Advancing Multidisciplinary Care Coordination in Primary and Subspecialty Care Settings (Part 2)
May 17, 2018
Noon – 12:45 pm Eastern Time

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Measure What Matters: Advancing Multidisciplinary Care Coordination in Primary and Subspecialty Care Settings

Brought to you by the National Center for Care Coordination Technical Assistance in collaboration with the National Center for Medical Home Implementation, a cooperative agreement between the American Academy of Pediatrics and the Maternal and Child Health Bureau

Co-Moderator
Michelle Zajac Esquivel, MPH
National Center for Medical Home Implementation
American Academy of Pediatrics
Division of Children with Special Needs
Disclosures

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- We do not intend to discuss an unapproved/investigative use of a commercial product/device in my presentation.
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Co-Moderator and Faculty
Richard Antonelli, MD, MS, FAAP
Boston Children’s Hospital
Harvard Medical School
National Center for Care Coordination Technical Assistance
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Faculty
Hannah Rosenberg, MSc
Boston Children’s Hospital
National Center for Care Coordination Technical Assistance
Learning Objectives

• Introduce and discuss a tool intended to track and quantify care coordination activities and outcomes.

• Demonstrate the impact of care coordination in diverse settings including pediatric subspecialty and primary care.
Our mission is to support the promotion, implementation and evaluation of care coordination activities and measures in child health across the United States.

Our team

- **Director:** Richard Antonelli, MD, MS, FAAP
- **Manager:** Hannah Rosenberg, MSc
- **Technical Assistance Coordinator:** Neha Safaya, MS

Information about NCCCTA tools and resources [available here.](#)
Capturing Value with the Care Coordination Measurement Tool

- Care coordination is a critical component of **high quality and safe health care delivery**
- It is rarely measured and not typically reimbursed
- The care *Coordination Measurement Tool (CCMT)* allows users to **collect data** that connect care coordination activities to...
  - Occurred/prevented outcomes
  - Time and staff necessary to complete these activities
- ...Ultimately, informing quality improvement and financing mechanisms
# Care Coordination Measurement Tool®

<table>
<thead>
<tr>
<th>Patient Level</th>
<th>Care Coordination Needs</th>
<th>Activity</th>
<th>Outcomes Occurred</th>
<th>Outcomes Prevented</th>
<th>Time Spent</th>
<th>Staff</th>
<th>Clinical Competence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
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<tr>
<td>2</td>
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</tr>
</tbody>
</table>

Patient Level
- 1a. Child/Youth with Special Health Care Needs – with complicating family/social issues
- 1b. Child/Youth without Special Health Care Needs - with complicating family/social issues
- 1c. Child/Youth with Special Health Care Needs - without complicating family/social issues
- 1d. Child/Youth without Special Health Care Needs - without complicating family/social issues
- 1e. Interpreter needed
- 1f. Interpreter not needed

**Care Coordination Needs**
- 2a. Clinical or Medical Management related to clinic (including education about medical or behavioral condition)
- 2b. Mental/Behavioral/Developmental Health
- 2c. Referral and Appointment Management
- 2d. Educational
- 2e. Social Services (housing, food, transportation)
- 2f. Financial/Insurance
- 2g. Advocacy/Legal/Judicial
- 2h. Connection to Community/Non-Medical Resources
- 2i. Prior Authorization

