

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)		Time Spent*							Staff	Clinical Comp.	Initials
						Prevented	Occurred	1	2	3	4	5	6	7			

<p><u>Patient Level</u></p> <p><u>Level</u> <u>Description</u></p> <p>I Non-CSHCN, Without Complicating Family or Social Issues</p> <p>II Non-CSHCN, With Complicating Family or Social Issues</p> <p>III CSHCN, Without Complicating Family or Social Issues</p> <p>IV CSHCN, With Complicating Family or Social Issues</p> <p><u>Focus of Encounter</u> (choose ONE)</p> <ol style="list-style-type: none"> 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.) <p>Rev-09/10</p>	<p><u>Care Coordination Needs</u> (choose all that apply)</p> <ol style="list-style-type: none"> 1. Make Appointments 2. Follow-Up Referrals 3. Order Prescriptions, Supplies, Services, etc. 4. Reconcile Discrepancies 5. Coordination Services (schools, agencies, payers etc.) <p style="text-align: center;"><u>Time Spent</u></p> <p>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)</p> <p style="text-align: center;"><u>Staff</u> RN, LPN, MD, NP, PA, MA, SW, Cler</p> <p style="text-align: center;"><u>Clinical Competence</u> C= Clinical Competence required NC= Clinical Competence not Required</p>	<p><u>Activity to Fulfill Needs</u> (choose all that apply)</p> <ol style="list-style-type: none"> 1. Telephone discussion with: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> a. Patient e. Hospital/Clinic b. Parent f. Payer c. School g. Voc. / training d. Agency h. Pharmacy 3. Contact with Consultant <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> a. E-Mail b. Letter 8. Chart Review 9. Patient-focused Research 10. Contact with Home Care Personnel <ul style="list-style-type: none"> a. Telephone c. Letter b. Meeting d. E-Mail 11. Develop / Modify Written Care Plan 12. Meeting/Case Conference 	<p><u>Outcome(s)</u></p> <p>As a result of this care coordination activity, the following was PREVENTED (choose ONLY ONE, if applicable):</p> <ol style="list-style-type: none"> 1a. ER visit 1b. Subspecialist visit 1c. Hospitalization 1d. Visit to Pediatric Office/Clinic 1e. Lab / X-ray 1f. Specialized Therapies (PT, OT, etc) <p>2. As a result of this care coordination activity, the following OCCURRED (choose all that apply):</p> <ol style="list-style-type: none"> 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 <p style="text-align: right;">Supported by grant HRSA-02-MCHB-25A-AB</p>
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