

Measure #3. Coleman Measures of Care Coordination

CARE COORDINATION MEASURE MAPPING TABLE

	MEASUREMENT PERSPECTIVE		
	<i>Patient/Family</i>	<i>Health Care Professional(s)</i>	<i>System Representative(s)</i>
CARE COORDINATION ACTIVITIES			
Establish accountability or negotiate responsibility	□		
Communicate	□		
<i>Interpersonal communication</i>	□		
<i>Information transfer</i>	■		
Facilitate transitions			
<i>Across settings</i>			
<i>As coordination needs change</i>			
Assess needs and goals	□		
Create a proactive plan of care			
Monitor, follow up, and respond to change	■		■
Support self-management goals			
Link to community resources			
Align resources with patient and population needs			
BROAD APPROACHES POTENTIALLY RELATED TO CARE COORDINATION			
Teamwork focused on coordination			
Health care home			□
Care management			
Medication management			□
Health IT-enabled coordination			

Legend:

- = ≥ 3 corresponding measure items
- = 1-2 corresponding measure items

Coleman Measures of Care Coordination

Purpose: To measure coordination of care post-hospital discharge as part of an evaluation of the association between care coordination and use of the Emergency Department (ED) in elderly patients.

Format/Data Source: Measures of care coordination constructed from data found in a self-reported health status survey, a telephone survey, and health plan utilization and pharmacy administrative data. The following information was collected from administrative data: (1) number of physicians involved with care, (2) number of prescribers involved with care, (3) percent of changes in 1 or more chronic disease medications that resulted in a followup visit within 28 days, (4) percent of missed ambulatory encounters that resulted in a followup visit within 28 days, (5) percent of same day ambulatory encounters that resulted in a followup visit within 28 days.

Date: Measure published in 2002.¹

Perspective: System Representative(s); survey items from Patient/Family perspective

Measure Item Mapping:

- **Establish accountability or negotiate responsibility:** 1b
- **Communicate:**
 - *Across health care teams or settings:* 1f
 - Interpersonal communication:
 - *Between health care professional(s) and patient/family:* 1i
 - Information transfer:
 - *Between health care professional(s) and patient/family:* 1e
 - *Across health care teams or settings:* 1g
 - *Participants not specified:* 1j
- **Assess needs and goals:** 1k
- **Monitor, follow up, and respond to change:** 4-6, 1a, 1c, 1d
- **Health care home:** 2
- **Medication management:** 3, 4

Development and Testing: Telephone-based survey utilized validated scales of the Components of Primary Care Index (CPCI) measure developed by Flocke.² Relevant administrative data measures were selected based on the evidence-based hypothesis that followup care would be particularly important post-discharge, when patients might be at increased risk for subsequent adverse events (urgent ambulatory visits, missed appointments, or medication changes). Two of the administrative data measures used have been utilized in other studies.^{3,4} Correlations between self-report and administrative-data-derived care coordination measures were examined, and the Person correlations ranged from 0.00 to 0.28, suggesting that the two types of measures were likely measuring distinct aspects of care coordination.

Link to Outcomes or Health System Characteristics: This multicomponent measure was used to measure the impact of care coordination on inappropriate emergency department (ED) use in older managed care enrollees with multiple chronic conditions. The measure was not found to be associated with inappropriate ED use in this study population. The study authors suggest that this may, in part, be due to the inability to adequately distinguish the role of care coordination from other potential factors that influence utilization.¹

Logic Model/Conceptual Framework: None described in the source identified.

Country: United States

Past or Validated Applications*:

- **Patient Age:** Adults, Older Adults
- **Patient Condition:** Combined Chronic Conditions, General Chronic Conditions, Multiple Chronic Conditions
- **Setting:** Emergency Care Facility, Other Outpatient Specialty Care Facility

*Based on the sources listed below and input from the measure developer.

Notes:

- The original measure did not have individual items numbered. In order to properly reference specific items within this profile, we consecutively numbered all measure items with a care coordination construct found in Table 1 of the source article.¹ Additionally, all question items included in Measure 1 (Care Coordination Telephone Survey) found in Appendix 1 were labeled 1a-1m.
- This instrument contains 18 items; 15 were mapped.

Sources:

1. Coleman EA, Eilertsen TB, Magid DJ, et al. The association between care coordination and emergency department use in older managed care enrollees. *Int J Integr Care* 2002;2:1-11.
2. Flocke SA. Measuring attributes of primary care: development of a new instrument. *J Fam Pract* 1997;45(1):64-75.
3. Roblin DW, Juhn PI, Preston BJ, et al. A low-cost approach to prospective identification of impending high cost outcomes. *Med Care* 1999;37(11):1155-63.
4. Chapko MK, Fisher ES, Welch HG. When should this patient be seen again? *Eff Clin Pract* 1999;2(1):37-43.