Advancing Family-Centered Care Coordination

Using the Care Coordination Measurement Tool

Colleen Lane

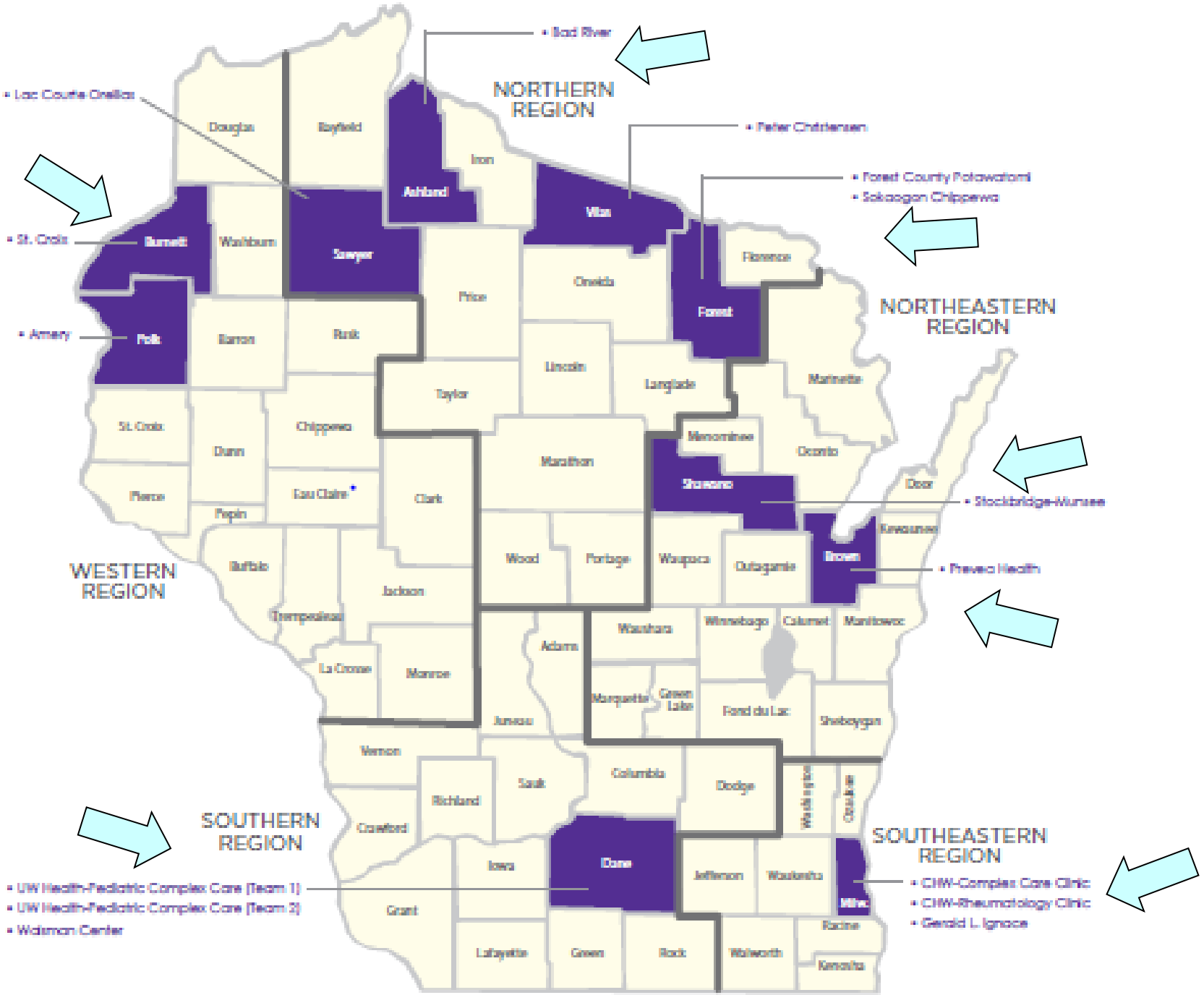
April 23, 2019

Learning Objectives

- Understand the *CCMT* as a way to track care coordination activities, time spent, and outcomes achieved or avoided
- Complete the *CCMT* for one case study
- Consider the person(s) on your team who will complete the *CCMT*, and those that will review the data it generates
- Begin to consider how the data captured by the CCMT might be used to inform decisions at your site

Participating Sites

- Bad River Tribal Health Center
- CHW/MCW-Rheumatology Clinic
- Forest Co Potawatomi Health and Wellness Center
- Prevea Pediatrics
- St. Croix Tribal Health Clinic
- Stockbridge-Munsee Health and Wellness Center
- UW Health/AFCH-Pediatric Complex Care
- Waisman Center Newborn Follow-up Clinic


