Measurement Matters: Creating an Effective and Sustainable Integrated Care Model

Richard Antonelli, MD, MS, FAAP
Sonja Ziniel, PhD
Hannah Rosenberg, MSc

2 » Module Overview
4 » Facilitator Guide–Slide Deck
13 » Case-Based Learning
Module 4—Objectives
At the end of this session, participants should be able to:
• Outline key elements of a care coordination measurement framework
• Use tools and measures to effectively assess elements of care coordination

Module 4—Elements
• Overview
• Facilitator Guide Slide Deck
• Case-Based Learning

Note to the facilitator:
This module includes a didactic portion, a set of tools and resources, case studies, worksheets, and suggested readings.
The curriculum is intended to be tailored to fit training needs. Therefore, any or all of the content from this module can be incorporated into the training. However, a suggested agenda for implementing this as a stand-alone module is included. Please be aware that it is crucial to input local-, state-, and region-specific content, as applicable, even if the entire module is implemented in its form.

A found in the module indicates the need for local content to be added, but facilitators should feel free to do so as they see fit.

Optimal Facilitation Guidance
To achieve the most efficient and effective outcomes from the learning sessions, it will be essential to assure vital and equitable input from all stakeholders, especially patients and families. Please see the section in the introduction (page 4) entitled Tips for the Facilitator: Ways to Keep the Workshop on Track.

There are two tables included below. The first is a high-level agenda of the module. The second is the facilitator guide that includes a breakdown of slide content and talking points. The facilitator should use the guide as a resource to tailor the training.
## Module Overview

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Time</th>
<th>Materials Required</th>
<th>Instruction/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-session reading</td>
<td>N/A</td>
<td>Vaz LE, Farnstrom CL, Felder KK, Guzman-Cotrill J, Rosenberg H, Antonelli RC. Utilizing a modified care coordination measurement tool to capture value for a pediatric outpatient parenteral and prolonged oral antibiotic therapy program. J Pediatric Infect Dis Soc. 2018;7(2):136-142. Available at: <a href="https://doi.org/10.1093/jpids/pix023">https://doi.org/10.1093/jpids/pix023</a></td>
<td>Prior to the day of the training session, the reading can be sent to the participants. The estimated amount of time to complete the reading (ie, it will take approximately 30 minutes to complete) and an explanation about the value of completing the readings beforehand (ie, the session will be drawing from the reading) should be communicated to the participants.</td>
</tr>
<tr>
<td>Introduction</td>
<td>10 min</td>
<td>Slide deck/handout</td>
<td>Sample slides and handouts are included with the module, but the facilitator is encouraged to embed local content.</td>
</tr>
<tr>
<td>Didactic</td>
<td>30 min</td>
<td>Slides</td>
<td>Content should be pulled from and formatted to be similar to the sample slide deck, and local content should be infused throughout. Review tactical steps toward implementation of measurement, including processes, measures, and tools. Make sure to discuss and/or workshop how the tools, measures, and processes can be incorporated into the learners’ environment.</td>
</tr>
<tr>
<td>Case studies</td>
<td>30 min</td>
<td>Case studies Questions</td>
<td>Ideally, case studies will be read and discussed in small groups, with one leader per group who can guide the group by jump starting the conversation or redirecting the group back onto the topic, if necessary. Case studies should be read and discussed in small groups, using recommended questions as a guide. Major points to think through include the following:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• In each of these case studies, how does the organization or team achieve the Triple Aim of outcomes with the support of measurement, or how is continuous measurement a crucial element in the process?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• How can measurement be broken down so it does not seem overwhelming and unattainable?</td>
</tr>
</tbody>
</table>
### Module Overview

#### Table 1 (continued)

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Time</th>
<th>Materials Required</th>
<th>Instruction/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action-oriented next-step activity</td>
<td>10 min</td>
<td>Worksheet</td>
<td>Ask participants to consider up to 5 things they have learned, and based on that, action steps they can take back to their work and teams over the next 1, 3, and 6 months. Perhaps ask them to consider goals they believe are valuable and achievable. This part of the workshop is intended to give participants the opportunity to think through how to apply their learning to their day-to-day work. Encourage them to think small: Are there elements of the overall measurement framework that would be particularly valuable to their work and relatively easy to adopt?</td>
</tr>
<tr>
<td>Report and closing</td>
<td>10 min</td>
<td>Whiteboard or flip chart</td>
<td>To close out the module, ask participants to report back to the larger group after small group discussions. A facilitator or volunteer participant can record key points shared by the small groups on a whiteboard or flip chart. This time is intended to summarize and close the loop on the learning. It should be facilitated by a facilitator but driven by participants. The facilitator can either invite anyone from the large group to jump in with thoughts on what was learned during the session or go table to table and ask people to share. Sometimes having the opportunity to speak ideas aloud helps people to formulate next steps. One option is to write down action steps and include them in a summary email sent to participants after the session.</td>
</tr>
<tr>
<td>Evaluation</td>
<td>N/A</td>
<td>Evaluation questions</td>
<td>After the workshop, evaluation questions should be emailed to the participants. Feedback from evaluations can be helpful to improving the workshop over time.</td>
</tr>
</tbody>
</table>

