Slides
Module 4 of Pediatric Care Coordination Curriculum

Measurement Matters: Creating an Effective and Sustainable Integrated Care Model

Educational Purposes Only – No Medical Advice

The Pediatric Care Coordination Curriculum is offered for educational purposes only and is not meant as a substitute for independent medical judgment or the advice of a qualified physician or health care professional. Users who choose to use information or recommendations made available by the Pediatric Care Coordination Curriculum do so at their own risk and should not rely on that information as professional medical advice or use it to replace any relationship with their physicians or other qualified health care professionals.

Why measure?

- To assess current gaps
- To prioritize improvement opportunities
- To measure success over time

L Add local content

Key Definitions

- Accountable Care Organizations (ACOs)
- Value-based care
- Fee-for-service
- Global budgeting

Rapid Cycle QI

- Rapid cycle is a type of quality improvement that assesses areas of improvement and implements and tests changes over time

- Measurement is extremely important to the success of quality improvement

Quality Measures That Can Drive Implementation of Care Coordination

2018 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set)

NQF #	Measure Steward	Measure Name
Primary Care Access and Preventive Care		
0024	NCQA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Assessment for Children/Adolescents (WCC-CH)
0033	NCQA	Chlamydia Screening in Women Ages 16–20 (CHL-CH)
0038	NCQA	Childhood Immunization Status (CIS-CH)
0418/0418e	CMS	Screening for Depression and Follow-Up Plan: Ages 12–17 (CDF-CH)*
1392	NCQA	Well-Child Visits in the First 15 Months of Life (W15-CH)
1407	NCQA	Immunizations for Adolescents (IMA-CH)
1448**	OHSU	Developmental Screening in the First Three Years of Life (DEV-CH)
1516	NCQA	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34-CH)
NA	NCQA	Adolescent Well-Care Visits (AWC-CH)
NA	NCQA	Children and Adolescents' Access to Primary Care Practitioners (CAP-CH)
Maternal and Perinatal Health		
0139	CDC	Pediatric Central Line-Associated Bloodstream Infections (CLABSI-CH)
0471	TJC	PC-02: Cesarean Birth (PC02-CH)
1360	CDC	Audiological Diagnosis No Later Than 3 Months of Age (AUD-CH)
1382	CDC	Live Births Weighing Less Than 2,500 Grams (LBW-CH)
1517**	NCQA	Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH)
2902	OPA	Contraceptive Care – Postpartum Women Ages 15–20 (CCP-CH)
2903/2904	OPA	Contraceptive Care – All Women Ages 15–20 (CCW-CH)*
Care of Acute and Chronic Conditions		
1800***	NCQA	Asthma Medication Ratio: Ages 5–18 (AMR-CH)*
NA	NCQA	Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)
Behavioral Health Care		
0108	NCQA	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)
0576	NCQA	Follow-Up After Hospitalization for Mental Illness: Ages 6–20 (FUH-CH)
2801	NCQA	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)
NA	NCQA	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)
Dental and Oral Health Services		
2508	DQA (ADA)	Dental Sealants for 6–9 Year-Old Children at Elevated Caries Risk (SEAL-CH)
NA	CMS	Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)
Experience of Care		
NA	NCQA	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC-CH)

Source: https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2018-child-core-set.pdf

Types of Measurement

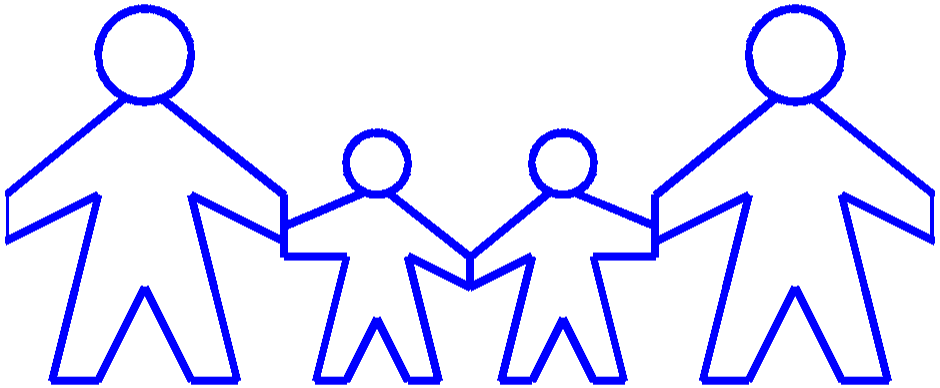
Measurement Type	Definition	Example
Structural measures	Measures of organizational characteristics	• Staffing ratios, number of hospital beds
Process measures	Interactions between the physician or nonphysician clinician and patient; a series of actions, changes, or functions bringing about a result (such as the rate of patients who left the emergency department without being seen); captures physician and nonphysician clinician productivity and adherence to standards of care	• Measured within the system (eg, electronic medical records) • Measured through self-reports by patients (eg, patient experience measures)
Outcome measures	Health status (desirable and undesirable) in individuals and populations that are attributed to health care (eg, health care-acquired adverse event, patient function, mortality, intermediate clinical outcome, service utilization as proxy for patient outcome, and health-related quality of life)	• Measured within the system (eg, surgical site infections, emergency department rates, hospitalizations, and length of stay) • Patient-reported outcome measures (eg, self-reported health and sense of well-being, ability to complete various activities, mood, and levels of fatigue and pain)
Balance measures	Used to assess how one change affects other variables in the system. For example, is making an improvement in one area affecting (negatively or positively) another area?	• If the intervention is decreasing length of hospital stay, a balance measure could be emergency department utilization.