• Bad River
NORTHERN REGION
• Lac Courte Oreilles
• Peter Christensen
• Forest County Potawatomi
• Sokaogon Chippewa
• St. Croix
• Amery
NORTHEASTERN REGION
• Stockbridge-Munsee
• Prevea Health
WESTERN REGION
SOUTHERN REGION
SOUTHEASTERN REGION
• UW Health-Pediatric Complex Care (Team 1)
• UW Health-Pediatric Complex Care (Team 2)
• Waisman Center
• CHW-Complex Care Clinic
• CHW-Rheumatology Clinic
• Gerald L. Ignace
Douglas
Bayfield
Iron
Ashland
Vilas
Florence
Burnett
Washburn
Sawyer
Price
Oneida
Forest
Polk
Barron
Rusk
Taylor
Lincoln
Langlade
Marinette
St. Croix
Dunn
Chippewa
Marathon
Menominee
Oconto
Door
Pierce
Pepin
Eau Claire
Clark
Shawano
Kewaunee
Buffalo
Wood
Portage
Waupaca
Outagamie
Brown
Trempealeau
Jackson
Waushara
Winnebago
Calumet
Manitowoc
La Crosse
Monroe
Adams
Marquette
Green Lake
Fond du Lac
Sheboygan
Juneau
Vernon
Richland
Sauk
Columbia
Dodge
Washington
Ozaukee
Crawford
Iowa
Dane
Jefferson
Waukesha
Milwaukee
Grant
Racine
Lafayette
Green
Rock
Walworth
Kenosha

Populations selected for piloting Shared Plans of Care

Clinic	Patient Focus
Bad River	Youth in foster care due to opiate-addicted parents
CHW/MCW-Rheumatology	Newly diagnosed children/adolescents with chronic rheumatic disease
Forest Co. Potawatomi	Children/youth who are diagnosed with global developmental delays or ASD.

Populations selected for piloting Shared Plans of Care

Clinic	Patient Focus
Prevea Pediatrics	Pediatric rheumatology patients
St. Croix	Native American children with special health care needs being served by St. Croix Tribe
Stockbridge-Munsee	Children with asthma (0-18 y.o.)

Populations selected for piloting Shared Plans of Care

Clinic	Patient Focus
UW Health/AFCH-Ped Complex Care	Children with medical complexity who are enrolled in the program
Waisman Center Newborn Follow-up Clinic	Children less than 36 months who spent time in neonatal intensive care units

Pilot the use of the CCMT

The goal of the CCMT is to gather information around which team member is performing care coordination, which activities are performed, time spent performing such activities, and outcomes achieved or avoided.

Focus on non-reimbursed activities

General Guidance

- Non-reimbursed activities only
- Complete for encounters >5 min.
- One row corresponds with one encounter on one day only
- Document encounters each day
  - Can select “outcome pending” if encounter not resolved within one day

Case Study

David

Encounter #1 - May 8

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
5/8/19	11	III	3	5	1c, 2c, 4, 5, 8		2L				X				RN	C	NR

- **Focus of Encounter: 3 (Educational/School)**
- **Care Coordination Needs: 5 (Coordination Services)**
- **Activity Code(s):**
  - **1c (Telephone discussion with school)**
  - **2c (Electronic contact with school)**
  - **4 (Form Processing-eg school, camp)**
  - **5 (Confer with PCP)**
  - **8 (Chart review)**
- **Outcome Prevented: n/a**
- **Outcome Occurred:**
  - **2l (Advocacy for family/patient)**

Encounter #2 – May 23

School social worker

Encounter #2 - May 23

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
5/8/19	11	III	3	5	1c, 2c, 4, 5, 8		2L				X				RN	C	NR
5/23/19	11	III	7	3	2h, 5, 8		2i, 2m			X					RN	C	NR

- **Focus of Encounter: 7 (Clinical/Medical Management)**
- **Care Coordination Needs: 3 (Order prescriptions)**
- **Activity Code(s):**
  - **2h (Electronic contact with pharmacy)**
  - **5 (Confer with PCP)**
  - **8 (Chart review)**
- **Outcome Prevented: n/a**
- **Outcome Occurred:**
  - **2i (Ordered prescription, equipment, diapers, etc)**
  - **2m (Met family's immediate needs)**

Questions on the Tool?

- Recorded presentation available (contact Colleen for link)

Considerations

- Who is best positioned within your team to complete the CCMT?
- Who will submit the data online & review the data that is gathered?
- How might the data be used within your organization?
- Reflections on last year

MAY 2019
Complete hard copy and submit online

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

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 Boston Children's Hospital

Hard copy

WISCONSIN Medical Home
Children's Health Alliance of Wisconsin

Care Coordination Measurement Tool 2019

Please complete the survey below.

Thank you!

