Module 1: High-Value Integrated Care Outcomes Depend on Care Coordination
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.
Objectives

• Discuss key components of care coordination within an integrated model of care delivery.
• Assess current practices that support care coordination and integrated care delivery in a variety of settings, including state, regional, delivery system, community agency, or clinics.
• Prioritize areas of improvement in care integration and care coordination in the current practice.
• Identify established tools and processes that can be used to implement key components of care coordination.
• Develop an action plan outlining specific goals to facilitate care coordination in the practice.
Overview

• Care coordination from theory to practice
• Asset and needs assessment
• Case study: introduction to tools
• Shared plan of care
• Action-oriented exercise
Objective

Participants will be able to…

Discuss key components of care coordination within an integrated model of care delivery.
What is Care Coordination?

2014 AAP Policy Statement

Patient-and Family-Centered Care Coordination: A Framework for Integrating Care for Children and Youth Across Multiple Systems

Defined care coordination as

A patient- and family-centered, assessment-driven, team-based activity designed to meet the needs of children and youth while enhancing the caregiving capabilities of families. Care coordination addresses interrelated medical, social, developmental, behavioral, educational, and financial needs to achieve optimal health and wellness outcomes.

Care Coordination Enables Integrated Care

Care Fragmentation

- Lack of communication between care providers
- Gaps in services
- Duplication of services

Care Integration

- Team-based care
- Connections to community
- Collaborative care planning

Care coordination

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Integrated Care Framework

Integrated Care “Holistic Care”

Team-Based Care
- Team Configuration
- Communication
- Knowledge Sharing

Connection to Community
- Information
- Family Impact

Collaborative Care Planning
- Long-Term Plan/Roadmap
- Goals
Who Is Involved in Care Coordination?

- Patients and families
- Pediatricians and other physicians
- Pediatric medical subspecialists and pediatric surgical specialists
- Case management
- Public and commercial payers
- Community health workers
- Schools
- State agencies
- Title V
One Family’s Care Map

Out-of-district school
- Bus Driver
- District Coordinator
- Sped Liaison
- Sped Director
- Sped Parent-Advisory Council
- Transportation

Clinic director
- SpEd Director
- SpEd Teacher
- PT
- OT
- Nurse
- 76 ABA therapists
- BCBA
- Sped-Pac

City Sped

DESE

School

Developmental Assessments

Our Family

Health

Pediatric specialty Hosp
- Endocrine
- Genetics
- Cardiology
- GI
- Ophthalm
- Ortho
- Dentist
- Referrals, triage, scripts

Specialty Hospital
- Meds+ Equip.
- Neuro
- Speciality Pharm
- Local Pharm
- Toileting Supplies
- Food

Support
- People
- Friends
- Neighbors
- Support groups
- N5
- CLSE
- Therapists
- Indiv.
- Family
- Daughter
- Sib.Shops
- Sibling Support Network

Blog: Durga’s Toolbox

Legal & Financial
- Trust & Estate
- Attorney
- Ed. consultant

Support
- Attorneys
- Planner

Education

Info, Advocacy
- Federation for Children w/SN
- Mass Advocates
- Mass Families Organizing for Change
- DPH

Various Orgs
- Family Voices
- Arc
- Disability Scoop
- Catalyst Center

List serves

CHIPRA
LEND

Reps
- Nat’l
- State
- Local

School committee

Adaptive sports coach
- Swim teacher
- Town Rec
- Comm. Arc

Medicaid
DDS

PCA

© 2012 Cristin Lind www.durgastoolbox.com

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Why Is Care Coordination Important?

Impact of Care Fragmentation

• Fragmentation leads to inefficient, less safe care

• Impact on families
  o Leaving employment
  o Divorce

• Impact on employers
  o Higher costs
  o Presenteeism and absenteeism
Measure What Matters
Domains of Integrated Care

Align with the Quadruple Aim for better health, better care, and less cost per capita.