<table>
<thead>
<tr>
<th>Activity to Fulfill Needs</th>
<th>Outcomes Occurred</th>
<th>Outcomes Prevented</th>
<th>Time Spent</th>
<th>Staff</th>
<th>Clinical Competence</th>
</tr>
</thead>
<tbody>
<tr>
<td>3a. Pre-visit review</td>
<td>4a. Medication-related discrepancies reconciled</td>
<td>5a. Abrupt discontinuation of medication by family/caregiver due to prior authorization requirement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3b. Patient education/anticipatory guidance</td>
<td>4b. Medication treatment adherence</td>
<td>5b. Non-adherence to treatment plan due to misunderstanding between care team and family</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3c. Communication with family [via telephone/email]</td>
<td>4c. Non-medications-related discrepancies reconciled, adherence to care plan</td>
<td>5c. Medication error</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3d. Communication with an internal clinic team member [via telephone/email/in-person]</td>
<td>4d. Ability for family to better manage at home care and treatment due to education/guidance provided virtually</td>
<td>5d. Presence of adverse medication side effects unnoticed by family/caregiver</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3e. Communication with an external health care provider, hospital, or care team member [via telephone/email]</td>
<td>4e. Modification of medical care plan (testing, medication, etc.)</td>
<td>5e. ER Visit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3f. Telehealth encounter</td>
<td>4f. Modification of care plan (non-medications component) to reduce unnecessary family burden/stress; increase adherence to care plan</td>
<td>5f. Unnecessary clinic visit [for this clinic]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3g. Update of clinical chart [electronic medical record system]</td>
<td>4g. Scheduled necessary clinic visit [for this clinic]</td>
<td>5g. Unnecessary specialist visit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3h. Communication with a community agency/educational facility/school [via telephone/email]</td>
<td>4h. Speciality referral</td>
<td>5h. Missed clinic visit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3i. Reviewed labs, diagnostic tests, notes, IEP</td>
<td>4i. Necessary ER referral</td>
<td>5i. MD/PA call to the family</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3j. Form processing (school, camp, etc.)</td>
<td>4j. Referral to community agency</td>
<td>5j. Unnecessary lab/test [prevented duplicative testing]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3k. Research of clinical/medical question</td>
<td>4k. Prior Authorization completed</td>
<td>5k. I don’t know</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3l. Development/modification of care plan</td>
<td>4l. Prescription/medical supplies ordered</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3m. Referral management or appointment scheduling</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3n. Prescription/Supplies order placement</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3o. Secured prior authorization for patient</td>
<td></td>
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<tr>
<td>3p. Connection to family navigator/family support group</td>
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</tbody>
</table>

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Faculty
Lori Hartigan, ND, RN, CPN
Department of Gastroenterology
Boston Children’s Hospital
Gastroenterology at Boston Children’s Hospital

• Approximately 60,000 outpatient visits per year on main campus and 12 satellite locations
• Approximately 350 enteral tubes placed/year
• At any point, 40% of inpatients have an enteral tube in place
• Nurses are key part of gastrointestinal (GI) care management team-13 Registered Nurses (RNs)
• 60 providers
What Does it Take?

.... to successfully implement and sustain model of care for patients with medical complexity:

• Experienced nursing staff for optimal outcomes
• Patient access to urgent appointments
• Strengthened community supports for management of patients (especially patients who live far away from hospital). Examples:
  • Primary care provider/Medical home providers
  • Home visiting providers
  • Durable medical equipment resources
...to coordinate care for patient population with g-tubes:

• GI nurses spend many hours conducting family initiated telephone triage for children with enteral feeding tubes (marker of complexity): “reactive” care coordination
• Goal was to determine if and how these telephone encounters met the needs of the family and led to outcomes
• Implementing the Care Coordination Measurement Tool (CCMT) allowed us to track activities and outcomes
What Did We Do?

- 216 encounters collected by 8 individuals between 10/5/15 and 1/8/16: 4 weeks of data collection
- Only phone encounters were recorded
- RNs were asked to collect as many as possible (without interfering with workflow) during week of data collection
- CCMT provided easy way to document care coordination activities and outcomes
- Created electronic version of CCMT using REDCap
- Embedded in banner bar in electronic medical record
Outcomes

- 73% of the time, calls took 10 minutes or less
  - Experienced GI nurses deliver this care efficiently with patient need being resolved during one phone call
- 96.7% of the encounters recorded required RN level clinical competence
  - Phone triage was appropriately allocated to nursing team
Outcomes: Primary Reason for Call