Tools for Measurement

- Online resources
  - National Quality Forum Measure Set
  - National Committee for Quality Assurance
  - National Survey on Children's Health

- Family experience tools
  - Family Experience with Coordination of Care
  - Pediatric Integrated Care Survey
  - Family Voices Family Centered Care Self-Assessment Tool

Family Experience Measurement



How to measure care coordination?

- Track activities and associated outcomes
- Suggested tool: Care Coordination Measurement Tool

Care Coordination Measurement Tool©

	Patient Level	Care Coordination Needs	Activity	Outcomes Occurred	Outcomes Prevented	Time Spent	Staff	Clinical Competence
1								
2								

Introduction to Case Studies

Case Study #1

Gordon Pediatrics

Part 1

Pause for Reflection

How could Gordon Pediatrics show that there is a need for and value in care coordination?

Gordon Pediatrics: Activities and Outcomes

Activities	Outcomes Occurred	Outcomes Prevented	Clinical Competence
40% of the time: reconciled medication discrepancies **35% of the time: advised families on the information needed for a school individualized education plan and processed additional school forms** **30% of the time: discussed insurance options with families** **20% of the time: secured prior authorizations**	30% of the time: connected families to community agencies 45% of the time: advised patients on home management 30% of the time: helped patients obtain additional services in school	20% of the time: prevented gaps in medication 45% of the time: prevented unnecessary office visits 20% of the time: prevented additional missed school days	30% of the time: recorded tasks did not require clinical competence (neither social worker nor nurse)

Nurse and social worker care coordination activities and outcomes

Pause for Reflection

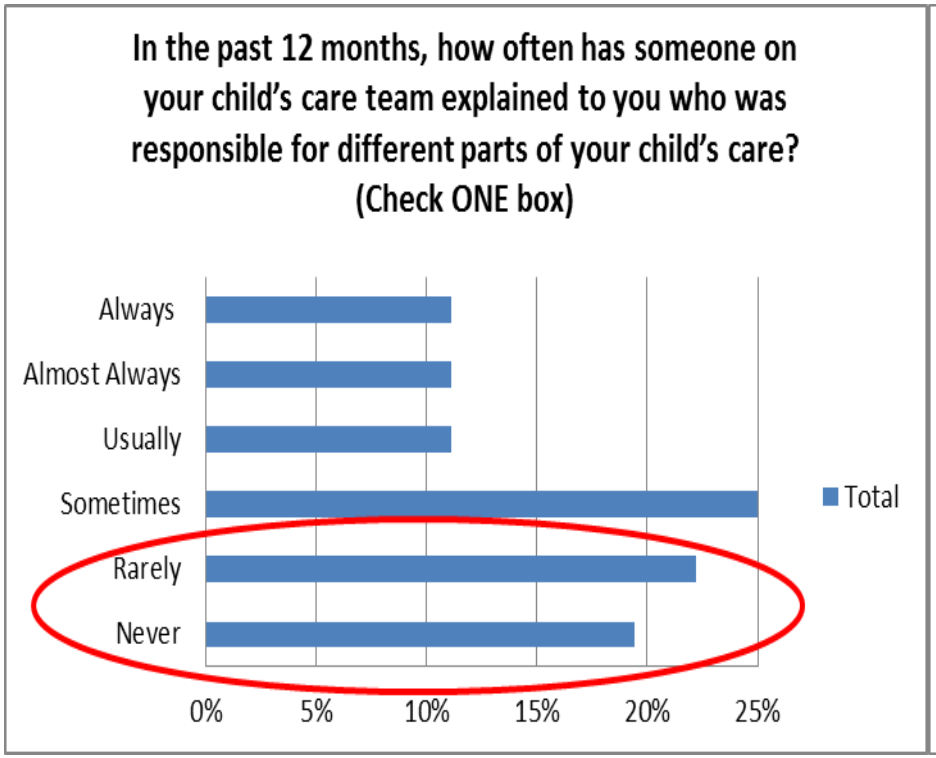
- What are conclusions that Gordon Pediatrics can draw based on the data collected with the Care Coordination Measurement Tool?
- What are the implications for the data as Gordon Pediatrics prepares for value-based care delivery?
- How can the data help to make the case for additional or different allocation of resources?