© 2019 Boston Children's Hospital. All rights reserved.
This time should be used to introduce the session objectives and frame the session. Think through the following:

**Why are we here today?** To discuss measurement and its importance in the changing health care delivery environment with its critical emphasis on high-value outcomes and accountability. Care coordination and care integration are essential to ensuring our ability to provide high-value care, which will likely be vital in advocating for necessary resources in supporting care coordination.

**What are we going to do today?** Engage in case-based learning around tools, processes, and measures to support measurement. Conduct thought exercises on how to apply these learnings and resources to our individual settings.
SLIDE 4 » Key Definitions

**Key Definitions**

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

**Accountable Care Organizations** (ACOs) are groups of physicians, hospitals, and nonphysician clinicians who come together voluntarily to give coordinated high-quality care to their Medicare patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program.

*Source:* [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html)

**Value-based programs** reward physicians with incentive payments for the quality of care they provide to patients.

*Source:* [https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html)

**Fee-for-service** is a system of health care payment in which a physician or nonphysician clinician is paid separately for each particular service rendered.

*Source:* [https://www.medicarerescources.org/glossary](https://www.medicarerescources.org/glossary)

In **global budgeting**, a government agency determines the total amount of money that it has available to reimburse all hospitals, physicians, nonphysician clinicians, and clinics in the nation. The global budget can be further subdivided in order for a government agency to establish a maximum amount of spending for treating a specific disease or a maximum budget for each hospital in a state.

*Source:* [https://bizfluent.com](https://bizfluent.com)

---

SLIDE 5 » Rapid Cycle QI

**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 improvement (QI) has proven to be a useful strategy for making changes to the health care system to improve performance. In this module, rapid cycle methodology examples will be used in the case studies. The measurement tools and processes that are discussed demonstrate an approach to evaluating rapid cycle quality improvement outcomes.

- The Institute for Healthcare Improvement’s Open School has numerous educational modules that anyone can use on quality improvement methodology and practical application. More information and links to the modules are available at: [http://www.ihi.org/education/ihiopenschool/Pages/default.aspx](http://www.ihi.org/education/ihiopenschool/Pages/default.aspx)

- Oftentimes, measurement and clinical improvement activities can qualify for Maintenance of Certification (MOC) for physician continuing education credit. More about MOC with the American Board of Pediatrics is available at: [https://www.abp.org/content/maintenance-certification-moc](https://www.abp.org/content/maintenance-certification-moc)

- Ask learners to share if they have been involved in rapid cycle QI work in their current or previous roles.
Use this time to describe different types of measures then encourage participants to brainstorm examples of measures, either in small groups or with the entire audience.

This slide can be broken up into different slides for easier readability. Additionally, using this slide as a handout is often helpful.

Source: [http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementEstablishingMeasures.aspx](http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementEstablishingMeasures.aspx)

Some measures and measurement tools that will be very helpful are listed on the slide.

Embed local content here. For example, are there tools that your institution or group use for which you can provide some training?
Family experience (outlined in detail in module 2 of this curriculum) of care integration is a true patient- and family-reported outcome measure. Other measures of care coordination are related to structure or process. None of these measures are mutually exclusive. However, for the sake of parsimonious implementation, prioritizing outcome measurement is recommended.

Introduce different family experience measures

- Pediatric Integrated Care Survey
  Available at: http://www.childrenshospital.org/integrated-care-program/patient-and-family-experience-outcome

- Family Experiences with Care Coordination
  Available at: https://www.ahrq.gov/sites/default/files/wysiwyg/policymakers/chipra/factsheets/chipra_15-p002-ef.pdf

- Family-Centered Care Assessment for Families

It is important to measure and quantify care coordination and integration. A valuable tool to achieving this is the Care Coordination Measurement Tool, which focuses on process rather than family experience.