Care Coordination Needs

- Clinical Management: 66%
- Education: 47%
- Make Appointments: 20%
- Coordination of Services/Schools...
- Reconcile Discrepancies
- Complicating Socioeconomic Issues
- Reviewed lab results/test results
- Urgent Supply Order/International Patients
- Follow up referrals

Number of Encounters

- Clinical Management: 160
- Education: 100
- Make Appointments: 20

Care Coordination Needs
Outcomes: Primary Reason for Call

• **66% of time**, clinical management was part of call.
• **47% of time**, prescriptions/supplies/services were ordered (troubleshooting gaps in needed medications/durable medical equipment/etc.).
• **20% of time**, patient/family education was provided.
Outcomes: Additional Needs

**Additional Needs Identified**

- Clinical Management: 160 encounters
- Growth/Nutrition: 50 encounters
- Referral Management: 10 encounters
- Developmental/Behavioral: 5 encounters
- Legal/Judicial: 2 encounters
- Social Services: 1 encounter
- Mental Health: 1 encounter

Additional Care Coordination Needs
Outcomes: Additional Needs

- Often, the triage calls would result in uncovering of additional unmet needs.
- Skilled nurses were able to identify and address the needs in same call, preventing adverse outcomes of unmet needs going unnoticed.
Outcomes: Because Care Coordination was Provided

- Ability to triage urgent issues to appropriate level of care; reduction of high cost, emergency service utilization.
- Care Coordination led to improved outcomes, reduced cost.
- Implications for safety.
Conclusions

• Created culture of willingness and flexibility
• Led to GI creating more RN visit availability for “urgent” enteral tube care- supporting diversion of patients from ED
• Reengineering of model put us in position for success with Accountable Care Delivery-Mass Medicaid ACO
• Work was foundational for spread to additional clinics:
  • Home Parenteral Nutrition Program
  • CAT Infusion Program
  • Spina Bifida Program
Next Steps

- Use Boston Children’s Hospital Simulation Lab to better train families to replace Nasogastric Tube at home.
- Pilot telemedicine visits for patients discharged home after enteral tube placement to address issues associated with tube.

- Contact: Lori.Hartigan@childrens.harvard.edu
Nursing Publications Related to Care Coordination Measurement


• Myers T, Aspinwall S, Flath Sporn S. The Ambulatory RN Role for Improving Patient Access and Care Coordination.-*Poster Presentation at Boston Children’s Hospital Nurses week in Boston MA May 2016 and at the AAACN (American Academy of Ambulatory Care Nursing ) annual conference in Palm Springs CA, May 2016*

• Myers T, Flath Sporn S. The Evolving Ambulatory RN Liaison Role for Improving Patient Access and Care Coordination. -*Poster Presentation at Boston Children’s Hospital Nurses Week, Boston MA, May 2017.*
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Faculty
Michael Yogman, MD, FAAP
Yogman Pediatric Associates
Coordinating Needs for Behavioral Health in Primary Care Settings
Yogman Pediatric Associates

- A small private pediatric practice committed to putting child and family needs at the center of our care, meeting the emotional, developmental, and educational issues in addition to their medical care.

- Patient-centered medical home, recognized by the National Committee for Quality Assurance (NCQA), and have a care coordination team that includes primary care physician, a licensed social worker, and a care coordinator to facilitate multifaceted care through one office.
What Are The Challenges We Face?

- Children and families face multiple barriers to accessing behavioral healthcare including:
  - stigma
  - lack of trained providers
  - long wait times
  - insufficient insurance payment for behavioral health services
What Are The Challenges We Face?

- A recent joint position paper by the American Academy of Pediatrics and the American Academy of Child and Adolescent Psychiatry reported that only 20% to 25% of affected children with a mental health diagnosis receive treatment.
- Many who do receive care are not receiving evidence-based care from a trained professional provider.
- In spite of this gap, in a 2013 periodic survey of pediatricians, less than 30% reported managing or co-managing any mental health condition other than attention deficit/hyperactivity disorder.
- Currently, the most common model of care for children with behavioral health disorders emphasizes referrals to outside behavioral health providers.
Our Work

- We developed a quality improvement project that utilizes a co-located behavioral health and care coordination integration model in a private pediatric primary care office that is a patient-centered medical home.