- Person, patient, family, and caregiver experience
- Care coordination
  - Closing the loop
  - High-quality handoffs
  - Care tracking
  - Care planning
- Utilization and financial outcomes
  - Admissions, readmissions, and emergency department utilization
- Provider experience
Achieving the Quadruple Aim

- Improved family experience
- Improved provider experience
- Care integration
- Improved quality
- Reduction of cost

Matching Services to Complexity

**Children with chronic conditions**
- Behavioral (ADHD, depression, anxiety, PTSD)
- Asthma
- Obesity
- Diabetes
- Adverse childhood experiences

**Children with complex needs**
- Neurodevelopmental (autism, etc.)
- Behavioral/psychiatric
- Hematology/oncology
  - Sickle cell
  - Hemophilia
- Technology dependent
- Multiple chronic conditions
- Adverse childhood experiences
Prevalence of Pediatric Complexity

- Healthy, Preventive: 74.5%
- Chronic: 25%
- Complex: 0.5%

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A subspecialty-based or primary care-based team may serve as the medical home for patients with complex needs. The members of the care team work to provide an integrated experience, with an accessible, designated care coordinator who supports patient and/or family needs, including social and behavioral health needs.

The primary care team serves as the medical home, and specialist visits are made as needed. Most care coordination is conducted by the patient and/or family.

The primary care team serves as the medical home within a collaborative care model, integrating services across settings. The primary care team supports care coordination with the patient and/or family.
Impact of Care Fragmentation
Patients with Behavioral Health Needs

86% of families are solely responsible for coordinating their children’s mental/behavioral health care.

Lambert, Pond, Hickey, Antonelli
Parent/Professional Advocacy League and Boston Children’s Hospital
2012
AAP Policy Statement

Patient- and Family-Centered Care Coordination: A Framework for Integrating Care for Children and Youth

POLICY STATEMENT

SUMMARY AND CONCLUSIONS

Care coordination should be a team- and family-driven process that...

RECOMMENDATIONS

1. Use and create mechanisms for patients/families to learn the skills they may need to be partners in their own care and in decision making for optimal care coordination.

2. Ensure that the patient's and family's needs for services and information sharing (eg, care planning) across people, systems, and functions are met through a formal system of coordination, including electronic medical records and paper-based systems.

3. Continuously involve the patient and family (eg, families as partners) in the coordination process, and support efforts to develop practical implementation of care coordination algorithms in practice, practice management, and team development.

4. Use data and analytics to inform care coordination efforts and to identify areas for improvement.

5. Ensure that care coordination and communication occur among specialists, and between primary and specialty care providers.

6. Ensure that care coordination and communication occur among specialists, and between primary and specialty care providers.

7. Ensure ongoing education of elements of care coordination and the medical home for practicing physicians, nurse practitioners, physician assistants, nurses, medical students, residents, and clinicians.

8. Understand the landscape of the PÖM and care coordination as they relate to national organizations and certification standards, such as ACOs, National Committee for Quality Assurance, the American Board of Pediatrics, and other organizations.

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AAP Policy Statement
Select Recommendations

• Create opportunities for family skill building.
• Ensure parent and family needs for services and information sharing are met.
• Utilize care coordination to support transitions of care.
• Create a system of comanagement and communication between pediatricians, pediatric medical subspecialists, and pediatric surgical specialists.
• Provide ongoing education for multidisciplinary care and the care coordination team.
• Collaborate with Title V Maternal and Child Health Services Block Grant state programs.
Ensure that patient and family needs for services and information-sharing are met.

Conduct formal assessments of family strengths, needs, and goals at new patient visits.

Using a survey and/or a family advisory group, gather family experience data to inform quality improvement.

Provide community and family networking resources and connections.

Collaborate with families to establish clear pathways, contingencies, and follow-up with medical-, community-, and educational-based services.
Ensure clear communication and delineation of responsibility across transitions in care.

Define and record action items resulting from each in-person visit.

Assign accountability and a timeline to every action item.

Involves patients and families as partners in handoffs, articulating family goals and developing action steps to achieve them.

Establish contingency plans with patients and families, such as saying, “If you don’t receive a call in 2 weeks, call us back at xxx-xxx-xxxx.”

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Coordinate care across all members of the care team, across multiple settings, and over time.

Facilitate transitions between entities with warm handoffs, including a standard process for follow-up of action items.

Define the nature of the relationship between teams and settings (ie, consultations or shared care).

Collaborate on the development of interagency agreements about how patient information will be shared.

