

# Measure # 5: Care Coordination Measurement Tool (CCMT)

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# Medical Home Care Coordination Measurement Tool<sup>®</sup>

Site Code: \_\_\_\_

Form # \_\_\_\_ of \_\_\_\_

Date	Patient Study Code And Age	Patient Level	Focus	Care Coordination Needs	Activity Code(s)	Outcome(s)		Time Spent*							Staff	Clinical Comp.	Initials
						Prevented	Occurred	1	2	3	4	5	6	7			

**Patient Level**

Level   Description

**I**   Non-CSHCN, **Without** Complicating Family or Social Issues

**II**   Non-CSHCN, **With** Complicating Family or Social Issues

**III**   CSHCN, **Without** Complicating Family or Social Issues

**IV**   CSHCN, **With** Complicating Family or Social Issues

**Focus of Encounter** (choose **ONE**)

1. Mental Health
2. Developmental / Behavioral
3. Educational / School
4. Legal / Judicial
5. Growth / Nutrition
6. Referral Management
7. Clinical / Medical Management
8. Social Services (ie. housing, food, clothing, ins., trans.)

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**Care Coordination Needs**  
(choose **all that apply**)

1. Make Appointments
2. Follow-Up Referrals
3. Order Prescriptions, Supplies, Services, etc.
4. Reconcile Discrepancies
5. Coordination Services (schools, agencies, payers etc.)

**Time Spent**

- 1 – less than **5** minutes
- 2 – **5 to 9** minutes
- 3 – **10 to 19** minutes
- 4 – **20 to 29** minutes
- 5 – **30 to 39** minutes
- 6 – **40 to 49** minutes
- 7 – **50** minutes and greater\*  
(\*Please NOTE **actual minutes** if greater than 50)

**Staff**  
RN, LPN, MD, NP, PA, MA, SW, Cler

**Clinical Competence**

C= Clinical Competence required  
NC= Clinical Competence not Required

**Activity to Fulfill Needs**  
(choose **all that apply**)

- 1. Telephone discussion with:**
  - a. Patient
  - b. Parent/family
  - c. School
  - d. Agency
  - e. Hospital/Clinic
  - f. Payer
  - g. Voc. / training
  - h. Pharmacy
- 2. Electronic (E-Mail) Contact with:**
  - a. Patient
  - b. Parent
  - c. School
  - d. Agency
  - e. Hospital/Clinic
  - f. Payer
  - g. Voc. / training
  - h. Pharmacy
- 3. Contact with Consultant**
  - a. Telephone
  - b. Meeting
  - c. Letter
  - d. E-Mail
- 4. Form Processing:** (eg. school, camp, or complex record release)
- 5. Confer with Primary Care Physician**
- 6. Written Report to Agency:** (eg. SSI)
- 7. Written Communication**
  - a. E-Mail
  - b. Letter
- 8. Chart Review**
- 9. Patient-focused Research**
- 10. Contact with Home Care Personnel**
  - a. Telephone
  - b. Meeting
  - c. Letter
  - d. E-Mail
- 11. Develop / Modify Written Care Plan**
- 12. Meeting/Case Conference**

**Outcome(s)**

As a result of this care coordination activity, the following was **PREVENTED** (choose **ONLY ONE**, if applicable):

- 1a. ER visit
- 1b. Subspecialist visit
- 1c. Hospitalization
- 1d. Visit to Pediatric Office/Clinic
- 1e. Lab / X-ray
- 1f. Specialized Therapies (PT, OT, etc)

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

- 2a. Advised family/patient on home management
- 2b. Referral to ER
- 2c. Referral to subspecialist
- 2d. Referral for hospitalization
- 2e. Referral for pediatric sick office visit
- 2f. Referral to lab / X-ray
- 2g. Referral to community agency
- 2h. Referral to Specialized Therapies
- 2i. Ordered prescription, equipment, diapers, taxi, etc.
- 2j. Reconciled discrepancies (including missing data, miscommunications, compliance issues)
- 2k. Reviewed labs, specialist reports, IEP's, etc.
- 2l. Advocacy for family/patient
- 2m. Met family's immediate needs, questions, concerns
- 2n. Unmet needs (**PLEASE SPECIFY**)
- 2o. Not Applicable / Don't Know
- 2p. Outcome Pending

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