- The project was designed to align with the Institute for Healthcare Improvement goals of the Triple Aim, targeting improved patient and provider experience, population health quality, and healthcare costs.
Behavioral Health Needs in Pediatric Primary Care

- Among the top 5 reasons for pediatric office visits.
- 20% of children have a mental health diagnosis.
- Quality improvement project in pediatric practice to demonstrate effect of co-located, integrated, behavioral health on Triple Aim.

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensed Independent Clinical Social Worker (LICSW)/Care Coordinator:</td>
<td>• Patient experience</td>
</tr>
<tr>
<td>• Consultation</td>
<td>• Provider experience</td>
</tr>
<tr>
<td>• Assessment</td>
<td>• Population health quality</td>
</tr>
<tr>
<td>• Short-term treatment</td>
<td>• Cost</td>
</tr>
<tr>
<td>• Care coordination</td>
<td></td>
</tr>
<tr>
<td>• Referral</td>
<td></td>
</tr>
</tbody>
</table>
# Intervention Encounters: Tracked in EMR

## Behavioral Health / Care Coordination Measurement Tool

<table>
<thead>
<tr>
<th>Patient Level</th>
<th>Care Coordination Needs (choose all that apply)</th>
<th>Outcome(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level</strong></td>
<td><strong>Description</strong></td>
<td><strong>As a result of this care coordination activity, the following was PREVENTED (choose all that apply)</strong></td>
</tr>
<tr>
<td>1.</td>
<td>1a. Low-Information/Referral (1-2 encounters)</td>
<td>1. ER Visit</td>
</tr>
<tr>
<td>2.</td>
<td>1b. Intermediate (2-5 encounters)</td>
<td>2. Subspecialist visit</td>
</tr>
<tr>
<td>3.</td>
<td>1c. Intensive (&gt;5 encounters)</td>
<td>3. Hospitalization</td>
</tr>
<tr>
<td></td>
<td><strong>Focus of Encounter</strong> (choose all that apply)</td>
<td>4. Visit to Pediatric Office/Clinic</td>
</tr>
<tr>
<td></td>
<td>1. Mental Health / Treatment</td>
<td>5. Specialized Therapies (PT, OT, etc)</td>
</tr>
<tr>
<td></td>
<td>2. Developmental / Behavioral</td>
<td><strong>Activity to Fulfill Needs (choose all that apply)</strong></td>
</tr>
<tr>
<td></td>
<td>3. Educational / Core / EI / IEP</td>
<td><strong>As a result of this care coordination activity, the following OCCURRED (choose all that apply)</strong></td>
</tr>
<tr>
<td></td>
<td>4. Assessing / Dx / Intake</td>
<td>A. Advised family/patient on behavioral health management</td>
</tr>
<tr>
<td></td>
<td>5. Referral Management</td>
<td>B. Behavioral health therapy/treatment</td>
</tr>
<tr>
<td></td>
<td>6. Clinical / Medical Management</td>
<td>C. Met family’s immediate needs, questions, concerns</td>
</tr>
<tr>
<td></td>
<td>7. Social Services / Community Agencies</td>
<td>D. General patient follow-up</td>
</tr>
<tr>
<td></td>
<td>8. Legal / Judicial</td>
<td>E. Advocacy for family/patient</td>
</tr>
</tbody>
</table>

## Contact With
- 1a. Patient
- 1b. Hospital/Clinic
- 1c. Parent/family
- 1d. Medical Consultant
- 1e. Medical Provider

## Event
- 2. Form Processing
- 3. Confer with Primary Care Physician
- 4. Develop/Modify Written Care Plan
- 5. Meeting/Case Conference
- 6. Intake Assessment/Therapy Visit
- 7. Group Meeting / Therapy
- 8. Family Meeting

