In order to evaluate the success of the Connected Communities Implementation Grant projects, Grantees are required to measure and report progress on outcome metrics that gauge whether or not these projects are having an impact on the cost or quality of healthcare.

If you are unsure about which measures to include in this project, work with your clinical or quality improvement team(s). Consider including outcomes that are already being tracked, or will start being tracked in the near future, as part of payment reform programs including Physician Quality Reporting System (PQRS), Hospital Inpatient Quality Reporting Program (Hospital IQR), Patient-Centered Medical Home (PCMH), or the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA). (See resource links below to learn more about these programs.)

**Outcome Measure Examples:** Below are some examples of anticipated outcomes, baseline and target measures that have been proposed by Connected Communities Grantees. The data sources that will be used for the baseline and target metrics are included.

|  |  |  |  |
| --- | --- | --- | --- |
| **Use Case Description** | **Anticipated Outcome Measure (What area related to cost or quality would you like to be impacted by this project?)** | **Baseline Measure**  **(What is the current number or percentage?)** | **Target Measure**  **(What would you like this number or percentage to be by the end of the project?)** |
| Summary of Care (CCD) and discharge summary sent from hospital to Skilled Nursing Facility (SNF) before the patient arrives to the SNF | Measure 1: Reduce the % of 30-day readmissions from collaborating SNF back to hospital | 22%  **Data source:** Medicare claims data and EHR data to track which SNF is sending patient back to hospital | 10% reduction to readmission rate of 20%  **Data source:** Medicare claims data and EHR data to track which SNF is sending patient back to hospital |
| Measure 2: Reduce average length of stay at collaborating SNF | 20 days **Data source:** EHR data at SNF | 10% reduction to 18 days **Data Source:** EHR data at SNF |
| Summary of Care record sent from hospital to SNF or Home Health Agency (if patient is discharged home) so that staff can reconcile patient’s medications | Increase the rate in which clinical staff perform medication reconciliation for a patient based on the medication list provided by the hospital | 50% (This is assumes that medication reconciliation is already part of the workflow for each patient for whom hospital discharge information is available.) **Potential data source:** HISP transaction report | 75% (This assumes that medication reconciliation will occur for each patient for whom hospital discharge information will be available) **Potential data source:** HISP transaction report |
| Discharge notification sent from hospital’s emergency department or inpatient to patient’s PCP, so PCP’s office can schedule a follow up appointment | Reduce the likelihood of patient being readmitted to ED or hospital as inpatient among a high risk patient population | 40% **Data source:** Medicare claims data or hospital registration data | 34% **Data source:** Medicare claims data hospital registration data |

**Additional Resources:**

**Quality Improvement**

<http://www.hrsa.gov/quality/toolbox/methodology/performancemanagement/index.html>

<http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx>

<http://www.ihi.org/resources/Pages/Measures/default.aspx>

**Physician Quality Reporting System (PQRS)**

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/pqri>

<https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/pqrs/qualified-clinical-data-registry-reporting.html>

**Hospital Inpatient Quality Reporting Program (IQR)**

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalRHQDAPU.html>

**Long-Term Care Hospital (LTCH) Quality Reporting (QRP)**

<https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/ltch-quality-reporting/>

**Patient Centered Medical Home (PCMH)- Proposed updates to this program are under review and will be available in the Fall of 2016**

https://www.pcmh.ahrq.gov/page/defining-pcmh

<http://primarycaremeasures.ahrq.gov/>

Information about the PCMH program re-design can be found [here](http://www.ncqa.org/newsroom/statements/pcmh-ideas).

**Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics (CCBHC)**

http://www.samhsa.gov/section-223

<http://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf>

**MACRA- Merit-Based Incentive Payment System (MIPS) & Alternative Payment Models (APMs)**

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html>