Care Coordination Value Capture

Presented to

Children's Health Alliance of Wisconsin

Hannah Rosenberg, MSc.
Project Manager, Boston Children's Hospital
Manager, National Center for Care Coordination Technical Assistance
Richard Antonelli, MD, MS
Medical Director of Integrated Care
Boston Children's Hospital/Harvard Medical School
National Center for Care Coordination Technical Assistance

April, 2017

Boston Children's Hospital

HARVARD MEDICAL SCHOOL
TEACHING HOSPITAL

National Center for Care Coordination Technical Assistance (NCCCTA)

The mission of the National Center for Care Coordination Technical Assistance is to support the promotion, implementation and evaluation of care coordination activities and measures in child health across the United States.

The National Center for Care Coordination Technical Assistance is working in partnership with the National Center for Medical Home Implementation (NCMHI) in the American Academy of Pediatrics. The NCMHI is supported by the Health Resources and Services Administration (HRSA) of the United States Department of Health and Human Services (HHS) grant number U43MC09134.

Please contact Hannah Rosenberg, Manager, NCCCTA, for more information.

- Email: hannah.rosenberg@childrens.harvard.edu
- Telephone: 617.919.3627

Care Coordination Measurement Tool (CCMT)

- Value capture tool designed to track care coordination activities that are currently being done but not being accounted or reimbursed for, assign value to them and get to a "true cost of care"

- Intended to be adapted to reflect activities and outcomes of teams in diverse settings

- Tool can be implemented in different ways depending on goal of collecting data

- Is in AHRQ Atlas, core tool can be found on BCH website: http://www.childrenshospital.org/care-coordination-curriculum/care-coordination-measurement

Medical Home Care Coordination Measurement Tool©

Site Code: ___ Form # ___ of ___

Date	Patient Study Code And Age	Patient Level	Focus	Care Coordination Needs	Activity Code(s)	Outcome(s) Prevented	Outcome(s) Occurred	Time Spent* 1 2 3 4 5 6 7	Staff	Clinical Comp.	Initials

Patient Level

Level	Description
I	Non-CSHCN, **Without** Complicating Family or Social Issues
II	Non-CSHCN, **With** Complicating Family or Social Issues
III	CSHCN, **Without** Complicating Family or Social Issues
IV	CSHCN, **With** Complicating Family or Social Issues

Focus of Encounter (choose ONE)

1. Mental Health
2. Developmental / Behavioral
3. Educational / School
4. Legal / Judicial
5. Growth / Nutrition
6. Referral Management
7. Clinical / Medical Management
8. Social Services (ie. housing, food, clothing, ins., trans.)

Rev-09/10

Care Coordination Needs (choose all that apply)

1. Make Appointments
2. Follow-Up Referrals
3. Order Prescriptions, Supplies, Services, etc.
4. Reconcile Discrepancies
5. Coordination Services (schools, agencies, payers etc.)

Time Spent

1 – less than **5** minutes
2 – **5 to 9** minutes
3 – **10 to 19** minutes
4 – **20 to 29** minutes
5 – **30 to 39** minutes
6 – **40 to 49** minutes
7 – **50** minutes and greater*
(*Please NOTE **actual minutes** if greater than 50)

Staff

RN, LPN, MD, NP, PA, MA, SW, Cler

Clinical Competence

C= Clinical Competence required
NC= Clinical Competence not Required

Activity to Fulfill Needs (choose all that apply)

1. **Telephone discussion with:**
   a. Patient e. Hospital/Clinic
   b. Parent/family f. Payer
   c. School g. Voc. / training
   d. Agency h. Pharmacy
2. **Electronic (E-Mail) Contact with:**
   a. Patient e. Hospital/Clinic
   b. Parent f. Payer
   c. School g. Voc. / training
   d. Agency h. Pharmacy
3. **Contact with Consultant**
   a. Telephone c. Letter
   b. Meeting d. E-Mail
4. **Form Processing**: (eg. school, camp, or complex record release)
5. **Confer with Primary Care Physician**
6. **Written Report to Agency**: (eg. SSI)
7. **Written Communication**
   a. E-Mail
   b. Letter
8. **Chart Review**
9. **Patient-focused Research**
10. **Contact with Home Care Personnel**
    a. Telephone c. Letter
    b. Meeting d. E-Mail
11. **Develop / Modify Written Care Plan**
12. **Meeting/Case Conference**

