Care Coordination Task Force *Key Elements* Framework

The MA Child Health Quality Coalition (CHQC) was created to facilitate a shared understanding of priorities for child health in Massachusetts and implement activities to drive improvements in identified. CHQC members identified gaps in care coordination, especially for children with behavioral health needs, as one of the highest priority areas for initial action.

CHQC's emphasis on improving care coordination is based on addressing the negative impact that fragmented care delivery and poor communication can have on children's health. The effort is bolstered by the strong body of evidence supporting the role of care coordination in achieving all three of the Triple Aim goals for high-value health care: improving individual health (quality/patient experience), reducing costs, and improving population health.

CHQC chartered the Care Coordination Task Force in May 2012 to develop tactical strategies for promoting improved care coordination for children in Massachusetts. Multi-stakeholder representation on the task force included strong family voices, medical and mental health providers, and other stakeholders including advocacy groups and public programs.

The Task Force has identified a set of **key elements of high-performing pediatric care coordination**, and is working to prioritize **process, structure, and outcome measures linked to those elements that can be used to monitor their adoption**. The Task Force work drew heavily on evidence from existing models and from the literature (see Appendix A). In creating this foundational framework, the task force developed elements that would be applicable to children and youth with severe, disabling conditions as well as those at lower acuity levels, to those with medical and/or behavioral health needs, and to children of different ages. The Framework also has broad applicability to adults as well as children; in fact, with the exception of a special domain for transitioning from pediatric to adult care and calling out school/day care community connections, all the domains apply equally well to adults.. By framing the Task Force's vision for assessing the effectiveness of care coordination activities under the Triple Aim value optimization constructs, the framework has proven an effective driver in strategic conversations with both commercial and public payers.

An overview of the framework details is presented in the following two tables:

Key Elements Framework (Table 1): *key elements identified within five domains:*

1. *Needs assessment for care coordination and continuing care coordination engagement*
2. *Care planning and communication*
3. *Facilitating care transitions (inpatient, ambulatory)*
4. *Connecting with community resources and schools*
5. *Transitioning to adult care*

Accountabilities Framework (Table 2):

A structure for addressing different stakeholders' accountabilities and identifying opportunities to build bundles of related measures for specific care coordination elements (e.g. developing the care plan) connected to the different care team participants.

Additional details on implementation strategies (priorities, tools, addressing barriers), measure landscape reviews that identify process, structure, and outcome measures that can be used to monitor adoption, and outreach activities to align stakeholders around feasibility testing are available on request (send email to Gina Rogers at grogers@mhqp.org).

Framework for Defining High-Performing Pediatric Care Coordination

Table 1: Stakeholder-Identified Key Elements and Measures to Monitor Their Adoption

Care Coordination Key Elements/Activities	Potential Focus Areas for Implementation and Measurement
1. Needs assessment for care coordination and continuing care coordination engagement • Family-driven, youth-guided needs assessment, goal setting • Use a standard process to assess care coordination needs (differs from clinical needs) • Engage team, assign clear roles and responsibilities • Develop authentic family-provider/care team partnerships; requires family/youth capacity building, professional skill building	❖ Using structured tool for needs assessment ❖ Family as active participant in goal setting ❖ Survey families: Did you get what you needed? Was your voice heard?
2. Care planning and communication • Family and care team co-develop care plans • Ensure communication among all members of the care team • Monitor, follow-up, respond to change, track progress toward goals • Workforce training occurs that promotes effective care plan implementation	❖ Family engagement in care plan development ❖ Care plan accessible to members of the care team ❖ Ongoing reassessment and refinement of the care plan (progress toward goals) ❖ Family-facing version: emphasize action plan, just-enough info
3. Facilitating care transitions (inpatient, ambulatory) • Family engagement to align transition plan with family goals, needs • Implement components of successful transitions (8 elements of a family-driven/youth guided care transition, including receiving provider acknowledging responsibility) • Ensure information needed at transition points is available	❖ Track "closing the loop" with referrals to outside behavioral health entities one priority ❖ Also timely transmission of therapeutic information from those external entities back to the PCP setting *Some existing measures within HEDIS (ADHD, FUH-follow up after hospitalization for mental illness), CAHPS/PES patient survey measures, components of Meaningful Use*
4. Connecting with community resources and schools • Facilitate connection to MA family support organizations/Family Partners • Coordinate services with schools, agencies, payers • Identify opportunities to reduce duplication of efforts in building knowledge of available community services	❖ High priority on providing access to Family Partner/mentor ❖ Ask the family: Did you get the connections you needed? ❖ Strategies for testing electronic, bi-directional communication loops (see MA e-Referral system development (SIM-grant funded) and AHRQ's new *Clinical-Community Relationships Measures Atlas*)
5. Transitioning to adult care • Implement Center for Health Care Transition Improvement's Six Core Elements of Health Care Transition (HCT) • Teach/model self-care skills, communication skills, self-advocacy	❖ Written transition goals co-developed with the youth ❖ Identification of adult providers with capacity, expertise ❖ Health information summary available at transition