Support information transfer during transitions by using electronic pathways (ie, patient portals).
# Key Elements of Care Coordination

| Needs assessment and goal setting | Use a structured tool to identify needs  
<table>
<thead>
<tr>
<th></th>
<th>Engage families in defining shared goals</th>
</tr>
</thead>
</table>
| Care planning and communication   | Cocreate and implement care plans with families  
|                                      | Ensure accessibility and regular updates or reassessments of care plans |
| Facilitating care transitions      | Close the loop on referrals  
|                                      | Ensure timely communication across transitions |
| Connecting with community resources and schools | Link to family partners and agencies  
|                                      | Coordinate services and ensure bidirectional communication |
| Transitioning to adult care        | Develop written plans for patients transitioning to adult care  
|                                      | Foster self-care and self-management skills |

Based on the Key Elements Framework from the Care Coordination Task Force, Massachusetts Child Health Quality Coalition. [http://www.masschildhealthquality.org](http://www.masschildhealthquality.org)
Objective

Participants will be able to…

• Assess current practices that support care coordination and integrated care delivery in a variety of settings, including state, regional, delivery systems, community agencies, or clinics.

• Prioritize areas for care integration and care coordination improvements in the practice.
Asset and Needs Assessment
### Key Elements

**Needs assessment for care coordination and continuing engagement**
- A family-driven, youth-guided needs assessment for goal setting
- Use a standard process to assess care coordination needs (differs from clinical needs)
- Engage team and assign clear roles and responsibilities
- Develop authentic family/care team partnerships; requires family and youth capacity building and professional skill building

**Care planning and communication**
- Family and care team codevelop care plans
- Ensure communication among all members of the care team
- Monitor, follow-up, respond to changes, and track progress toward goals
- Workforce training occurs, promoting effective care plan implementation

**Facilitating care transitions (inpatient and ambulatory)**
- Engage family to align transition plan with family goals and needs
- Implement components of successful transitions (8 elements of a family-driven and youth-guided care transition, including physician acknowledgement of responsibility)
- Ensure information needed at transition points is available

**Connecting with community resources and schools**
- Facilitate connection to family-to-family support organizations, including chapters of Family Voices and federally-funded Family-to-Family Health Information Centers
- Coordinate services with schools, agencies, and payers
- Identify opportunities to reduce duplication of efforts in building knowledge of available community services

**Transitioning to adult care**
- Implement Center for Health Care Transition Improvement’s Six Core Elements
- Teach or model self-care skills, communication skills, and self-advocacy

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**Source:** Adapted from *Massachusetts Child Health Quality Coalition Care Coordination Task Force*
Objective

Participants will be able to…

Identify established tools and processes that can be used to implement key components of care coordination.
Case Study: Keystone Pediatrics

- Keystone Primary Care is a community-based primary care office that serves approximately 7,000 pediatric patients, 35% of whom are insured by Medicaid.

- The office leadership receives the Quality Report Card and notes that the metric for adolescent well visits is 30%.

- This presents an opportunity for improvement. As the practice implements a quality improvement initiative to increase adolescent well visit rates, it anticipates that behavioral screening rates will increase.

- Currently, 25% of the screens are returning positive. Providers have started sending referrals to social work. It is unclear how many adolescents are actually connecting with someone from social work, and the clinic team realizes it doesn’t have a process for closing the loop on these referrals.
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- A gap in the structured process for completing well visits
- A gap in the system of referrals and handoffs between team members
Areas of Improvement

• Identifying how to improve family well-visit attendance
  o Is there something(s) that is preventing the family from scheduling or attending well-child visits?
  o Are there things that the team could do to make it easier for families?

