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## Original Study

# Development of an Interdisciplinary Team Communication Framework and Quality Metrics for Home-Based Medical Care Practices

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## A B S T R A C T

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house calls  
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**Background:** The unique needs of homebound adults receiving home-based medical care (HBMC) (ie, home-based primary care and home-based palliative care services) are ideally provided by interdisciplinary care teams (IDTs) that provide coordinated care. The composition of team members from an array of organizations and the unique dimension of providing care in the home present specific challenges to timely access and communication of patient care information. The objective of this work was to develop a conceptual framework and corresponding quality indicators (QIs) that assess how IDT members for HBMC practices access and communicate key patient information with each other.

**Methods:** A systematic review of peer-reviewed and gray literature was performed to inform a framework for care coordination in the home and the development of candidate QIs to assess processes by which all IDT members optimally access and use patient information. A technical expert panel (TEP) participated in a modified Delphi process to assess the validity and feasibility of each QI and to identify which would be most suitable for testing in the field.

**Results:** Thematic analysis of literature revealed 4 process themes for how HBMC practices might engage in high-quality care coordination: using electronic medical records, conducting interdisciplinary team meetings, sharing standardized patient assessments, and communicating via secure e-messaging. Based on these themes, 9 candidate QIs were developed to reflect these processes. Three candidate QIs were assessed by the TEP as valid and feasible to measure in an HBMC practice setting. These indicators focused on use of IDT meetings, standardized patient assessments, and secure e-messaging.

**Conclusion:** Translating the complex issue of care coordination into QIs will improve care delivered to vulnerable home-limited adults who receive HBMC. Guided by the literature, we developed a framework to reflect optimal care coordination in the home setting and identified 3 candidate QIs to field-test in HBMC practices.

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There are an estimated 2 to 4 million homebound older adults in the United States today with functional impairments and multiple chronic conditions. This number is expected to increase with the aging population.<sup>1,2</sup> Home-based primary care and home-based palliative care (henceforth called home-based medical care [HBMC]) can provide high-quality, patient-centered, cost-effective care for homebound persons. First-year results from the Centers for Medicare and Medicaid Services (CMS) Innovation Center's Independence at Home Demonstration showed significant cost savings,<sup>3</sup> as did a randomized trial of home-based palliative care.<sup>4</sup> A recent systematic review

demonstrated that HBMC programs are associated with reduced health service utilization, lower costs of care, better quality of life, and better patient and caregiver satisfaction. In the review, the use of an interdisciplinary team (IDT) to coordinate care for complex patients was one key factor associated with better outcomes.<sup>5</sup>

High-quality care coordination is more likely when the IDT has access to timely patient data at the time of care delivery.<sup>6</sup> Such access to up-to-date patient information is often more challenging for home-based practices than for office-based or institutional practices. This is because in HBMC, IDTs are often formed when home-based practices or providers partner with community-based organizations and disciplines that may be grounded in separate health entities and geographic locations.<sup>7</sup> Lack of complete health information technology interoperability between these organizations' records often means that team members from organizations partnering with a HBMC practice have more difficulty sharing health records, electronic or otherwise.

Given both the unique challenges of HBMC in care coordination and the critical role such coordination plays in HBMC effectiveness, the development of a framework for considering the quality of team-based communication and of associated quality indicators (QIs) relevant for HBMC is needed. The passage of the Medicare Access and CHIP Reauthorization Act of 2015 with its Merit-Based Incentive Payment System evaluates health care providers through their performance on quality.<sup>8</sup> Thus, population- and setting-appropriate QIs are vital to equip the field of HBMC to engage in value-based care. Recently, the National Home Based Primary Care and Palliative Care (NHBPCPC) Network recognized care coordination, particularly with respect to IDT access to patient information, as a critical area for the development of HBMC-specific QIs. Such QIs have not previously been represented among existing quality measures endorsed by payers, quality organizations, and professional societies.<sup>2</sup>

The aim of this work was to develop a framework and corresponding QIs for care coordination that address how IDT members in the HBMC setting access and share key patient information.

## Methods

### Systematic Literature Review

A systematic literature review was conducted to inform the development of a conceptual framework and QIs by addressing the following question: "What are the evidence base, current practices, and existing guidelines for how IDT members access and share patient information with one another in home-based medical practices?"