Site:

- ○ Amery Hospital and Clinic
- ○ Bad River Tribal Health Center
- ○ CHW-Complex Care Clinic
- ○ CHW-Rheumatology Clinic
- ○ Forest Co. Potawatomi Health and Wellness Center
- ○ Gerald L. Ignace Indian Health Center
- ○ Lac du Flambeau Peter Christensen Health Center
- ○ Lac Courte Oreillas Community Health Center
- ○ Prevea Health Clinic
- ○ St. Croix Tribal Health Center
- ○ Sokaogon Chippewa Health Center
- ○ Stockbridge Munsee Health and Wellness Center
- ○ UW Health AFCH-Pediatric Complex Care TEAM 1 (Ehlenbach)
- ○ UW Health AFCH-Pediatric Complex Care TEAM 2 (Sodergren)
- ○ Waisman Center Newborn Follow-up Clinic

Online

CYSHCN Network of Support

Family Voices of Wisconsin

PARENT TO PARENT WISCONSIN

Wisconsin Title V Children and Youth with Special Health Care Needs Program

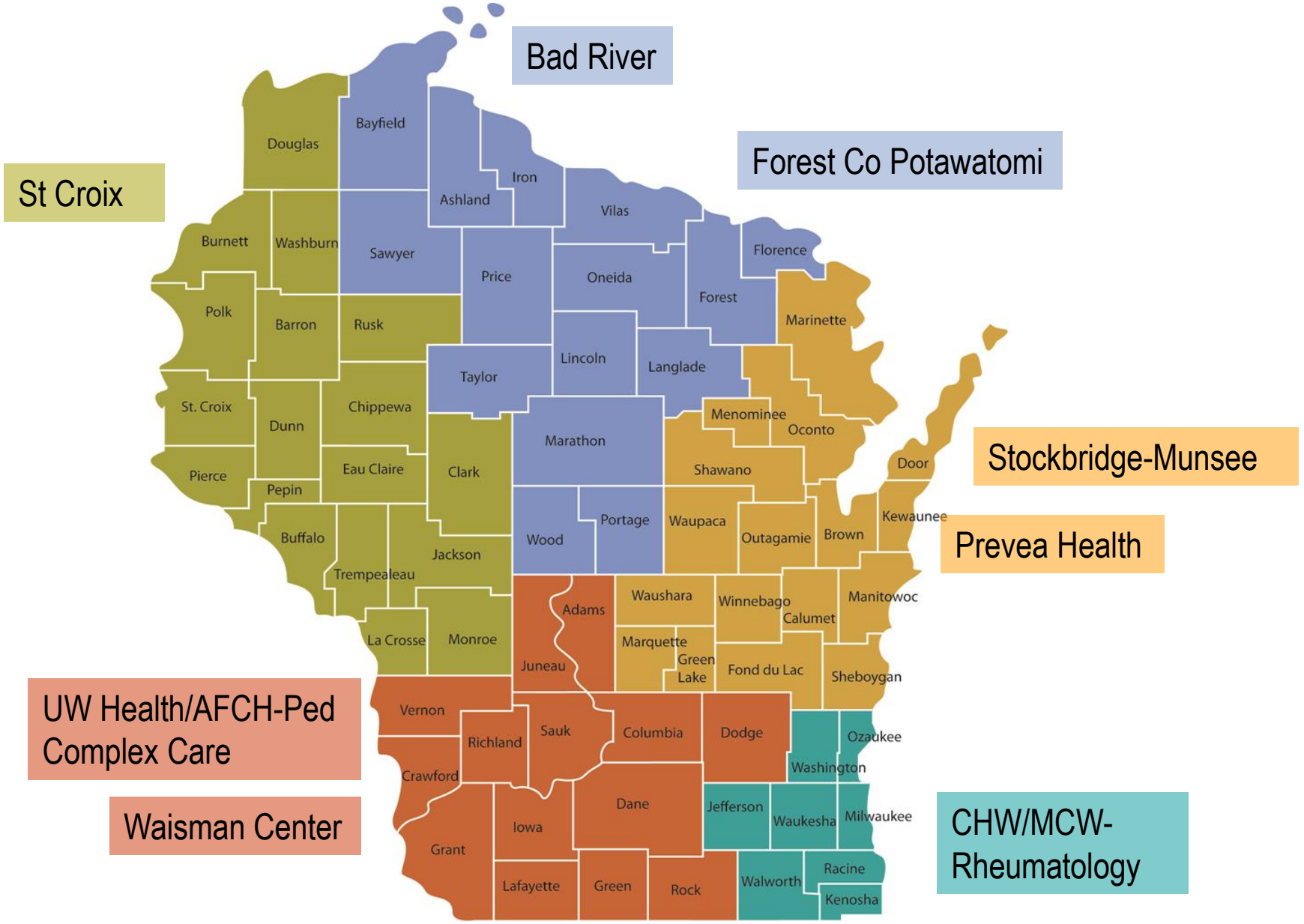
WISCONSIN Medical Home
Children's Health Alliance of Wisconsin