• Creating a system for closing the loop on referrals

• Getting feedback from patients and families

• Communicating more clearly

• Creating a system for handoffs between care team members (including family!)
The Focus With Today’s Case

• Ensuring that patient and family needs for services and information sharing are met

• Ensuring clear communication and delineation of responsibility across transitions in care

• Coordinating transitions of care across teams and settings over time

Patient- and Family-Centered Care Coordination: A Framework for Integrating Care for Children and Youth Across Multiple Systems. AAP policy statement, 2014
Measuring Patient and Family Experience

- Family Experiences with Coordination of Care (FECC) Survey
- Pediatric Integrated Care Survey (PICS)
Family Experiences with Coordination of Care (FECC)

• Assessment of 20 caregiver-reported care coordination quality measures for children with medical complexity
  o Care coordination services
  o Messaging
  o Protocols/plans

• 12-month time frame
3a. Did anyone in the main provider’s office help you to manage your child’s care or treatment from different doctors or care providers?
   Yes
   No

26. In the last 12 months, did the main provider’s office have a web site or app you could use between visits to look up information about your child’s visits and health care?
   Yes
   No
   I don’t know if my child’s main provider’s office has a web site or app

29. A shared care plan is a written document that contains information about your child’s active health problems, medicines he or she is taking, special considerations that all people caring for your child should know, goals for your child’s health, growth and development, and steps to take to reach those goals.
Has the main provider created a shared care plan for your child?
   Yes
   No

Boston Children’s Hospital
Pediatric Integrated Care Survey
For Parents/Guardians
Version 1.0

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For permissions to use the Pediatric Integrated Care Survey, please contact
Dr. Richard Antonelli (Richard.Antonelli@childrens.harvard.edu)
Funded by a grant from
the Lucile Packard Foundation for Children’s Health, Palo Alto, California
Pediatric Integrated Care Survey (PICS)

- A measure of patient and family experience with care integration
- 19 items in the following 5 domains:
  - Access
  - Communication
  - Family impact
  - Creation of care goals
  - Team functioning
- 12-month time frame
In the past 12 months, how often have your child’s care team members...

**Treated you as a full partner in your child's care?**

- **Always**: Fall 2014 and Spring 2016
- **Almost Always**: Fall 2014 and Spring 2016
- **Usually**: Fall 2014 and Spring 2016
- **Sometimes**: Fall 2014 and Spring 2016
- **Rarely**: Fall 2014 and Spring 2016
- **Never**: Fall 2014 and Spring 2016

**Explained who was responsible for different parts of your child's care?**

- **Always**: Fall 2014 and Spring 2016
- **Almost Always**: Fall 2014 and Spring 2016
- **Usually**: Fall 2014 and Spring 2016
- **Sometimes**: Fall 2014 and Spring 2016
- **Rarely**: Fall 2014 and Spring 2016
- **Never**: Fall 2014 and Spring 2016
Tools to Support High-Quality Handoffs

Collaborative Consults

Closing the Loop: Action Grid
What is a handoff?
The transfer of pertinent knowledge between members of a patient’s care team to establish a shared understanding.

Elements of High-Quality Handoffs

**SENDER (ie, general pediatrician)**
- Purpose of patient encounter
- Relevant clinical and/or psychosocial information
- Requested referral relationship
- Care plan or action item list

**RECEIVER (ie, subspecialist, social worker)**
- Defined action items
- Accountability
- Timeline
- Contingency planning

Funded in part by a grant from the Harvard Pilgrim Health Care Quality Grants Program.
Collaborative Consults

• Why is the patient being referred (reason for referral)?

• What clinical/psychosocial information is pertinent to the referral?

• What is the requested referral relationship?

• What are the questions to be answered?
High-Quality Handoffs: Collaborative Consults

Clinician Reason for Visit

<table>
<thead>
<tr>
<th>Referring Provider</th>
<th>Today's Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name:</td>
<td>Patient Address:</td>
</tr>
<tr>
<td>DOB:</td>
<td>Requested Referral Relationship:</td>
</tr>
<tr>
<td>Phone Number(s):</td>
<td>- One-time consultation</td>
</tr>
<tr>
<td>Requested Subspecialty:</td>
<td>- Co-management/shared care</td>
</tr>
<tr>
<td></td>
<td>- Subspecialty-based management</td>
</tr>
<tr>
<td></td>
<td>- To be determined</td>
</tr>
</tbody>
</table>

Clinician Reason for Visit:

<table>
<thead>
<tr>
<th>Relevant Clinical/Psychosocial Information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommended Timeframe of Appointment:</td>
</tr>
<tr>
<td>- 24-48 hrs (Urgent)</td>
</tr>
<tr>
<td>- 72hrs-1 week</td>
</tr>
<tr>
<td>- 2-4 weeks</td>
</tr>
<tr>
<td>- 4-6 weeks</td>
</tr>
<tr>
<td>- No preference</td>
</tr>
</tbody>
</table>

Clinicians Reason for Visit © 2019 Boston Children's Hospital, Integrated Care Program
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Requested Referral Relationship

Clinical/Psychosocial Information

Reason for Visit

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High-Quality Handoffs: Closing the Loop

Families should know the answers to the following questions:

• WHAT will be done before our next appointment? WHAT can I expect?