The search strategy was developed with the assistance of a medical librarian using variations of key MeSH terms (Appendix Figure A1) relating to the concepts of "home care services," "home care team," "adult" or "older adult," "interdisciplinary communication," and "access to information." The search strategy was applied to the following databases for the period from January 1, 1997 to February 13, 2015: PubMed, The Cumulative Index to Nursing & Allied Health, Cochrane Library, Embase, Web of Science, and Scopus databases as well as gray literature Web sites, including New York Academy of Medicine Grey Literature Report, National Library of Medicine Catalog, Google, Proquest Digital Dissertations and Theses, and guidelines/Web sites (Commonwealth Fund, Kaiser Family Foundation, California Healthcare Foundation, SCAN Foundation, National Center for Quality Assurance). Hand searches were conducted of the reference lists of retrieved articles.

Due to the dearth of literature around this aspect of care coordination in HBMC, we also considered literature from areas that could be adapted to HBMC. Studies cited in the evidence table (Appendix Table A1) were accepted for review using the following inclusion criteria: any intervention, guideline, study, or expert opinion that involves information transfer about patients' care plans between IDT members, or how IDT members or health care professionals access

patient information. Because evidence-based approaches to care coordination were limited, a thematic analysis of the literature was conducted to inform development of a conceptual framework and a list of candidate QIs.

### Development of Conceptual Framework on How IDT Members in HBMC Access and Communicate Patient Information

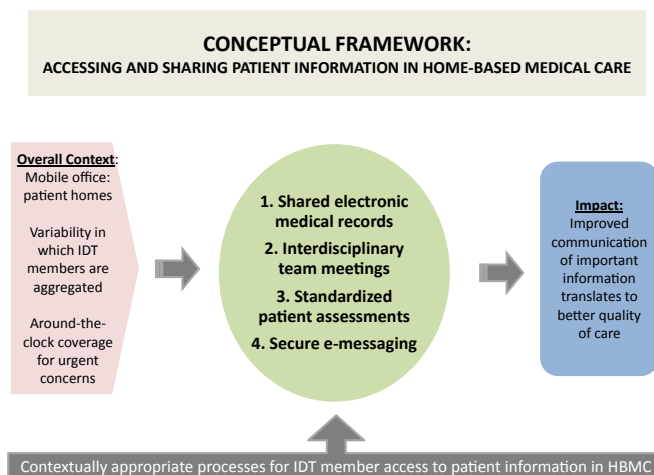
One purpose of the literature review was to inform the development of a conceptual framework (Figure 1) to describe the processes by which IDT members in HBMC access and communicate patient information. The "overall context" portion of the framework was informed by a recent survey of 272 HBMC practices.<sup>7</sup>

### Development of Candidate QIs

Informed by the conceptual framework and the clinical experience of the investigators, we developed a preliminary list of 5 QIs. Two were patient-level QIs, in which the numerator defined the process of care to be performed on behalf of a patient and the denominator defined the eligible population. In addition to the patient-level QIs, we developed 3 practice-level QIs, which were structured as "yes" or "no" questions to ascertain whether a process recommended for optimal care coordination was being performed by an HBMC practice.

### Formation of the Technical Expert Panel

We convened a Technical Expert Panel (TEP) consisting of representatives from the NHBPCPC Network to rate the candidate QIs. This Network consists of stakeholders and leaders from 12 exemplary home-based medical practices, 3 professional societies (American Academy of Home Care Medicine, American Academy of Hospice and Palliative Medicine, and American Geriatrics Society), and 3 patient advocacy groups (American Association of Retired Persons, Kaiser Family Foundation, and National Partnership for Women and Families). The TEP members pre-rated the candidate QIs for validity and feasibility using the RAND modified-Delphi process.<sup>9–15</sup> TEP members discussed the literature findings related to care coordination in home-based practices. During discussions of the merits and issues of each QI, the panel was given the option to suggest additional candidate QIs or to modify the wording of the proposed candidates before a further round of anonymous voting on the validity and feasibility of each QI. TEP members were then asked to rate feasibility of implementation of



**Fig. 1.** Conceptual framework for how IDT members access and communicate patient information in HBMC practices.

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