latino/a, or Spanish origin?

1 ☐ Yes, Hispanic, Latino/a, or Spanish origin
2 ☐ No, not of Hispanic, Latino/a, or Spanish origin

61. What is your race? *Mark one or more.*

1 ☐ White
2 ☐ Black or African American
3 ☐ American Indian or Alaska Native
4 ☐ Asian Indian
5 ☐ Chinese
6 ☐ Filipino
7 ☐ Japanese
8 ☐ Korean
9 ☐ Vietnamese
10 ☐ Other Asian
11 ☐ Native Hawaiian
12 ☐ Guamanian or Chamorro
13 ☐ Samoan
14 ☐ Other Pacific Islander

62. What is your preferred language?

1 ☐ English
2 ☐ Other
Please specify:
_____

63. How well do you speak English?

1 ☐ Very well
2 ☐ Well
3 ☐ Not well
4 ☐ Not at all

64. Did someone help you complete this survey?

1 ☐ Yes → **If Yes, go to #65**
2 ☐ No → **If No, go to #66**

65. How did that person help you? Mark one or more.

1 ☐ Read the questions to me
2 ☐ Wrote down the answers I gave
3 ☐ Answered the questions for me
4 ☐ Translated the questions into my language
5 ☐ Helped in some other way

66. Have you ever received professional treatment for any of the following conditions? Professional treatment refers to any treatment supervised by a health professional.

	YES, I have received professional treatment for this condition	**NO, I have NOT received professional treatment for this condition**
Arthritis?	☐	☐
Chronic back/neck pain?	☐	☐
Any other chronic pain?	☐	☐
High blood pressure or hypertension?	☐	☐
Congestive heart failure?	☐	☐
Coronary artery disease?	☐	☐
High blood cholesterol or hyperlipidemia?	☐	☐
Asthma?	☐	☐
Chronic Obstructive Pulmonary Disease (COPD)?	☐	☐
Diabetes?	☐	☐
Osteoporosis?	☐	☐
Skin cancer?	☐	☐
Any other kind of cancer?	☐	☐
Anxiety disorder?	☐	☐
Depression?	☐	☐
Any other emotional problem?	☐	☐
Substance problems (drugs or alcohol)?	☐	☐
Stroke	☐	☐
Chronic Kidney Disease	☐	☐
Hepatitis	☐	☐

Thank You
Please return the completed survey in the postage-paid envelope.

Suggested Citation: Agency for Healthcare Research and Quality. Care Coordination Measure for Primary Care Survey. Prepared under Contract No. HHS290-2010-00005I. AHRQ Publication No. 16-0042-1-EF. Rockville (MD): Agency for Healthcare Research and Quality; 2016.
http://www.ahrq.gov/carecoordination

This project was funded under contract number HHS290-2010-00005I from the Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services. The opinions expressed in this document are those of the authors and do not reflect the official position of AHRQ or the U.S. Department of Health and Human Services.

AHRQ Pub. No. 16-0042-1-EF
July 2016

www.ahrq.gov



Measures: Family Experiences with Care Coordination measure set (FECC)

Measure Developer: Center of Excellence on Quality of Care Measures for Children With Complex Needs (COE4CCN)

Numerator	Denominator	Exclusions	Data Source(s)
The FECC Survey is composed of 20 separate and independent quality indicators related to care coordination for children with medical complexity. Each indicator's numerator is determined by caregiver response to specific questions, as described in the detailed measure specifications section of the candidate measure submission form (CPCF).	The denominators for each of the 20 FECC quality indicators are described in the detailed measure specifications. The population of caregivers eligible for the FECC survey overall is composed of those who meet the following criteria: 1. Parents or legal guardians of children 0–17 years of age. Child classified as having a complex, chronic condition using the pediatric medical complexity algorithm (PMCA).[1] 2. Child had adequate data available for running the PMCA algorithm. For our validation study, this was defined as having at least 2 Medicaid eligibility months in the 3 months prior to obtaining the sample. 3. Parents speak English or Spanish.	Exclusions for individual indicators are listed in the detailed measure specifications. Overall exclusion criteria for survey participation were either of the following: 1. Child had died. 2. Listed household contact <18 years of age.	Administrative data including visit clinical classification software ICD-9 codes are used to run the PMCA and to identify children whose caregivers might be eligible for survey participation. Indicator numerators and denominators are constructed from caregiver responses to the FECC Survey.