Outcome(s)

As a result of this care coordination activity, the following was **PREVENTED** (choose **ONLY ONE**, if applicable):

1a. ER visit
1b. Subspecialist visit
1c. Hospitalization
1d. Visit to Pediatric Office/Clinic
1e. Lab / X-ray
1f. Specialized Therapies (PT, OT, etc)

2. As a result of this care coordination activity, the following **OCCURRED** (choose **all that apply**):

2a. Advised family/patient on home management
2b. Referral to ER
2c. Referral to subspecialist
2d. Referral for hospitalization
2e. Referral for pediatric sick office visit
2f. Referral to lab / X-ray
2g. Referral to community agency
2h. Referral to Specialized Therapies
2i. Ordered prescription, equipment, diapers, taxi, etc.
2j. Reconciled discrepancies (including missing data, miscommunications, compliance issues)
2k. Reviewed labs, specialist reports, IEP's, etc.
2l. Advocacy for family/patient
2m. Met family's immediate needs, questions, concerns
2n. Unmet needs (**PLEASE SPECIFY**)
2o. Not Applicable / Don't Know
2p. Outcome Pending

Supported by grant HRSA-02-MCHB-25A-AB

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CCMT Today

Many institutions are using CCMT to capture value of work that they are doing to conduct quality improvement or inform financing mechanisms

- Pediatric and Adult primary care and specialty clinics (inpatient and ambulatory)
- Research settings
- Family-partner organizations

What to focus on?

Quality Improvement

If practice/clinic/organization is:

- Focusing on re-assigning responsibilities/accountability, making sure everyone is working at "top of their license"
- In space where already moved from fee-for-service to global budgets

Finance

If practice/clinic/organization is:

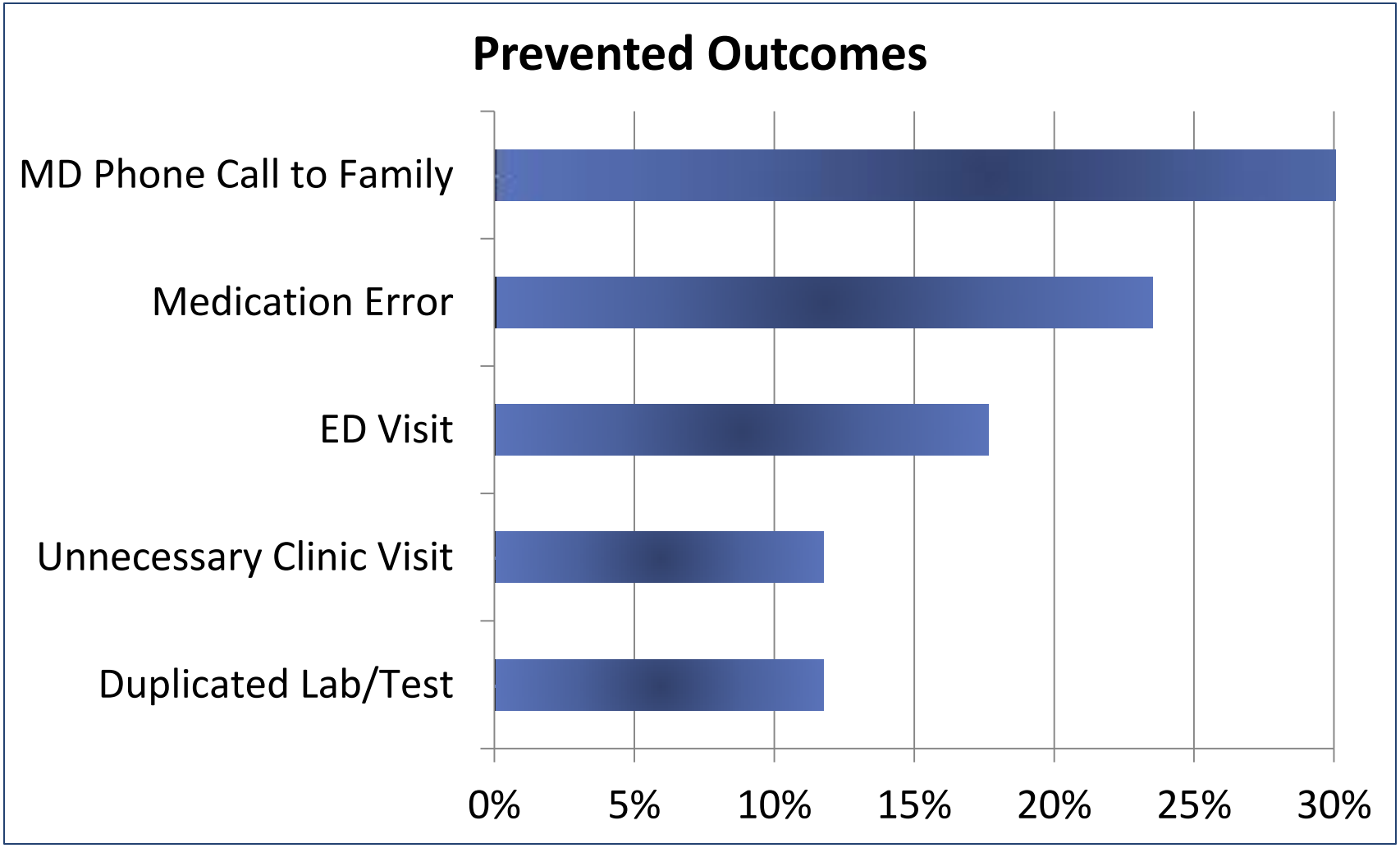
- In space to inform conversations about financing options

