International Check
Appendix

Work Package: 11
PICS Example Measures

In the past 12 months, how often did your child’s care team members explain things in a way that you could understand?

In the past 12 months, how often did you feel that your child’s care team members knew about the advice you got from your child’s other care team members?

In the past 12 months, how often did you feel that your child’s care team members followed through with their responsibilities related to your child’s care?

In the past 12 months, how often has someone on your child’s care team explained to you who was responsible for different parts of your child’s care?

In the past 12 months, how often have your child’s care team members treated you as a full partner in the care of your child?
## 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

## 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

## Facilitating care transitions (inpatient, ambulatory)
- Family engagement to align transition plan with family goals, needs
- Implement components of successful transitions (eight elements, including receiving provider and acknowledging responsibility)
- Ensure information needed at transition points is available

## Connecting with community resources and schools
- Facilitate connection to family-run organization/family partner
- Coordinate services with schools, agencies, payers
- Identify opportunities to reduce duplication of efforts in building knowledge of available community services

## Transitioning to adult care (for children), self-care skill development
- 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

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*Source:* Massachusetts Child Health Quality Coalition Care Coordination Task Force, funded by the Centers for Medicare and Medicaid Services (CMS) through grant funds issued pursuant to CHIPRA section 401(d) (Care Coordination Task Force. Rogers. Antonelli. & Leadholm. 2013)
### Key Elements

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<tr>
<th>Key Elements</th>
<th>Sample Measures</th>
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| 1) Needs assessment, continuing CC engagement            | Use of a structured care coordination needs assessment tool/process  
                                                                                                    Ask family: did you get what you wanted?                                                                                                          |
| 2) Care planning and coordination                         | Family engagement in co-creation and implementation of care plan  
                                                                                                    Care team members can access, update plan                                                                                                         |
| 3) Facilitating care transitions                          | “Closing the loop”: timely communication after referral visit (to PCP/family/others)  
                                                                                                    Measure bundles, adaptations (HEDIS, CTM–P, CAHPS–PCMH/PICS, ABCD)                                                                                |
| 4) Connecting with community resources/schools            | Link to family partner/family–run org/peers  
                                                                                                    Referral connections made  
                                                                                                    Bi-directional communication of results                                                                                                          |
| 5) Transitioning to adult care                            | Acquisition of self-management skills  
                                                                                                    ID adult providers with capacity, expertise                                                                                                         |
# Referral to BCH Subspecialty Department

*High-Quality Handoff from Primary to Subspecialty Care Team Members*

<table>
<thead>
<tr>
<th>Patient Name</th>
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<tbody>
<tr>
<td>Patient DOB</td>
</tr>
<tr>
<td>Appointment Date/Time</td>
</tr>
<tr>
<td>Referring Provider</td>
</tr>
<tr>
<td>Referring Provider Organization</td>
</tr>
<tr>
<td>BCH Subspecialty Provider</td>
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<tr>
<td>BCH Subspecialty Department</td>
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</tbody>
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**Purpose of the upcoming patient encounter based on the perspective of the medical home team:**

**Relevant clinical and/or psychosocial information:**

**Status of the referral relationship:**

- [ ] One-time consultation
- [ ] Co-management/shared care
- [ ] Subspecialty-based management
- [ ] Unknown

If other, please specify:
Capacity Building and Measurement Tools

The following tools were developed and implemented in the Integrated Care Program at Boston Children’s Hospital

• Pediatric Integrated Care Survey (PICS)
  (contact: Hannah.Rosenberg@childrens.harvard.edu for access to the PICS tools)

• Care Coordination Measurement Tool (CCMT)
  (http://www.childrenshospital.org/care-coordination-curriculum/care-coordination-measurement)

• Pediatric Care Coordination Curriculum
  (http://www.childrenshospital.org/care-coordination-curriculum)
US National Center for Care Coordination Technical Assistance
Sustaining a Community of Learners

Legend

- states with entities that are in early stages of engagement. Expressed interest in developing care coordination workforce capacity on level of individual institution and/or state-wide program.*some sites may have implemented since our last communication

- states with entities that have used the Pediatric Care Coordination Curriculum as a resource to implement care coordination workforce capacity building

+ = states engaged in statewide implementation, some partnering with State Title V programs

Across these states, we are aware of over 20 different institutions using the Pediatric Care Coordination Curriculum

Funded by US Health Resources and Services Administration, Maternal and Child Health Bureau,

In partnership with American Academy of Pediatrics National Center Medical Home Implementation
CHQC:  http://www.masschildhealthquality.org/


Communication Matters, a guide for sharing information about a child’s care:

Measure Development:  proposed measures to evaluate the quality of care coordination for children with behavioral health needs:

MA CHIPRA/NICHQ Medical Home Initiative

Best practices from MA PCMH Learning Collaborative participants:
  medicalhome.nichq.org/solutions/spreading-medical-home-transformation
References

- **MA 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 [www.masschildhealthquality.org/work/care-coordination/](http://www.masschildhealthquality.org/work/care-coordination/)
- **AHRQ Care Coordination Atlas** (McDonald Nov 2010, June 2014) and companion document Care Coordination Accountability Measures for Primary Care (McDonald Jan 2012).
- **Care Coordination Curriculum and Care Mapping Tool User Guides:** Antonelli, Browning, Hackett-Hunter, McAllister, Risko; Lind. Boston Children’s Hospital; funded thru Family Voices/MCHB HRSA grant. 2012. [www.childrenshospital.org/care-coordination-curriculum](http://www.childrenshospital.org/care-coordination-curriculum)
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