Measure Importance

Increasing numbers of children in the United States are living with medical complexity.[2] Although these children with medical complexity comprise only 13 percent of the pediatric population, they account for a disproportionately high percentage (26–49 percent) of hospital days[3,4] and 70 percent of overall health care expenditures.[5] Given the cost and complexity of caring for these children, optimizing the quality of their care is likely to yield significant health and economic benefits.

Evidence Base for Focus of the Measures

Comprehensive, well-coordinated care improves patient and family experiences of care[6-8] and patient medical outcomes.[6,7,9,10] Care coordination interventions among children with medical complexity have also been associated with decreased unmet specialty care needs,[11] improved utilization of health care services, decreased hospitalizations, and lower costs.[8,9,12-14] Improving care coordination for children with medical complexity is likely to improve many aspects of care received by these children and their families.

The little evidence that is currently available suggests that 29–41 percent of parents of children with special health care needs report not getting needed help with care coordination.[15,16] However, very little is known about the quality of the help that is being received.

Advantages of the Measures

- The quality indicators on the FECC Survey fill a gap in current approaches to pediatric quality assessment by measuring the quality of care coordination for children with medical complexity, rather than just whether care coordination was provided or not.
- These survey-based indicators measure care coordination in a family-centered way.
- Indicators function independently of one another, and so they may be used together, separately, or in any combination.
- Field testing showed that caregivers of children with medical complexity are willing to complete the survey.
- Both telephone-only and mail followed by telephone methods of survey administration were feasible.
- These measures are publicly available for noncommercial use.

Levels of Aggregation Applicable to the Measures

These measures are intended for aggregation and comparison at the State, regional, and health plan levels. They can also be used within provider groups to drive and monitor internal quality improvement interventions using repeated surveys over time; however, most provider groups will not have enough children with medical complexity to do so, and the low likelihood of multiple provider groups having large numbers of children with medical complexity makes between-group comparisons unlikely to be feasible.

Reliability and Validity of the Measures

- We tested the construct reliability of the six multi-item indicators included with the FECC survey using polychoric ordinal alphas.
  - In five out of six of the multi-item indicators, the alpha was > 0.7, indicating good inter-item reliability and therefore that the items all relate to the same underlying construct
  - The multi-item indicator with an alpha < 0.7 includes items that are independent attributes, so the lower alpha was not unexpected.
- Content validity was established through the indicator and survey development process by using the RAND-UCLA Modified Delphi Method[17] (described below) and cognitive interviews with caregivers of children with medical complexity.
- Construct validity was established by demonstrating convergent validity with previously validated measures of outpatient care experiences from the Clinician and Groups Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS®) Child 12-month survey.[18] Most indicators were associated with better experience in terms of access to care and provider rating, both in unadjusted linear regression (not shown) and after adjusting for patient and caregiver characteristics (see Table).

Table: Validation of developed indicators using access composite and overall provider rating from CG-CAHPS as validation metrics