<table>
<thead>
<tr>
<th>Outcome(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ER Visit</td>
</tr>
<tr>
<td>2. Subspecialist visit</td>
</tr>
<tr>
<td>3. Hospitalization</td>
</tr>
<tr>
<td>4. Visit to Pediatric Office/Clinic</td>
</tr>
<tr>
<td>5. Specialized Therapies (PT, OT, etc)</td>
</tr>
</tbody>
</table>

As a result of this care coordination activity, the following OCCURRED (choose all that apply):

- A. Advised family/patient on behavioral health management
- B. Behavioral health therapy/treatment
- C. Met family’s immediate needs, questions, concerns
- D. General patient follow-up
- E. Advocacy for family/patient
- F. Reviewed labs, specialist reports, IEP’s etc.
- G. Referral for assessment
- H. Referral to specialized therapies (OT/PT/SLP)
- I. Referral to community agency
- J. Referral to behavioral health subspecialist
- K. Referral to ER
- L. Unmet needs (please specify)
- M. Identification of resources
Results: Total Encounters

- Total number of services provided: 1573
- Total number of patients seen by LICSW and/or care coordinator: 366

Patients Seen in Each Registry

<table>
<thead>
<tr>
<th>Registry Sub-category</th>
<th>N total Population</th>
<th>N Subgroup seen by LICSW</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADD/ADHD</td>
<td>123</td>
<td>13</td>
</tr>
<tr>
<td>SED</td>
<td>153</td>
<td>44</td>
</tr>
<tr>
<td>CSHCN</td>
<td>129</td>
<td>17</td>
</tr>
<tr>
<td>CSHCN Co-morbidity/Behavioral Health</td>
<td>79</td>
<td>15</td>
</tr>
<tr>
<td>EI/IEP</td>
<td>110</td>
<td>12</td>
</tr>
<tr>
<td>Preschool</td>
<td>72</td>
<td>7</td>
</tr>
</tbody>
</table>
Results: Patient and Provider Experience Measures Pre and Post Intervention

Patient Experience

- Parenting Stress Index: Improved
- Family Centered Care Assessment for Families: Improved
- Client Satisfaction Questionnaire: Improved

Provider Experience

- Family Centered Care Assessment Self Assessment: Improved
- Physician Belief Scale: Improved
- Organizational Social Context Scale: Improved
  - Gains in provider proficiency and engagement
  - Decreases in stress and rigidity
Population Health Quality Outcomes

• Improved outcomes for
  • Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder
  • Complex Special Healthcare Needs (CSHCN)
  • Complex Special Healthcare needs with co-morbid behavioral health concerns
  • Early Intervention/Individual Education Plan (EI/IEP)
  • But not for Serious Emotional Disturbance (SED: anxiety, depression, substance abuse)
# Population Health Quality Outcomes

## Quality Outcome: ADD/ADHD Measure for Total Population

<table>
<thead>
<tr>
<th>ADD/ADHD</th>
<th>Pre-Intervention</th>
<th>Post-Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=46</td>
<td>N=44</td>
</tr>
<tr>
<td>Vanderbilt</td>
<td>Vanderbilt</td>
<td>Vanderbilt</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Average Total Symptom Score (1-18)</th>
<th>15.5</th>
<th>12.47</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Performance Score (19-26)</td>
<td>2.41</td>
<td>2.13</td>
</tr>
</tbody>
</table>

## Quality Outcome: SED measure Threshold and Averages for total population

<table>
<thead>
<tr>
<th>SED</th>
<th>Pre-Intervention</th>
<th>Post-Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PHQ-9</td>
<td>% PHQ-9</td>
</tr>
<tr>
<td></td>
<td>N=60</td>
<td></td>
</tr>
<tr>
<td>Above Threshold</td>
<td>11</td>
<td>18</td>
</tr>
<tr>
<td>Below Threshold</td>
<td>49</td>
<td>82</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SED</th>
<th>Pre-Intervention</th>
<th>Post-Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PHQ-9</td>
<td></td>
</tr>
<tr>
<td>Average</td>
<td>5.27</td>
<td>5.46</td>
</tr>
</tbody>
</table>
### Quality Outcome CSHCN: Measure Average for total population

