Overview of Potential Measures:
Integrated Communities Care Management Learning Collaborative

Qualitative Reporting by Each Team

Measures:

1. Identification of at-risk people:

Purpose: To assist teams in sharing effective strategies and lessons learned in identifying at risk people.

a. How did your team define at-risk people?
b. How did your team use data to identify their population?
c. How many people did your team identify?
d. Successes/barriers

2. Coordination Agreements

a. **Presence of agreements regarding information sharing between participating providers and community organizations:**

Purpose: To identify organizations and providers in each pilot area that should share information on at-risk people, to evaluate the presence of information sharing agreements between those organizations and providers, and to identify elements to include in the information sharing agreements (e.g., development of shared care plans, domains in shared care plans, and frequency of review and updates to shared care plans). To share strategies and lessons learned in establishing information sharing agreements between organizations and providers.

1. Participating providers and community organizations in your pilot community that have established or are in the process of establishing information sharing agreements
2. Elements in the information sharing agreements (e.g., development of shared care plans for at-risk people, qomains to be included in shared care plans, and frequency of review and updates to shared care plans)
3, Successes/barriers

b. **Presence of care coordination protocols between participating providers and community organizations:**

Purpose: To identify organizations and providers in each pilot area that should have care coordination protocols, elements to include in care coordination protocols, and strategies and lessons learned in developing/updating care c_oordination protocols.

1. Participating providers and community organizations in your pilot community who have developed or are in the process of developing care coordination protocols
2. Elements in the care coordination protocols
3. Successes/barriers

Mechanism for reporting: Each team provides a presentation at the October webinar; Power Point template will be provided.

Quantitative Measures to Evaluate Care for At-Risk People and Provider Experience

The following measures will be collected consistently across teams. More detail about the measures will be provided during the October webinar.

Process Measures (collected in the community}:

1. Presence of shared plan of care in at-risk person's medical record

2. Presence of lead care coordinator in at-risk person's medical record

3. Identification of single point of contact in at-risk person's medical record

Outcome Measures (collected statewide from claims data):

1. Avoidable ED Visits

2. Readmissions

3. Ambulatory Care Sensitive Admissions

Patient Experience:

1. Consider focus groups or interviews to ascertain experience of at-risk people with integrated care management.

Provider Experience:

1. Measure provider experience with principles of team:..based care using existing survey tool.

Columns	Code Book for Care Coordination Learning Collaborative Data Collection Tool	
A	Person/Patient Identification Number	
B-H	Lead Care Coordinator	
B	LCC Identified	"No" or "Yes" (choose from dropdown)
C	LCC Last Name	Last name of the Lead Care Coordinator
D	LCC First Name	First Name of the Lead Care Coordinator
E	LCC Organization	Organization that employs Lead Care Coordinator
F	Shared Care Plan	Is an up-to-date shared care plan included in the person's/patient's record maintained by the Lead Care Coordinator? 1. Shared Care Plan include, at a minimum, the following elements: • Date updated • Patient/family goal(s) • Clinical goal(s) • Action plan for achieving above goals • Overall current progress on reaching goals • Contact/communication information • Name of Lead Care Coordinator • List of members of care team and their organization 2. The 'Interval between care conferences' will compute automatically. To be considered up-to-date the Shared Care Plan should be updated no less frequently than the desired number of days between care conferences determined by the team. Response Key (choose from dropdown): • "None" if no Shared Care Plan has been developed for person/patient, or Lead Care Coordinator does not have copy; • "Partial" if any element is missing or out-of-date; • "Complete" if all elements are present and up-to-date.
G	Date of Most Recent Care Conference	Date of the most recent Care Conference defined as a regularly scheduled evaluation of participant/patient's progress by participating care organizations
H	Interval Between Care Conferences (days)	Will compute automatically the number of days since the most recent Care Conference

I-AB	Organizations (Please identify Other Organization in place holders in columns S-AB)	
I,K,M,O,Q,S,U,W,Y,AA	Participating In Care Team	"No" or "Yes" (choose from dropdown) for each listed organization for each enrolled individual.
J,L,N,P,R,T,V,X,Z,AB	Updated Progress Report on File	Does the Lead Care Coordinator have and up-to-date progress note from the listed organization for the identified individual? 1. Progress Reports include, at a minimum, the following elements: • Date of most recent visit • Treatment plan • Progress • Referrals (if applicable) • Date or deadline of follow-up (if applicable); Follow-up can be any significant next step in the person/patient's care such as an appointment or phone call with person/patient, or outreach or coordination with another organization on care team. If not follow-up is required, this should also be noted in progress report. 2. To be up-to-date, there should be a progress report in the LCC's record within 10 business of days of the "date of follow-up" as listed in previous progress report. If the progress report is missing or no progress report has been filed within the 10 business days, the file is considered out-of-date or incomplete. Additionally, if there is no date for follow-up and no note stating that follow-up is unnecessary, the file is considered out-of-date or incomplete. Response Key (choose from dropdown): • "None" if Lead Care Coordinator does not have an up-to-date progress report; • "Partial" if some but not all elements of progress update are present and up-to-date; • "Complete" if all elements are present and up-to-date.

Progress on Lead Care Coordinator (LCC) and Up-to-date Shared Care Plan (SCP)

	Baseline	Round 2	Round 3	Round 4	Round 5	Round 6
% with Partial Progress Update	32%	37%	#N/A	#N/A	#N/A	#N/A
% with Complete Progress Update	47%	48%	#N/A	#N/A	#N/A	#N/A
% of patients with LCC	28%	56%	#N/A	#N/A	#N/A	#N/A
% of patients whose LCCs have Shared Care Plan	86%	100%	#N/A	#N/A	#N/A	#N/A