Send comments to Gina Rogers: grogers@mhqp.org

The Centers for Medicare and Medicaid Services (CMS) supports the CHQC through grant funds issued pursuant to CHIPRA section 401(d)
The statements and opinions expressed in this Framework are those of the authors and not those of CMS.

Framework for Defining High-Performing Pediatric Care Coordination

Table 2: Pediatric Care Coordination Accountability Framework

This framework focuses on identifying the levels of accountability or responsibilities that belong to each group, not the source of input for data on measures. Embedded measures will include both quality and costs/total medical expenses (TME) measures with risk adjustment.

Levels of Accountability	Measures *To be populated from each of the five domains* Structure	Process	Outcomes
Child/Family			
Community/Schools			
Group Practice/Medical Home (Primary Care)/Individual Providers			
Specialty Practices (Psychiatric, Other) Individual Providers (Sub-Specialists)			
Community-Based Organizations, Community Service Agencies (CSAs) Other Service Providers (EI, CSA, rehab)			
Inpatient Facilities			
Health Systems/ACOs			
Health Plans			
State, Local/Community Public Health			
National/Regional			

The Centers for Medicare and Medicaid Services (CMS) supports the CHQC through grant funds issued pursuant to CHIPRA section 401(d)
The statements and opinions expressed in this Framework are those of the authors and not those of CMS.

Appendix A: Key References for Care Coordination Frameworks and Measures

Frameworks

- **AHRQ Care Coordination Atlas**
  - McDonald KM, Schultz E, Albin L, Pineda N, Lonhart J, Sundaram V, Smith-Spangler C, Brustrom J, and Malcolm E. "Chapter 3. Care Coordination Measurement Framework: Care Coordination Measures Atlas." *Agency for Healthcare Research and Quality, Rockville, MD.*January 2011. http://www.ahrq.gov/professionals/systems/long-term-care/resources /coordination/ atlas/chapter3.html
  - Dymek C, Johnson M, Mardon R, Hassell S, Carpenter D, McGinnis P, Buckley D, Fagnon L. Clinical-Community Relationships Measures (CCRM) Atlas. *Agency for Healthcare Research and Quality, Rockville, MD.*March 2013. http://www.ahrq.gov/professionals/prevention-chronic-care/resources/clinical-community-relationships-measures-atlas/index.html
- **Commonwealth/Antonelli Pediatric Framework**
  - Antonelli R, McAllister J, Popp J. "Making Care Coordination a Critical Component of the Pediatric Health System: A Multidisciplinary Framework." *The Commonwealth Fund.* May 21, 2009. p. 10-11
- **System of Care/Wraparound Framework**
  - Stroul, Blau, Friedman. "Updating the System of Care: Concept and Philosophy." *Georgetown Center for Child and Human Development*. 2010. Pg 6
  - Lyons, John S. "CANS Comprehensive Form." *The Praed Foundation.* January 31, 2008. http://www.praedfoundation.org/CANS-Comprehensive%20form.pdf
  - Bruns, Eric J. "Wraparound Fidelity Assessment System: Team Observation Measure." *National Wraparound Initiative.* October 1, 2007. http://www.nwi.pdx.edu/NWI-book/Chapters/App-6c.2-WFAS-Team-Observation-Measure.pdf.
  - Bruns, Eric J. "Wraparound Fidelity Index 4." *National Wraparound Initiative*. March 18, 2008. http://www.nwi.pdx.edu/NWI-book/Chapters/SECTION-6.pdf
- **NCQA Meaningful Measures of Care Coordination**
  - Scholl SH. "Meaningful Measures of Care Coordination." *National Committee on Vital Health Statistics* . October 13, 2009. http://www.ncvhs.hhs.gov/091013p9 .pdf
- **National Quality Forum (NQF), National Priorities Partnership (NPP) – Measure Application Partnership (MAP)**
  - Care Coordination Family of Measures (request for public comment August 10, 2012)
  - Corrigan, J. "Building High Value Health Systems: The Role of Performance Measurement."*National Quality Forum*. January 13, 2012. http://ldihealtheconomist.com/media/janet_corrigan_slides.pdf.