<table>
<thead>
<tr>
<th>Complex</th>
<th>Pre-intervention</th>
<th>Post-intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSC</td>
<td>PSC</td>
<td></td>
</tr>
<tr>
<td>Average</td>
<td>10.31</td>
<td>8.17</td>
</tr>
</tbody>
</table>

### Quality Outcome: Comorbid CSHCN/Behavioral health: Measure Average for total population

<table>
<thead>
<tr>
<th>CC&amp;BH</th>
<th>Pre-Intervention</th>
<th>Post-Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PSC</td>
<td>PHQ-9</td>
</tr>
<tr>
<td>Average</td>
<td>18.26</td>
<td>5.47</td>
</tr>
</tbody>
</table>

### Quality Outcome: EI/IEP: Average for total population

<table>
<thead>
<tr>
<th>EI/IEP</th>
<th>Pre-intervention</th>
<th>Post-intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PSC</td>
<td>PSC</td>
</tr>
<tr>
<td>Average</td>
<td>13.70</td>
<td>9.22</td>
</tr>
</tbody>
</table>
Outcomes: Cost

- Total medical expenditures for the subset of patients who were continuously enrolled in the practice, 2013-2015

<table>
<thead>
<tr>
<th>Complex Special Health Care Needs with co-morbid Behavioral Health Concerns</th>
<th>Average Overall</th>
</tr>
</thead>
</table>
| - N=19  
  - Average Pm/Pm 2013: $1,587.17  
  - Average Pm/Pm 2015: $208.55  
  - Change: (-$1,378.62)  
  - % Change: -86.86% | - N=137  
  - Average Pm/Pm 2013: $692.16  
  - Average Pm/Pm 2015: $344.16  
  - Change: (-$348.00)  
  - % Change: -50.28% |

Outcomes: Cost

- Total medical expenditures for patients enrolled in 2013 and 2015, regardless of when they enrolled

<table>
<thead>
<tr>
<th>Complex Special Health Care Needs with co-morbid Behavioral Health Concerns</th>
<th>Average Overall</th>
</tr>
</thead>
</table>
| • N 2013 = 27  
• Average Pm/Pm 2013: $2,473.00  
• N 2015 = 33  
• Average Pm/Pm 2015: $1,757.32  
• Change: (-$715.68)  
• Change as % of original: -28.94% | • N 2013 = 204  
• Average Pm/Pm 2013: $989.95  
• N 2015= 294  
• Average Pm/Pm 2015: $653.97  
• Change: (-$335.98)  
• Change as % of original: -33.94% |

More Information

References

- Brenda Reiss-Brennan, Phd, APRN; Kimberly D. Brunisholz, PhD; Carter Dredge, MHA; Pascal Briot, MBA; Kyle Grazier, PhD; Adam Wilcox, PhD; Lucy Savitz, PhD; Brent James, MD, MStat “Association of Integrated Team-Based Care With Health Care Quality, Utilization, and Cost.” *JAMA* 316 (8) 826-834, August 2016
- Thomas L. Schwenk, MD “Integrated Behavioral and Primary Care What is the Real Cost?” *JAMA* 316 (8) 822-823 August 2016
- National Research Council and Institute of Medicine. Preventing Mental, Emotional, and Behavioral Disorders Among Young People. Washington, DC: National Academies
Resources

- AAP Policy Statement: Patient- and Family- Centered Care Coordination: A Framework for Integrating Care for Children and Youth Across Multiple Settings
- National Center for Medical Home Implementation Web site
- National Center for Care Coordination Web Site
  - Care Coordination Measurement Tool
  - Care Coordination Measurement Tool Adaptation and Implementation Guide
- Boston Children’s Hospital Integrated Care Program
• National Center for Care Coordination Technical Assistance
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• National Center for Medical Home Implementation
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    www.medicalhomeinfo.org