This slide shows the domains of the Care Coordination Measurement Tool. Even if the tool will not be used by learners, these domains can be helpful to thinking through what components of care coordination are important to track.

The Care Coordination Measurement Tool template and the accompanying Adaptation and Implementation Guide can be downloaded at the following site:
Module 4
Pediatric Care Coordination Curriculum
2nd Edition

SLIDE 11 » Intro to Case Studies

After introducing the framework and definitions, move to case-based learning.

The following case studies introduce 2 distinct groups that are focused on providing integrated care for children and youth:

- **Case Study #1** is an in-depth look at quality improvement.
- **Case Study #2** offers an example of how measurement concepts, tools, and processes can be used in different settings.

Facilitators are encouraged to amend these cases to best reflect their organization or institution and the patients and families that the module audience serves.

**Suggested format for case study learning and discussion**

- Read and discuss the case study in small groups.
- Reconvene the larger group, asking 1 representative from each group to share what his or her small group discussed.
- Have one facilitator (or a learner) take notes on a flip chart or board.

**Start case study #1, which revolves around Gordon Pediatrics, a small community-based pediatric practice**

- Depending on the size of the group, either separate people into groups of 3 to 6 people or have one larger group discussion.
- Before reading the case, remind the audience that the goal is to take what has been learned during the session and apply it in a practical application setting.
- Ask groups to read part 1 of case study #1 then pause for reflection.
- Encourage the learners to think through how they might also apply learnings to their own practice.

SLIDE 12 » Pause for Reflection

The pauses throughout the case study indicate an opportunity to brainstorm and discuss as a group before proceeding.

The facilitator can ask each group to pause at these points in the case and either reflect as a small group or have a larger group discussion.

These pauses are good opportunities for the learners to practice thinking about how to use measurement.
Encourage the learners to discuss the information obtained from the data.

Display this slide during the upcoming pause for reflection so that learners can review it during their discussion time.

Encourage learners to think through what is helpful about the data. For instance, if data collected from the registered nurse and licensed clinical social worker indicate that 30% of the tasks they are performing do not require their licensure, what conclusions might be drawn – perhaps someone else with a different skill set could take responsibility for those items while the nurse and social worker perform tasks that require clinical competence? The term for this is sometimes called “working at the top of your license.”

Case Study #1, Part 2 delves into measurement to inform gaps and assess change.

Allow the learners to read through this next part of the case study in small groups.
Similar to data from the Care Coordination Measurement Tool, ask learners to consider how they interpret the data. For example, if respondents say that important aspects of integrated care never occur, then this could have implications for the overall health and well-being of patients.

Ask learners to reflect on their experiences as a care team member and/or family member.

These questions are from the Pediatric Integrated Care Survey (PICS). Feel free to use other measures from the PICS if they are more relevant to a case study that has been adapted.

Ask the learners to think through how the data can be used to drive change. What decisions or changes could Gordon Pediatrics make based on the data?

In this case study, Gordon Pediatrics implements the action grid, which is introduced in module 1 and included in module 2. For additional introductory content to the action grid, please refer to the tool guide in module 1.

The action grid can be found at: [http://www.childrenshospital.org/integrated-care-program/multidisciplinary-care-planning](http://www.childrenshospital.org/integrated-care-program/multidisciplinary-care-planning)
Pause for Reflection

Based on the interventions that Gordon Pediatrics is implementing, what measures could be put in place to evaluate success? Ask the learners to discuss this in small groups or call out suggestions from the larger group.

Outcome/Process/Balance Measures

These are examples of process, outcome, and balancing measures. Different examples may be given, based on how the case study may have been adapted for the learners.

Before offering examples to the learners, give them an opportunity to brainstorm about examples of process, outcome, and balancing measures. Ask them to consider how the measures might be collected in the context of the case.

Pause for Reflection

Ask learners to brainstorm about how the coordinators could collect quantitative data to demonstrate how they are creating value, and to use the following framework: Because of the coordinators, “x, y, and z” are occurring or not occurring (THINK EXPERIENCE, OUTCOMES, and COST).
SLIDE 23 » Connect Activities and Outcomes

Similar to the first case study, encourage the learners to discuss the information obtained from the data.

Display this slide during the upcoming pause for reflection so that the learners can review it during their discussion time.

SLIDE 24 » Pause for Reflection

Ask the learners to brainstorm about how the data could be presented to demonstrate optimal value.

This time could also be an opportunity for the learners to apply concepts to their individual settings: After the data are collected, how are the results messaged? Who are the key players that need to be involved in messaging? With whom are the data shared? WHO to involve and WHEN and HOW they are involved are crucial components.