Inventory of Measure Sets

- NCQA Healthcare Effectiveness Data and Information Set (HEDIS) (selected measures applicable to pediatric care coordination)
- NQF-Endorsed 12 Care Coordination measures (August 2012)
- NQF-Endorsed Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination (NQF 2010)
- Physician Consortium for Performance Improvement (PCPI) (AMA-convened) Care Transitions Measurement Set (2009) and STAAR
- Medicaid Meaningful Use Measures (Stage 1) (for incentive payments for EHR adoption)
- NCQA's Patient-Centered Medical Home (PCMH) and new Accountable Care organization (ACO) Accreditation Programs
- MA Statewide Quality Advisory Committee (SQAC) recommended measure sets; MassHealth Comprehensive Primary Care Payment Reform potential list of metrics (p. 5-6)

Practice-based surveys

- Medical Home Care Coordination Measurement Tool (CCMT)
- Center for Medical Home Improvement (CMHI) Medical Home Index (MHI)
- Primary Care Assessment Tool (PCAT-PE, PCAT-FE)
- Medical Home Health Care Transition Index (HCTI)
- Behavioral Health Integration Needs Assessment (survey developed for the MA Patient-Centered Medical Home Initiative)

Family/patient experience surveys

- National Survey Children w/ Special Health Care Needs (NS-CSHCN)
- MHQP Ambulatory Patient Experience Survey (PES)
- NQF-Endorsed 3-item Inpatient Care Transition Questions (CTM-3)
- Families and Communities Together (FCT) Parent Satisfaction Svy
- Medical Home Family Index (MHFI), companion to CMHI
- Family-Centered Care Self-Assessment Tool (Family Voices/MCHB)
- Patient Activation Measure (PAM) (Hibbard et al)
- The Right Question Effective Patient Strategy™

The Centers for Medicare and Medicaid Services (CMS) supports the CHQC through grant funds issued pursuant to CHIPRA section 401(d)
The statements and opinions expressed in this Framework are those of the authors and not those of CMS.

Appendix B: MA Child Health Quality Coalition Care Coordination Task Force Members

Co-Chairs and CHQC Staff Lead	
Rich Antonelli, MD, MS	Medical Director for Integrated Care Boston Children's Hospital
Barbara Leadholm	Principal, Health Management Associates, and former Commissioner DMH and Senior Advisor, MassHealth Office of Behavioral Health
Gina Rogers	Consultant and Founding Director MA Child Health Quality Coalition
Task Force Members	
Deborah Allen, ScD	Director, Bureau of Child, Adolescent, and Family Health Boston Public Health Commission
Nancy Borreani	Family Support and Training Director, Families and Communities Together (N. Central Worcester CSA)
Susan Epstein, MSW*	Strategic Consultant and former President, New England Serve and the Massachusetts Consortium for Children with Special Health Care Needs
Emma Smizik and Elaine Fitzgerald*	Project Managers, National Initiative for Children's Healthcare Quality (NICHQ)
Christina Fluet	Director of Planning and Policy Development, Child/Adolescent Division, MA Department of Mental Health (DMH)
David Keller, MD*	Associate Medical Director, Office of Clinical Affairs/MassHealth/ Commonwealth Medicine
Katherine (Kate) Hobbs Knutson, MD	Associate Medical Director in Psychiatry, Office of Clinical Affairs, MassHealth ; Child & Adolescent Psychiatry, South Boston Community Health Center
Cristin Lind*	Family Leader and Project Advisor, Medical Management Innovations AB, Stockholm, Sweden
Peter Metz, MD	Pediatric and Adolescent Psychiatry; Director, Communities of Care, Dept of Psychiatry, Univ of MA Medical School
Beth Pond	Training Coordinator Parent/Professional Advocacy League (PPAL)
Gita Rao, MD*	Program Manager, MYCHILD, Early Childhood Mental Health Program, Boston Public Health Commission
John Straus, MD	Director, MA Child Psychiatry Access Project (MCPAP); SVP of Medical Affairs, MA Behavioral Health Partnership (MBHP)
Bonnie Thompson	Family Resource Specialist and CHIPRA Family Leader, Mass Family Voices at the Federation for Children with Special Needs
Judith Vessey, PhD, MBA	Professor of Nursing Connell School of Nursing, Boston College
Jean Zotter and Laura Nasuti	Director, Office of Integrated Policy, Planning, and Management, Bureau of Community Health and Prevention, MA Department of Public Health (DPH)

*Denotes former TF members no longer as active participants as a result of job changes