WELL BADGER RESOURCE CENTER

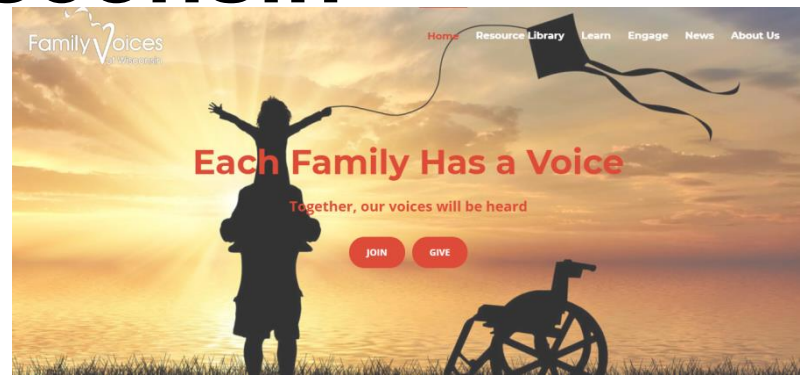
ABC FOR HEALTH Since 1994

HEALTH TRANSITION WISCONSIN
SUPPORTING YOUTH TO ADULT HEALTHCARE

Regional Centers



Family Voices of Wisconsin



Why would a parent contact Family Voices of Wisconsin?

- To serve in a leadership or advisory role to impact health care or long-term supports
- To join our regional Facebook groups, be added to the Family Action Network and our mailing list
- Register for a training
- Have resources printed from our website
- Have suggestions for a newsletter article, fact sheet, or new training

Parent to Parent of Wisconsin

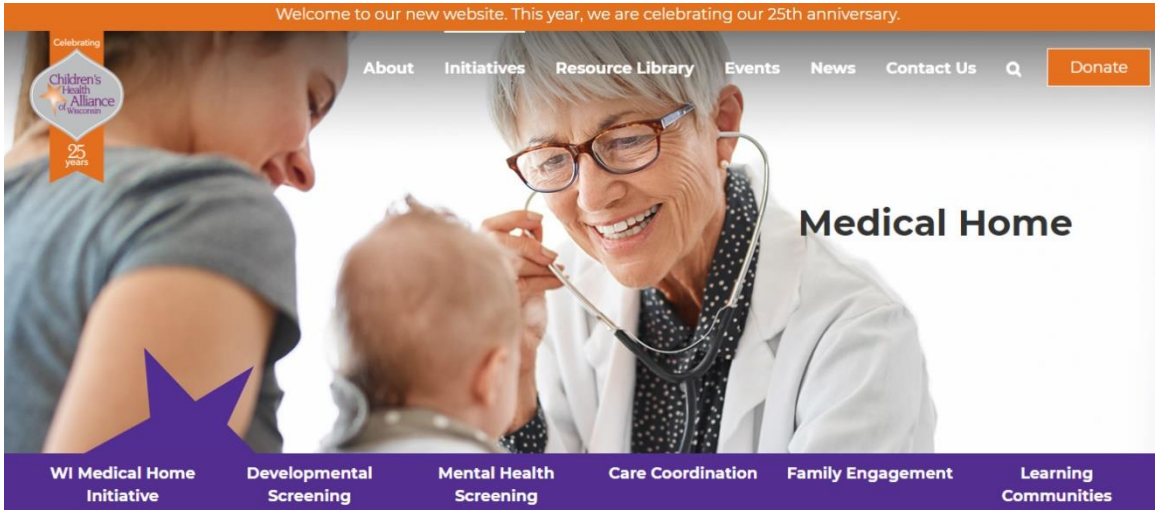
Parent Parent
WISCONSIN

Why would a parent contact Parent to Parent of Wisconsin?

- To request a "match."
- To register for a Support Parent training.
- To schedule a Support Parent training in their area.

Wisconsin Medical Home Initiative

WISCONSIN Medical Home
Children's Health Alliance of Wisconsin



Why would a provider or family member contact the Wisconsin Medical Home Initiative?

- To learn more about partnering with their child's doctor.
- To learn more about use of a shared plan of care to facilitate care for CYSHCN.

Wisconsin Youth Health Transition Initiative

HEALTH TRANSITION WISCONSIN
SUPPORTING YOUTH TO ADULT HEALTHCARE

Why would a provider or family member contact the Wisconsin Youth Health Transition Initiative?

- Visit the YHTI website for information, tools and resources to help prepare and plan for health transition.
- Seek and receive more information through training programs sponsored by partners including things to consider at different ages as well as ways they can support their child to become more involved in their health care.

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