SLIDE 25 » Closing

Use this final time to reflect on the session and allow the learners time to think through their next steps. A worksheet could be provided so that the learners can record their thoughts and next steps and have something to take with them.

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.
Case-Based Learning

Following are 2 distinct case studies. The first takes place in a general pediatric care practice, and the second is set in a practice funded by the Title V Maternal and Child Health Services Block Grant Program. The authors intentionally chose 2 diverse settings to show that care coordination and care integration measurement can be applied across settings in the pediatric space. These case studies use tools that the Integrated Care Program at Boston Children’s Hospital includes in its quality improvement tool kit; however, there are other measurement tools in this space. Some additional tools are listed throughout this module.

Case Study #1: Gordon Pediatrics

A SMALL, COMMUNITY-BASED, GENERAL PEDIATRIC CARE PRACTICE

PART 1: Why measure? To show value

Gordon Pediatrics is a small, community-based, general pediatric care practice that is part of the network for a larger hospital system. The hospital system is preparing to enter into a risk-based contract with an Accountable Care Entity and will be responsible for improving outcomes for its patient population. The hospital system has tasked the primary care practices in its network with improving care coordination service delivery as a strategy to lead to better outcomes for patients and their families.

In addition to pediatricians and administrative staff members, Gordon Pediatrics has a nurse and licensed clinical social worker who both spend time helping to coordinate care for families. The nurse and social worker both describe their work as piecemeal and say that they are able to do things when they can, but that they are often unable to carve out time in their schedules to help families with care coordination. While brainstorming, the practice gets the idea to hire a part-time, nonclinical care coordinator to offload some of the coordination done by the nurse and social worker. In addition, having a dedicated care coordinator would help Gordon Pediatrics meet outcomes expected by the Accountable Care Entity. In order to move forward with hiring a case coordinator, Gordon Pediatrics has to make a case for why adding a care coordinator to the team would be valuable to the hospital system.

Pause for Reflection

How could Gordon Pediatrics show that there is a need for and value in care coordination?
The team decides to have the nurse and social worker collect data on their daily care coordination activities and outcomes for a 2-week time period.

Example methodology: The nurse and social worker adapt the Care Coordination Measurement Tool to collect care coordination activity and outcomes data. For 2 weeks, they each collect data on their first 10 care coordination encounters every day. They decide that an important goal is to collect data in domains related to activities, outcomes prevented, outcomes occurred, and clinical competence. Included below is a sample of their data.

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

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?
The Gordon Pediatrics team discusses the data and determines that there is a significant volume of care coordination needs from the patients and families it serves. In addition, many of the requests do not require nursing or social work clinical competence to be able to fulfill the need. Rather, they necessitate knowledge about available community, local, and state resources and information about how to access these resources, connect to medical care and education, and link to resources that help pay for medical and health-related expenses. The nurse and social worker also believe that if they were able to give away some of their nonclinical responsibilities, some of their time would be free to focus on proactive intervention, such as reaching out to families that potentially need more frequent support. They conclude that with value-based care, in which they are taking full financial risk for their patient population, they need to operate as an integrated system and address needs outside of the strictly medical domain. Thirty percent of the 200 care coordination encounters were tasks that did not require clinical competence, and they conclude that if these tasks are reallocated to a nonclinical person, the nurse and social worker could focus on expanding their clinical scopes of work.

Gordon Pediatrics uses the data, in conjunction with a description of the volume of requests and different types of roles that the care team members play, to make a request for additional resources to support a nonclinical care coordinator.

**PART 2: Why measure? To inform gaps and measure change**

Gordon Pediatrics is now fully on board with the Accountable Care Organization (ACO) contract. Clinic leadership has been able to prove that there is value in having care coordination support on the team, and the resources needed for this role have been budgeted into the ACO contract.

The team is granted permission to hire a nonclinical care coordinator to work 20 hours per week. Gordon Pediatrics decides to offer the position to one of its part-time administrative assistants, Anne, who works at the front desk. From working in the clinic, Anne has some knowledge about the health care system and the needs of the patients and families as well as a general understanding of community and state resources. She will begin to work an additional 20 hours as a care coordinator for the office.

