

## Measure #50. Degree of Clinical Integration Measures

**CARE COORDINATION MEASURE MAPPING TABLE**

	MEASUREMENT PERSPECTIVE		
	<i>Patient/Family</i>	<i>Health Care Professional(s)</i>	<i>System Representative(s)</i>
<b>CARE COORDINATION ACTIVITIES</b>			
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			
<b>BROAD APPROACHES POTENTIALLY RELATED TO CARE COORDINATION</b>			
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

# Degree of Clinical Integration Measures

**Purpose:** To measure functional integration, which is defined as the extent to which patient care services are coordinated across various functions, activities, and operating units of a system.

**Format/Data Source:** 17 measures used to assess 6 dimensions of clinical integration: (1) clinical protocol development, (2) medical records uniformity and accessibility, (3) clinical outcomes data collection and utilization, (4) clinical programming and planning efforts, (5) shared clinical support services, and (6) shared clinical services lines.

**Date:** Measures published in 1994.<sup>1</sup>

**Perspective:** System Representative(s)

## Measure Item Mapping:

- **Communicate:**
  - Information transfer:
    - *Across health care teams or settings:* 8,9
- **Facilitate transitions:**
  - Across settings: 16,17
- **Health IT-enabled coordination:** 3-7

**Development and Testing:** Measures were developed based on a literature review, interaction with the study research advisory group committee, and site visits.<sup>1</sup>

**Link to Outcomes or Health System Characteristics:** None described in the source identified.

**Logic Model/Conceptual Framework:** Builds on the work of models and frameworks of vertically integrated health systems.<sup>1</sup>

**Country:** United States

## Past or Validated Applications\*:

- **Patient Age:** Not Age Specific
- **Patient Condition:** General Population/Not Condition Specific
- **Setting:** Not Setting Specific

\*Based on the source listed below.

## Notes:

- The original measure did not have individual items numbered. In order to properly reference specific items within this profile, all instrument items found in Table 3 of the source article were consecutively numbered.<sup>1</sup>
- This instrument contains 17 items; 9 were mapped.

**Source:**

1. Devers KJ, Shortell SM, Gillies RR, et al. Implementing organized delivery systems: An integration scorecard. *Health Care Manage Rev* 1994;19(3):7-20.