• WHO will do this? WHO will follow up?

• WHEN should I expect results? WHEN will I receive an update? WHEN should I follow up?

• WHY is this important to my child’s health?

• HOW will my primary care provider be informed about this?

• HOW will this affect other parts of my child’s care?
## Closed-Loop Communication: Action Grid

### Encounter-Based Action Grid

**Date:**
**Patient Name:**
**Clinic:**
**Provider Name:**

<table>
<thead>
<tr>
<th>Goal</th>
<th>Action</th>
<th>Who</th>
<th>When</th>
<th>Contingency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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?

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*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*
Principles of the Action Grid

• Family and patient centered
• Encounter specific
• Developed collaboratively with families and other members of the health care team
• Accessible and shared across care team members
• Includes elements of timeline and ownership for each action identified
• Reviewed and revised as needed
Pause for Reflection

• How could Keystone Pediatrics implement these tools to address the issues they have identified?
  o Patient and family experience: FECC and/or PICS
  o Handoff communication: collaborative consults, action grid

• Think about the needs of your own teams. What tools might be valuable and feasible for your team to implement?
Keystone Pediatrics re-engineers part of the administrative role of Anne, who is currently an administrative assistant.

- Anne has background knowledge about the health care system and the needs of the patients and families from working in her role. She also has a general understanding of community and state resources from working in the clinic. She will transition her role to spend 10 hours a week focusing on care coordination.

- Anne will manage a registry of adolescent patients to ensure that well visits are scheduled and completed.

- She will help to organize and distribute action grids for families after in-person visits.
# Collaborative Consults

<table>
<thead>
<tr>
<th>Requested Subspecialty</th>
<th>Requested Referral Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>• School psychologist</td>
<td>• One-time consultation</td>
</tr>
<tr>
<td></td>
<td>• Comanagement or shared care</td>
</tr>
<tr>
<td></td>
<td>• Subspecialty-based management</td>
</tr>
<tr>
<td></td>
<td>• To be determined</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinician Reason for Visit</th>
<th>Relevant Clinical/Psychosocial Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>• First-time evaluation for potential counseling in school setting</td>
<td>• Patient screened positive for behavioral health concerns at last well visit</td>
</tr>
<tr>
<td></td>
<td>• Parent shared that patient has not previously received behavioral health support but would be open to it</td>
</tr>
<tr>
<td>Goal</td>
<td>Action</td>
</tr>
<tr>
<td>------</td>
<td>--------</td>
</tr>
<tr>
<td>Complete HPV immunizations.</td>
<td>Immunization 1,2,3</td>
</tr>
<tr>
<td>Assess potential need for in-school counseling.</td>
<td>Evaluation with school psychologist</td>
</tr>
</tbody>
</table>
Implementing a Shared Plan of Care
A 3-year-old boy with developmental delay and his family (Burmese refugees) were referred to your clinic by pediatric neurology for care coordination.
Workflow: Five Phases Using a SPoC as an Approach to Family-Centered Care Coordination

1. **Family Outreach & Engagement**
   - Build Rapport

2. **Partnership & Pre-Visit Preparation**
   - Assess

3. **Teamwork & Population Care**
   - Team Prepares

4. **“Planned Care Visit” & SPoC Coproduction**
   - Listen/hear Coproduce

5. **Ongoing CC & Community Transfer**
   - Use, learn & improve
## Ten Steps to Achieving a Shared Plan of Care

