

## Measure #27. Care Coordination Services in Pediatric Practices

**CARE COORDINATION MEASURE MAPPING TABLE**

	MEASUREMENT PERSPECTIVE		
	<i>Patient/Family</i>	<i>Health Care Professional(s)</i>	<i>System Representative(s)</i>
<b>CARE COORDINATION ACTIVITIES</b>			
Establish accountability or negotiate responsibility			
Communicate			
<i>Interpersonal communication</i>			
<i>Information transfer</i>		□	
Facilitate transitions			
<i>Across settings</i>		□	
<i>As coordination needs change</i>			
Assess needs and goals		□	
Create a proactive plan of care		□	
Monitor, follow up, and respond to change			
Support self-management goals			
Link to community resources		□	
Align resources with patient and population needs			
<b>BROAD APPROACHES POTENTIALLY RELATED TO CARE COORDINATION</b>			
Teamwork focused on coordination		□	
Health care home			
Care management		■	
Medication management			
Health IT-enabled coordination			

**Legend:**

- = ≥ 3 corresponding measure items
- = 1-2 corresponding measure items

# Care Coordination Services in Pediatric Practices

**Purpose:** To assess the frequency at which pediatricians implement care coordination services in the treatment of children with special health care needs.

**Format/Data Source:** 8-item, self-administered, mailed survey adapted from the 1998 Medical Home Best Practices Survey developed by the Institute for Child Health Policy. Care coordination services inquired about within the survey included: (1) integrating a child's medical care plans with the care plans developed by other providers or organizations, (2) discussing a family's potential needs for non-medical services, (3) scheduling extra time for an office visit when seeing a child with special needs, (4) contacting the school about a child's health and education needs as part of care coordination, (5) meeting with the hospital discharge planning team to assist in a child's transition to the community, and (6) scheduling time with the family to discuss the results of a visit to a specialist.

**Date:** Measure published in 2004.<sup>1</sup>

**Perspective:** Health Care Professional(s)

## Measure Item Mapping:

- **Communicate:**
  - Information transfer:
    - *Between health care professional(s) and patient/family:* 6
- **Facilitate transitions:**
  - Across settings: 5, 7
- **Assess needs and goals:** 3, 8
- **Create a proactive plan of care:** 4
- **Link to community resources:** 3, 8
- **Teamwork focused on coordination:** 2, 3
- **Care management:** 2-5, 7

**Development and Testing:** This survey, adapted from the 1998 Medical Home Best Practices Survey developed by the Institute for Child Health Policy, was pilot tested prior to use.<sup>1</sup>

**Link to Outcomes or Health System Characteristics:** None described in the source identified.

**Logic Model/Conceptual Framework:** None described in the source identified.

**Country:** United States

## Past or Validated Applications\*:

- **Patient Age:** Children
- **Patient Condition:** General Population/Not Condition Specific
- **Setting:** Inpatient Facility, Primary Care Facility, Other Outpatient Specialty Care Facility

\*Based on the source listed below and input from the measure developer.

**Notes:**

- Instrument items located in Table 1 of the source article.<sup>1</sup>
- This instrument contains 8 items; 7 were mapped.

**Source:**

1. Gupta VB, O'Connor KG, Quezada-Gomez C. Care coordination services in pediatric practices. *Pediatrics* 2004;113(5):1517-21.