	Access Composite (0-100)		Overall Provider Rating (0-100)	
	N	β (95%CI)[a]	N	β (95%CI)[a]
Care Coordination Services				
Has care coordinator	771	0.07 (0.04, 0.1)***	768	0.06 (0.03, 0.08)***
Access to care coordinator	557	0.11 (0.03, 0.19)**	556	0.08 (0.02, 0.14)*
Care coordinator helped to obtain community services	250	0.06 (0.01, 0.11)*	250	0.05 (0.02, 0.09)**
Care coordinator contact in the last 3 months	551	0.07 (0.03, 0.1)***	550	0.05 (0.03, 0.07)***
Care coordinator asked about concerns and health changes	244	0.29 (0.2, 0.38)***	244	0.14 (0.08, 0.2)***
Care coordinator asked about progress towards goals	99	0.06 (-0.03, 0.16)	99	0.1 (0.03, 0.16)**
Care coordinator assisted with specialist service referrals	417	0.05 (0.01, 0.09)*	416	0.08 (0.05, 0.11)***
Care coordinator was knowledgeable, supportive, and advocated for child's needs	513	0.21 (0.12, 0.3)***	513	0.28 (0.22, 0.35)***
Caregiver has access to medical interpreter when needed	113	0.27 (0.08, 0.46)**	114	0.04 (-0.04, 0.12)
Messaging				
Appropriate written visit summary content	649	0.26 (0.18, 0.34)***	648	0.15 (0.09, 0.2)***
Written visit summary was useful and easy to understand	726	0.32 (0.24, 0.39)***	724	0.22 (0.17, 0.27)***
Invited to join hospital rounds	238	0.01 (-0.04, 0.06)	236	-0.01 (-0.05, 0.03)
Appropriate written hospitalization summary content	220	0.21 (0.05, 0.36)*	219	0.2 (0.06, 0.33)**
Written hospitalization summary was easy to understand	221	0.09 (-0.03, 0.22)	220	0.2 (0.09, 0.31)***
Caregiver has access to electronic health record	1084	0.03 (0, 0.06)*	1084	0.03 (0.01, 0.05)**
Electronic health record has immunization and medication information	321	0.05 (0, 0.11)	321	0.07 (0.03, 0.11)**
Health care provider communicated with school staff about child's condition	601	0.07 (0.03, 0.1)***	601	0.05 (0.02, 0.08)***
Protocols/Plans				
Child has shared care plan	998	0.07 (0.04, 0.09)***	996	0.07 (0.05, 0.09)***
Child has written transition plan	162	0.2 (0.08, 0.31)***	162	0.1 (0, 0.19)
Child has emergency care plan	1042	0.07 (0.04, 0.1)***	1040	0.06 (0.03, 0.08)***

*p<0.05; **p<0.01, ***p<0.001

[a]Adjusted for State, mode of survey administration (mixed mode or phone only mode), child age, child race/ethnicity, caregiver gender, caregiver age, caregiver race/ethnicity, caregiver education, caregiver relationship to child, caregiver English language proficiency, and language of survey used (English or Spanish).

Measure Development and Testing

The development of the FECC Survey included creation of a conceptual framework, extensive literature reviews, a modified Delphi panel for indicator selection, cognitive interviews, and multi-modal field testing in two States.

Based on potential gaps in care identified through development of the conceptual framework, the process began with literature reviews across six domains to identify care coordination processes associated with improved outcomes for children with medical complexity. Measure developers then created draft indicators based on the literature reviews and expert consensus.

Following the RAND-UCLA Modified Delphi Method, a panel of nine experts, nominated by relevant professional organizations, was convened to review the literature reviews and evaluate the draft indicators. Panelists independently scored the indicators on validity and feasibility twice, with group discussion in between. For a quality indicator to be retained for the survey, it had to have a median validity score of seven or greater (scale 1-9).

Indicators retained by the Delphi panel were then operationalized into survey items, which then underwent structured cognitive interviews with nine caregivers of children with medical complexity, in both English and Spanish. Changes to problematic items were made as needed. This process ensured understandability of survey items by families.

The resulting survey items were field tested among caregivers of Medicaid-eligible children with medical complexity in Washington and Minnesota. Children with medical complexity were identified using the Pediatric Medical Complexity Algorithm (PMCA),[1] which uses administrative ICD-9 codes to classify children according to disease chronicity and complexity. One thousand five hundred caregivers in each State were administered the survey from July to November 2013 via both mixed mode (mail with telephone followup) and telephone only; the survey was available in English and Spanish. There were 600 completed surveys in Washington and 609 in Minnesota. Following testing, one indicator and 11 sub-parts were removed from the FECC survey due to low eligibility and/or ceiling effects.

Selected Results from Tests of the Measures

- The final FECC Survey has 20 separate indicators; each scored from 0 to 100.
- Average scores on individual indicators ranged from 9.7 to 95.9 out of 100.
- Differences in individual indicators were found on the basis of child race/ethnicity, caregiver English proficiency, and rurality.

Issues to Consider

- The FECC Survey only addresses elements of care coordination for which the caregiver is the best source of information (e.g., caregivers are not asked about whether subspecialists verbally communicated recommendations to the primary care provider).
- The quality indicators included in the FECC Survey ask about care coordination over the previous 12 months. While for most of the indicators, asking caregivers to reflect back over a shorter time period would not be relevant (e.g., shared care plans only need to be updated annually), it does introduce the possibility of recall bias.