With Anne on board as the care coordinator, Gordon Pediatrics wants to ensure that it is optimizing its team’s resources. Since Gordon Pediatrics is now accountable for the overall care and well-being of the children it serves, it wants to begin identifying areas for improvement. From talking with families that frequently visit the practice, Gordon Pediatrics knows they often have difficulty accessing community resources and even knowing what resources are available. Families also indicate difficulty with understanding how to pay for their children’s services. Even though Gordon Pediatrics knows this qualitatively, it is still struggling with determining where to start and what to prioritize.

Additionally, Gordon Pediatrics wants to ensure that it is focusing on the families that would benefit the most from additional support. In order to select the patients for care coordination support, Gordon Pediatrics decides to choose a cohort of patients who have visited the emergency room 3 or more times in the past year.
The team decides to collect family experience data using the Pediatric Integrated Care Survey (PICS), along with emergency and inpatient service utilization data.

The survey is sent to all families whose children have had 3 or more emergency room visits in the past year. The practice is hoping to identify gaps in the system that can be closed to reduce overall use of emergency services.

Below are data received from the families.

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? (Check ONE box)

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
<td>12%</td>
</tr>
<tr>
<td>Almost Always</td>
<td>18%</td>
</tr>
<tr>
<td>Usually</td>
<td>20%</td>
</tr>
<tr>
<td>Sometimes</td>
<td>22%</td>
</tr>
<tr>
<td>Rarely</td>
<td>15%</td>
</tr>
<tr>
<td>Never</td>
<td>13%</td>
</tr>
</tbody>
</table>

In the past 12 months, how often did you feel that someone on child’s care team gave you enough information about state or community organizations, such as Early Intervention, Head Start, Family to Family Support, Social Security Disability Insurance (SSD)

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
<td>10%</td>
</tr>
<tr>
<td>Almost Always</td>
<td>15%</td>
</tr>
<tr>
<td>Usually</td>
<td>18%</td>
</tr>
<tr>
<td>Sometimes</td>
<td>20%</td>
</tr>
<tr>
<td>Rarely</td>
<td>20%</td>
</tr>
<tr>
<td>Never</td>
<td>15%</td>
</tr>
</tbody>
</table>

**Pause for Reflection**

- What do the family experience data tell Gordon Pediatrics?
- How can the data be used to drive changes?
Inpatient/Emergency Service Utilization Data

Through this initiative, Gordon Pediatrics discovers that patients with complex care needs are more likely to utilize emergency and inpatient services. The survey results also show that families often feel confused about who among the care team is responsible for different elements of their children's care. Additionally, the data identify a gap in the ability of families to connect to community, local, and state resources and that families do not believe they were asked about how making care decisions impacts them.

These 2 measures linked together help Gordon Pediatrics to understand that there is room for improvement in shifting patients from using emergency or inpatient services to care and coordination in the ambulatory setting.

The team works with Anne to craft her role, ensuring that she is focused on the needs of families. In an email and letter sent to all Gordon Pediatrics families, Anne’s new role is introduced as a resource to families, along with Anne’s contact information. Additionally, whenever a pediatrician or nurse believes that a family would benefit from some help in a nonmedical area, the family is referred to Anne who helps them navigate the system and ensures referral loop closure.

The team implements a short huddle at the beginning of each day to review patient visits from the previous day. The team also launches a registry to identify all children with complex social or medical care needs. Anne participates in the daily huddles and takes responsibility for completing grids for families that list action items resulting from appointments. Action grids include a list of tasks and individual accountability for completing tasks. She sends a completed action grid to each family after its appointment and also follows up with each family to ensure it understands next steps.

Measure

To measure the impact of her efforts, Anne collects data 3 days every month on care coordination activities and outcomes.

Pause for Reflection

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

<table>
<thead>
<tr>
<th>Measure Type</th>
<th>Measure</th>
</tr>
</thead>
</table>
| Process      | What: How often the action grid was 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: Provider experience with the action grid  
              | How: Providers were asked rating questions to assess their experience with implementation of the action grid |

Since Anne was able to take over many nonclinical tasks, the nurse was able to spend more time proactively reaching out to families about medications and clinical care needs in between visits. If a patient had an emergency department visit, the nurse would call the family to assess the reason for the visit, review the care plan, and link the family to the medical home team for follow-up care. The family was able to more readily access the nurse and, therefore, began calling the nurse first with clinical questions rather than going straight to the emergency room.

PART 3: Why measure? To create value stream for social determinants of health support

How might Gordon Pediatrics use this value-capture methodology to address the additional care coordination needs of children, youth, and families with significant social determinant of health (SDoH) risks, such as food insecurity, housing insecurity, poverty, social isolation, and parental co-existing risk factors? This effort allowed the practice to proactively identify those SDoH risk factors that put patients at risk for unnecessary emergency department visits. Potential interventions include office-based encounters or referrals for home visit or payer-based care management intervention. In providing care for vulnerable, high-risk SDoH populations, it is essential to include the value of nonmedical care coordination.

