

Measure #5. Care Coordination Measurement Tool (CCMT)

CARE COORDINATION MEASURE MAPPING TABLE

	MEASUREMENT PERSPECTIVE		
	<i>Patient/Family</i>	<i>Health Care Professional(s)</i>	<i>System Representative(s)</i>
CARE COORDINATION ACTIVITIES			
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		□	
BROAD APPROACHES POTENTIALLY RELATED TO CARE COORDINATION			
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 Measurement Tool (CCMT)

Purpose: To collect information (activities, resource-use, outcomes, time) on care coordination encounters for the purpose of determining the cost of care coordination and related outcomes.

Care coordination encounters were defined as “any activity performed by any primary care office-based personnel that contributed to the development and/or implementation of a plan of care for a patient or family.”²

Format/Data Source: Written form placed at office workstations and filled out by health care providers and staff at the time the care coordination encounter occurs. Providers received instruction on how to fill out the form.

Date: Measure published in 2004.¹

Perspective: Health Care Professional(s)

Measure Item Mapping:

- **Establish accountability or negotiate responsibility:** Staff
- **Communicate:**
 - *Between health care professional(s) and patient/family:* Activity to Fulfill Needs: 1a, 1b, 2a, 2b
 - *Within teams of health care professionals:* Activity to Fulfill Needs: 1e, 1g, 2e, 2g, 5
 - *Across health care teams or settings:* Activity to Fulfill Needs: 1c-h, 2c-h, 3a-d, 10a-d
 - *Participants not specified:* Activity to Fulfill Needs: 7a, 7b, 12
 - Information transfer:
 - *Participants not specified:* Activity to Fulfill Needs: 4, 6, 8; Outcomes: 2k
- **Facilitate transitions:**
 - Across settings: Outcomes: 2b-I; Care Coordination Needs: 3; Focus Encounter: 6
- **Assess needs and goals:** Outcomes: 2m, 2n
- **Create a proactive plan of care:** Activity to Fulfill Needs: 11
- **Monitor, follow up, and respond to change:** Outcomes: 2j; Care Coordination Needs :2, 4
- **Support self-management goals:** Outcomes: 2a
- **Link to community resources:** Focus Encounter: 3, 4, 8
- **Align resources with patient and population needs:** Outcomes: 2l
- **Care management:** Care Coordination Needs: 5; Focus Encounter: 7;

Development and Testing: Pilot testing was conducted in several general pediatric practices with varying sizes, locations, patient demographics, and care coordination models. The tool was successfully used to document care coordination encounters during the daily operations of pediatric primary care offices. Statistical comparisons across practices were not performed due to heterogeneity in practice type, sample design, and study methodology.²

Link to Outcomes or Health System Characteristics: Use of the CCMT provided outcomes-based information on trends in costs, resource utilization, and patient characteristics associated with care coordination activities for children with special health care needs. Information included associations between patient complexity and time spent coordinating care, number of encounters, and type of care coordination required. Estimates of the annual cost of the time spent coordinating care and average cost of care coordination activities were also calculated based on data collected.¹

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

Country: United States

Past or Validated Applications*:

- **Patient Age:** Children
- **Patient Condition:** Combined Chronic Conditions, Children with Special Health Care Needs, Other – cardiology ambulatory care and cleft lip and palate care, General Population/Not Condition Specific
- **Setting:** Primary Care Facility, Other Outpatient Specialty Care Facility

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

Notes:

- All instrument items are located in the Appendix of the source article.²
- This instrument contains 76 items; 56 were mapped.

Sources:

1. Antonelli RC, Antonelli DM. Providing a medical home: The cost of care coordination services in a community-based, general pediatric practice. *Pediatrics* 2004;113:1522-28.
2. Antonelli RC, Stille CJ, Antonelli DM. Care coordination for children and youth with special health care needs: A descriptive, multi-site study of activities, personnel costs and outcomes. *Pediatrics* 2008;122:e209-16.