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Identify who will benefit from having a shared plan of care.</td>
</tr>
<tr>
<td>2</td>
<td>Discuss with families and colleagues the value of developing and using a comprehensive and integrated plan of care.</td>
</tr>
<tr>
<td>3</td>
<td>Select, use, and review multifaceted assessments with the child, youth, and family.</td>
</tr>
<tr>
<td>4</td>
<td>Set shared personal (child and family) and clinical goals.</td>
</tr>
<tr>
<td>5</td>
<td>Identify other crucial partners, such as subspecialists or community resource providers, and include them in the process for the plan of care.</td>
</tr>
<tr>
<td>6</td>
<td>Develop the medical summary for the plan of care and merge it with negotiated actions.</td>
</tr>
<tr>
<td>7</td>
<td>Establish the negotiated actions for the plan of care and merge them with the medical summary.</td>
</tr>
<tr>
<td>8</td>
<td>Ensure that the plan of care is accessible, retrievable, and available.</td>
</tr>
<tr>
<td>9</td>
<td>Provide tracking, monitoring, and oversight for the plan of care.</td>
</tr>
<tr>
<td>10</td>
<td>Systematically use the process for the plan of care as a model for a life course and a population health approach.</td>
</tr>
</tbody>
</table>
Objective

Participants will be able to…

Develop an action plan outlining specific goals to facilitate care coordination in the practice.
SMART Goals

Specific
Measurable
Achievable
Relevant
Time-bound
## Your Action Plan

### Action Planning

1. Identify one short-term and one long-term goal you have to improve care coordination in your clinical practice.

2. Once you have decided on your goals, consider the following:
   - What barriers do you anticipate in achieving this goal?
   - What is your plan to achieve this goal? (How? When? Where?)

<table>
<thead>
<tr>
<th>Goal</th>
<th>Potential Barriers</th>
<th>Specific Action Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within 7 days we will...</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within 90 days we will...</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Take-Home Points

• Care coordination is the set of activities that occurs in the space between
  o Visits, providers, hospital stays, agency contacts.
• Care coordination is necessary but insufficient for achieving integration.
  o Integration is essential for achieving optimal value.
• The only way to succeed is to engage all stakeholders—including patients and families—as participants and partners.
Take-Home Points

• Build capacity: families and workforce.
  o Develop competencies to support integration.
  o Improve interprofessional education.

• Implement measures of care integration.

• Track outcomes, including value.
  o Quality and safety
  o Cost
  o Experience
Citations


• Care Coordination Measurement Tool (CCMT)
  • Antonelli RC, Stille CJ, Antonelli DM. Care coordination for children and youth with special health care needs: a descriptive, multisite study of activities, personnel costs, and outcomes. *Pediatrics.* 2008;122(1)


• Agrawal R, Still C. Building systems that work for children with complex health care needs. *Pediatrics.* 2018;141(s3):e20171284

• Ferrari LR, Ziniel SI, Antonelli RC. Perioperative care coordination measurement: a tool to support care integration of pediatric surgical patients. *A A Case Rep.* 2016;6(5):130-136


Resources (continued)

Links

• **Massachusetts Child Health Quality Coalition Care Coordination Framework.** Funded by the Centers for Medicare and Medicaid Services (CMS) through grant funds issued pursuant to CHIPRA section 401(d). Contact: grogers@mhqp.org

• **National Resource Center for Patient/Family-Centered Medical Home.** American Academy of Pediatrics.
  [https://medicalhomeinfo.aap.org/about/Pages/National%20Resource%20Center%20Overview.aspx](https://medicalhomeinfo.aap.org/about/Pages/National%20Resource%20Center%20Overview.aspx)

• **Boston Children’s Hospital Integrated Care Program.** [http://www.childrenshospital.org/integrated-care-program](http://www.childrenshospital.org/integrated-care-program)


• **Lucile Packard Foundation for Children’s Health.** [https://www.lpfch.org/](https://www.lpfch.org/)


Presentations


• McCrave JM, Curro-Harrington C, et al. The clinical and economic impact of telephone triage. Poster presented at: American Association of Neuroscience Nurses; March 2017

• Myers T, Aspinwall S, Flath Sporn S. The ambulatory RN role for improving patient access and care coordination. Poster presented at: Boston Children’s Hospital Nurses Week; Boston MA; and American Academy of Ambulatory Care Nursing Annual Conference; May 2016; Palm Springs, CA

• Myers T, Flath Sporn S. The evolving ambulatory RN liaison role for improving patient access and care coordination. Poster presented at: Boston Children’s Hospital Nurses Week; May 2017; Boston, MA