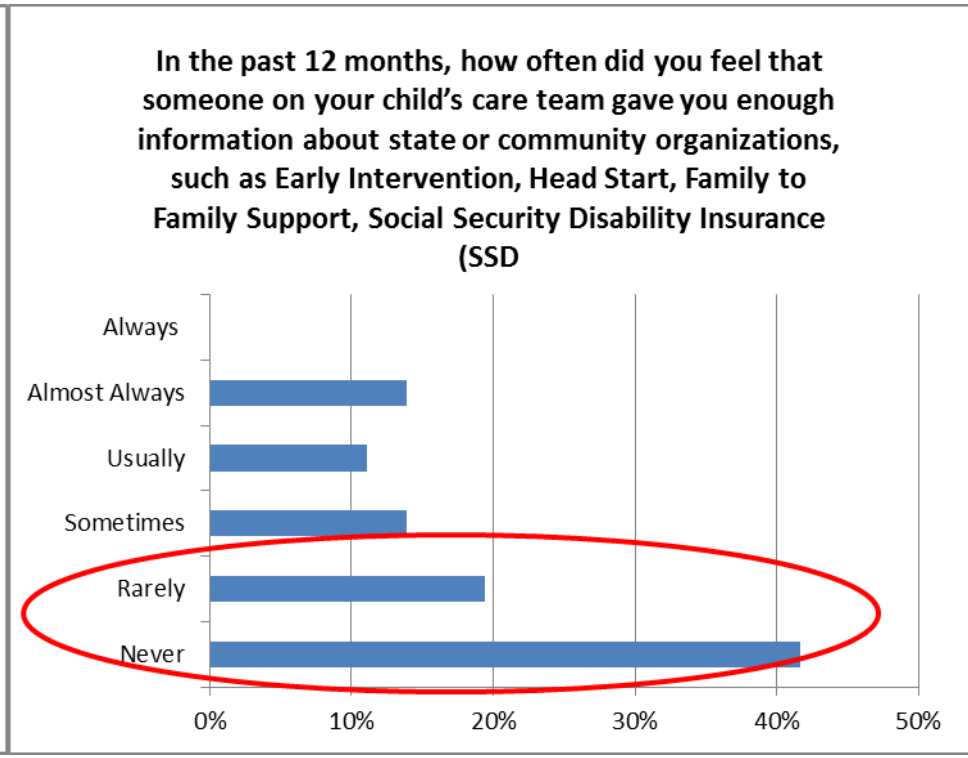
Case Study #1

Gordon Pediatrics

Part 2

Gordon Pediatrics: Family Experience Data





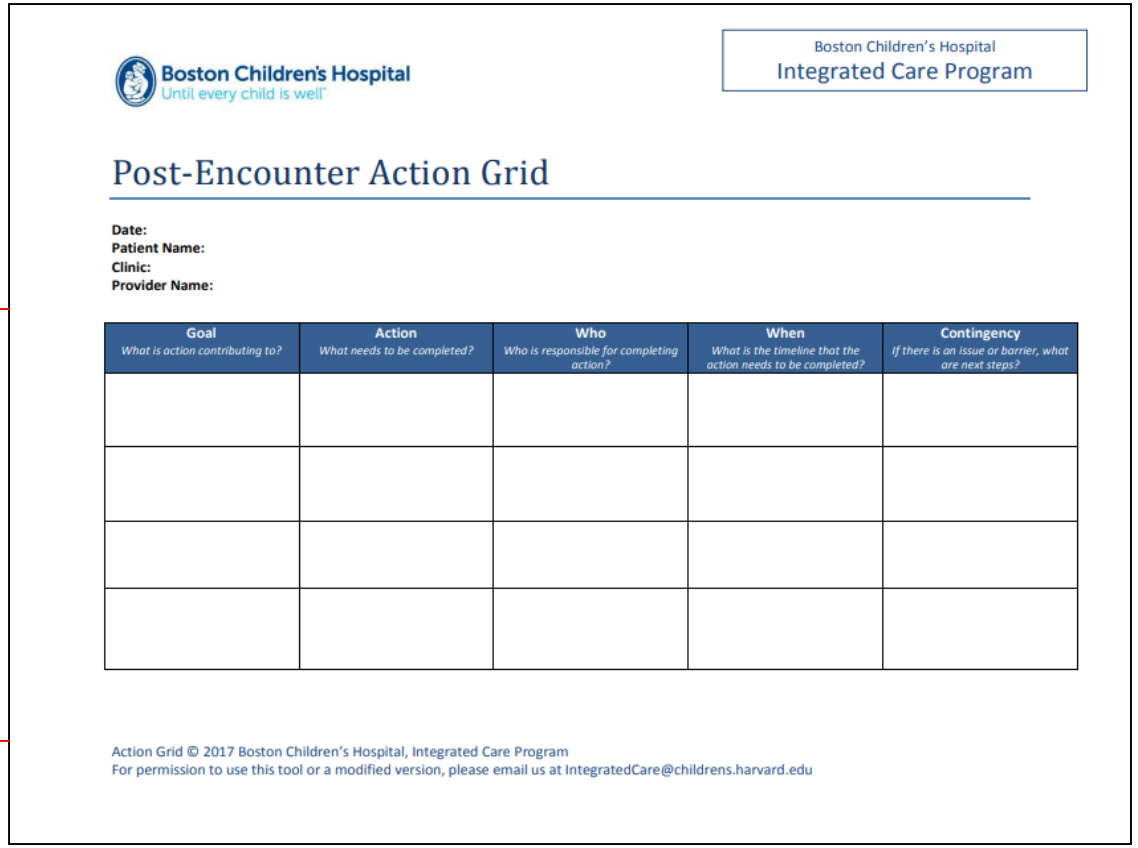
Pause for Reflection

- What do the family experience data tell Gordon Pediatrics?
- How can the data be used to drive changes?

Action Grid

The action grid is a care planning tool intended to document action items resulting from an in-person visit or encounter.

Answers
- **WHO**
- **WHAT**
- **WHEN**
- **WHERE**
- **HOW**



Boston Children's Hospital
Until every child is well®

Boston Children's Hospital
Integrated Care Program

Post-Encounter Action Grid

Date:
Patient Name:
Clinic:
Provider Name:

Goal *What is action contributing to?*	Action *What needs to be completed?*	Who *Who is responsible for completing action?*	When *What is the timeline that the action needs to be completed?*	Contingency *If there is an issue or barrier, what are next steps?*

Action Grid © 2017 Boston Children's Hospital, Integrated Care Program
For permission to use this tool or a modified version, please email us at IntegratedCare@childrens.harvard.edu

Pause for Reflection

What are types of process, outcome, and balancing measures that the team could collect?

Outcome/Process/Balance Measures

Measure Type	Measure
Process	What: Action grids shared with families How: The number of families that received the action grid/the total number of families seen in the clinic
Outcome	What: Emergency department utilization How: Emergency department visits were counted for all patients included in the cohort
Balancing	What: Physician and nonphysician clinician experience with the action grid How: Physicians and nonphysician clinicians were asked rating questions to assess their experience with implementation of the action grid

Case Study #2

Connect

Title V Program

Pause for Reflection

How could Connect coordinators create a value stream for their work? Are there processes, tools, or measures that could be used?

Connect Activities and Outcomes

Activities	Outcomes Occurred	Outcomes Prevented
20% of the time: introduced supplementary insurance options to families **25% of the time: communicated with a community agency, educational facility, or school via telephone or email** **40% of the time: connected families and family support groups** **60% of the time: connected families and community services**	15% of the time: a family was financially able to access a service that supported care for its child at home 20% of the time: a family found an educational program that was suitable for its child's needs 35% of the time: a family connected to a peer support network	15% of the time: prevented a gap in service due to a family's inability to afford the cost 20% of the time: prevented a gap in time so that a child was able to attend school or an educational program

Connect Care Coordinators data

Pause for Reflection

How could Connect message these outcomes to demonstrate the instrumental role they play?

Closing

- Ask learners to reflect on what they learned today that they will take back to their individual settings.

- Ask for final questions and thoughts.