Validation is most necessary when addressing finance domain

- In past, created vignettes
- Posed to subject matter experts
- Inter-rater reliability

Successes with CCMT

- Community based health center onboarding RN Care Coordinator
- Outpatient Specialty Care Program gained additional CC resources
- In Specialty Clinics, we have generally found that effective care coordination is linked to avoided ED visits 15-20% of time
- CCMT has proved ability across multiple sites to quantify how care coordination leads to reduction in safety issues and increased error prevention


Prevented Outcomes
MD Phone Call to Family
Medication Error
ED Visit
Unnecessary Clinic Visit
Duplicated Lab/Test
0%
5%
10%
15%
20%
25%
30%

Steps to Get This Done

1. Decision to Proceed
   - Why?
   - How long to commit?
   - Expected Outcomes
2. Decide on parameters for “encounter”
3. Modify CCMT
4. Implement CCMT
5. Incorporate CCMT in electronic format

Adaptation

Step 1: Review the Core: "Medical Home Care Coordination Measurement Tool" (MHCCMT)

- Consider what elements in the core MHCCMT are relevant to work that is being done by those who will be using CCMT in your program/institution and should be kept in your adapted version
- Brainstorm what would need to be added to the tool
- Collect qualitative data

Step 2: Develop a set of common definitions

This is to ensure that everyone completing CCMT is using the same definitions.

Step 3: Develop a draft tool

Pilot test the draft tool for at least a week in a paper version. Most likely, you will identify things that you would like to add to the tool or categories that are not relevant.

Step 4: Validate the tool

Connect with our team

Contact:

Hannah Rosenberg, MSc., Manager, National Center for Care Coordination Technical Assistance
Email: hannah.rosenberg@childrens.harvard.edu

Neha Safaya, Coordinator, National Center for Care Coordination Technical Assistance
Email: neha.safaya@childrens.harvard.edu

- For questions, technical assistance
- To join our listserv

Find us on the web:

National Center for Medical Home Implementation: https://medicalhomeinfo.aap.org/tools-resources/Pages/Care-Coordination.aspx

Boston Children's Hospital: http://www.childrenshospital.org/care-coordination-curriculum