In administering the PICS, Gordon Pediatrics also discovers that families feel disconnected to social services and that, often, this disconnect leads to bad outcomes and higher medical and utilization costs. In order to address this, Gordon Pediatrics determines that it needs to focus resources on addressing social determinants of health.

Gordon Pediatrics decides that it will begin deploying a social determinants of health screener, and if families express a need for support, they will be referred to the social worker. The team hopes that by using a systematic screener, it will be able to capture more families who need these services. The social worker has the ability to spend more time on clinical social work issues and shares some of the administrative tasks with the new care coordinator. Both the care coordinator and social worker continue to use the Care Coordination Measurement Tool.

Note for the facilitator: In module 3 of the Pediatric Care Coordination Curriculum, there are examples of screeners on social determinants of health.
CASE STUDY #2  Title V Program

Connect is a Title V-funded program that sits in the U.S. Department of Health and Human Services.

It helps parents of children with chronic or complex conditions locate appropriate services in local, regional, and state communities, but it does not target diagnoses-specific children. Connect acts as a referral program, which is advertised to pediatric and subspecialty programs. Using a coordinator model, Connect coordinators are each assigned a caseload of families, with whom they initiate partnerships. The coordinators also work together as a team, reviewing their cases in weekly and monthly huddles to draw on the expertise of the group.

Tom, the director of Connect, has found it difficult to quantify Connect's value when asked about its outcomes. The Connect coordinators act as liaisons between families and community service groups, insurance agencies, educational programs, and other state-run initiatives. However, when pressed for quantitative data, Tom has a difficult time showing that this model has improved outcomes and experience or lowered cost. He only has rich qualitative data obtained from family testimonials about how instrumental Connect was when their children were diagnosed.

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 coordinators decide to modify the Care Coordination Measurement Tool and collect data for 1 month. Below are sample data.

<table>
<thead>
<tr>
<th>Activities</th>
<th>Outcomes Occurred</th>
<th>Outcomes Prevented</th>
</tr>
</thead>
<tbody>
<tr>
<td>20% of the time: introduced supplementary insurance options to families</td>
<td>15% of the time: a family was financially able to access a service that supported care for its child at home</td>
<td>15% of the time: prevented a gap in service due to a family’s inability to afford the cost</td>
</tr>
<tr>
<td>25% of the time: communicated with a community agency, educational facility, or school via telephone or email</td>
<td>20% of the time: a family found an educational program that was suitable for its child’s needs</td>
<td>20% of the time: prevented a gap in time so that a child was able to attend school or an educational program</td>
</tr>
<tr>
<td>40% of the time: connected families and family support groups</td>
<td>35% of the time: a family was connected to a peer support network</td>
<td></td>
</tr>
<tr>
<td>60% of the time: connected families and community services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Collecting this information enables Tom and his team to link their activities to 3 essential domains of high-value outcomes: quality, cost, and experience. For example, Connect educates families about benefits coverage, therefore, decreasing the likelihood that there will be gaps in their children’s medications. These data impact patient safety and health outcomes.

Similarly, by providing guidance and warm handoffs from families to educational programs, Connect is able to improve outcomes and experience for patients and families.
   http://www.childrenshospital.org/integrated-care-program/multidisciplinary-care-planning 
   Accessed April 10, 2019

   https://www.abp.org/content/maintenance-certification-moc 
   Accessed April 18, 2019

   Accessed April 18, 2019

   http://www.childrenshospital.org/integrated-care-program/care-coordination-measurement 
   2017. Accessed April 18, 2019

   Accessed April 18, 2019

6. Family Voices National Center for Family-Professional Partnerships. Family-Centered Care Assessment for Families (FCCA-F). 
   Accessed April 10, 2019

7. Seattle Children’s. Family Experience with Coordination of Care Measurement Set. 
   Accessed April 18, 2019

   Accessed April 18, 2019

   Accessed April 18, 2019

    Accessed April 18, 2019

    Accessed April 18, 2019

12. The National Survey of Children’s Health. Data Resource Center for Child and Adolescent Health: 
    a project of the Child and Adolescent Health Measurement Initiative. 
    http://childhealthdata.org/learn-about-the-nsch/NSCH 
    Accessed April 18, 2019

    Accessed April 18, 2019