More Information

- AHRQ: CHIPRAqualitymeasures@ahrq.hhs.gov
- COE: Rita Mangione-Smith, rita.mangione-smith@seattlechildrens.org

For more information about the PQMP, visit www.ahrq.gov/CHIPRA

The Children's Health Insurance Health Insurance Program Authorization Act (CHIPRA) called for establishment of a Pediatric Quality Measures Program (PQMP) as a followup to identifying the initial core set of children's health care quality measures. This fact sheet was produced by the Agency for Healthcare Research and Quality (AHRQ), based on information provided by the AHRQ-CMS Center of Excellence on Quality of Care Measures for Children with Complex Needs (COE4CCN) at the University of Washington-Seattle and Seattle Children's Research Institute. A listing of all submitted PQMP Centers of Excellence can be found at www.ahrq.gov/CHIPRA. All measures are publicly available for noncommercial use.

References

[1]Simon TD, Cawthon ML, Stanford S, et al. Pediatric medical complexity algorithm: a new method to stratify children by medical complexity. Pediatrics 2014;133:e1647-54.

[2]Bethell CD, Read D, Blumberg SJ, et al. What is the prevalence of children with special health care needs? Toward an understanding of variations in findings and methods across three national surveys. Matern Child Health J 2008;12:1-14.

[3]Berry JG, Hall M, Hall DE, et al. Inpatient growth and resource use in 28 children's hospitals: a longitudinal, multi-institutional study. JAMA Pediatr 2013;167:170-7.

[4]Simon TD, Berry J, Feudtner C, et al. Children with complex chronic conditions in inpatient hospital settings in the United States. Pediatrics 2010;126:647-55.

[5]Ireys HT, Anderson GF, Shaffer TJ, et al. Expenditures for care of children with chronic illnesses enrolled in the Washington State Medicaid program, fiscal year 1993. Pediatrics 1997;100:197-204.

[6]Farmer JE, Clark MJ, Sherman A, et al. Comprehensive primary care for children with special health care needs in rural areas. Pediatrics 2005;116:649-56.

[7]Farmer JE, Clark MJ, Drewel EH, et al. Consultative care coordination through the medical home for CSHCN: a randomized controlled trial. Matern Child Health J 2011;15:1110-8.

[8]Palfrey JS, Sofis LA, Davidson EJ, et al. The Pediatric Alliance for Coordinated Care: evaluation of a medical home model. Pediatrics 2004;113:1507-16.

[9]Counsell SR, Callahan CM, Clark DO, et al. Geriatric care management for low-income seniors: a randomized controlled trial. JAMA 2007;298:2623-33.

[10]Rocco N, Scher K, Basberg B, et al. Patient-centered plan-of-care tool for improving clinical outcomes. Qual Manag Health Care 2011;20:89-97.

[11]Boudreau AA, Perrin JM, Goodman E, et al. Care coordination and unmet specialty care among children with special health care needs. Pediatrics 2014;133:1046-53.

[12]Casey PH, Lyle RE, Bird TM, et al. Effect of hospital-based comprehensive care clinic on health costs for Medicaid-insured medically complex children. Arch Pediatr Adolesc Med 2011;165:392-8.

[13]Dorr DA, Wilcox AB, Brunker CP, et al. The effect of technology-supported, multidisease care management on the mortality and hospitalization of seniors. J Am Geriatr Soc 2008;56:2195-202.

[14]Gordon JB, Colby HH, Bartelt T, et al. A tertiary care-primary care partnership model for medically complex and fragile children and youth with special health care needs. Arch Pediatr Adolesc Med 2007;161:937-44.

[15]Zickafoose JS, Davis MM. Medical home disparities are not created equal: differences in the medical home for children from different vulnerable groups. J Health Care Poor Underserved 2013;24:1331-43.

[16]Toomey SL, Chien AT, Elliott MN, et al. Disparities in unmet need for care coordination: the national survey of children's health. Pediatrics 2013;131:217-24.

[17]Brook RH. The RAND/UCLA appropriateness method. In: McCormick KA, Moore SR, Siegel RA, eds. Clinical practice guidelines development:methodology perspectives. Rockville, MD: Agency for Health Care Policy and Research; 1994.

[18]Clinician and Group Surveys. (Accessed at https://cahps.ahrq.gov/surveys-guidance/cg/instructions/index.html.)

AHRQ Pub. No. 15-P002-EF
March 2015