In Oregon, the pace of medical home transformation is moving quickly. Standards and proposed measures for the patient-centered primary care home (PCPCH, medical home) were adopted in December, 2010, and starting October 1, 2011, practices may apply for enhanced reimbursement for children participating in the Oregon Health Plan (Medicaid) based on the PCPCH standards. The medical home has received attention throughout the country for its potential to advance the goals of health care reform; a healthy population, extraordinary patient care and reasonable costs. Care coordination is a critical component of the medical home. The goal of the OCCYSHN Care Coordination Toolkit is to support primary care providers in the implementation of a comprehensive care coordination program in their offices as part of medical home transformation. Our tool kit is based on two primary resources, the National Center for Medical Home Implementation (NCMHI) of the American Academy of Pediatrics (AAP) and the Center for Medical Home Improvement. Activities are linked to the Oregon PCPCH standards for care coordination and integration where appropriate.

The NCMHI has created an online interactive toolkit entitled, Building Your Medical Home, at www.pediatricmedhome.org. It is organized into 6 building blocks which are linked to the requirements of the National Committee for Quality Assurance’s (NCQA) Patient Centered Medical Home (PPC-PCMH) Recognition program. The tool kit contains checklists for self-assessment, recommended tools, and a care coordination summary sheet that includes a definition and discussion of care coordination roles and responsibilities. The building blocks are care management support, clinical care information, care delivery management, resource & linkages, practice performance, measurement and payment & finance. Care coordination activities are represented in all of the 6 areas.
Another very useful resource is the Center for Medical Home Improvement (CMHI) at www.medicalhomeimprovement.org. Their workbook, Medical Home Practice-Based Care Coordination (McAllister, Presler & Cooley, 2007), is available at www.medicalhomeimprovement.org/pdf/MHPacticeBasedCC-Workbook_7-16-07.pdf. The workbook provides the rationale for an office-based care coordination program, an office self-assessment, a detailed position description and list of responsibilities for an office care coordinator, a care coordination framework including important structures and processes, and information on incorporation of the care coordination program into the office’s on-going quality improvement efforts.

What is care coordination? The Medical Home Practice-Based Workbook provides the following description: “Practice-based care coordination within the medical home is a direct, family/youth-centered, team-oriented, outcomes focused process designed to:

1. Facilitate the provision of comprehensive health promotion and chronic condition care,
2. Ensure a locus of ongoing, proactive, planned care activities,
3. Build and use effective communication strategies among family, the medical home, schools, specialists and community professionals and community connections; and
4. Help improve, measure, monitor and sustain quality outcomes (clinical, functional, satisfaction and cost, McAllister, 2007).”

The Agency for Healthcare Research and Quality (AHRQ) lists the following care coordination activities at www.ahrq.gov/qual/caretatlas/caretatlas3.htm:

1. Establish accountability and negotiate responsibility
2. Communicate
3. Facilitate transitions
4. Assess needs and goals
5. Create a proactive plan of care
6. Monitor, follow up and respond to change
7. Support self-management goals
8. Link to community resources
9. Align resources with patient and population needs
Some authors draw a distinction between care coordination and care management. Care management is defined as a process that addresses only health needs and includes assessment, planning, implementation of services, monitoring and reassessment (Antonelli, McAllister and Popp, 2009). In the OCCYSHN Care Coordination Toolkit, we consider care coordination and care management together. Care coordination and care management involve many of the same processes (for example, team-based care is critical to both), may be provided by the same individual in the office, and the success of care management depends on the effectiveness of care coordination. Both strive to build the family’s/youth’s knowledge of the chronic condition and its treatment; both encourage self-advocacy (speaking up) and shared decision making (self-determination); and both support the family and child in building self-care skills and independence.

Effective practice-based care coordination requires primary care offices build collaborative relationships with health plans and a number of community providers including medical specialists, mental health providers, parent support and advocacy groups, Early Intervention/Early Childhood Special Education, schools and public health. Care coordination is facilitated by family involvement at all levels of program development, a designated office care coordinator, and a standardized electronic health information system. Critical times for coordination of care are during health care transitions, for example, from hospital to home and pediatric to adult health care.

In the OCCYSHN Care Coordination Tool Kit, we present a basic framework for care coordination services that generally follows the principles noted in the definition of care coordination and the AHRQ activities. We provide examples of specific tools to support each activity and link them to Oregon’s PCPCH standards. Our recommendations reference and add to the resources in the AAP’s Medical Home Tool Kit and CMHII’s Care Coordination workbook.

Implementation

The Medical Home Practice-Based Care Coordination Workbook, www.medicalhomeimprovement.org/pdf/MHPracticeBasedCC-Workbook_7-16-07.pdf, is a great resource to help you implement a care coordination program in your office. The first steps are to create an office quality improvement team and begin to build or improve your office’s care coordination program through Plan-Do-Study-Act quality improvement cycles. This model of quality improvement is described in detail in the workbook. We strongly encourage you to include family members or individuals with special health needs on your office team or create a family advisory group for your office. Next conduct an office self-assessment: Is it Medical Home Care Coordination; Checklist—how are you doing? You will need to identify an office care coordinator. The workbook presents a Care Coordinator Position Description with a detailed discussion of the qualifications and responsibilities of a medical home care coordinator. Try one step at a time and follow the Plan-Do-Study-Act cycle. The next steps in creating your office care coordination program will include building a contact list of important community resources and adopting a process for the identification of children and youth with special health needs (CYSHN).
## The Framework (activities and related tools):

### Care Coordination in the Primary Care Setting

(Key: Staff = Office Staff, C/C = Care Coordinator, CYSHN = Children & Youth with Special Health Needs)

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<tbody>
<tr>
<td><strong>Office Infrastructure:</strong></td>
<td></td>
<td>Primary care offices will need to make specific changes to the office infrastructure</td>
<td></td>
</tr>
<tr>
<td>Plan for implementation</td>
<td></td>
<td>Primary care offices will need to make specific changes to the office infra-structure. The first step is to <em>identify an office quality improvement team</em>. Implementation of a comprehensive office-based care coordination program is best done through the office’s quality improvement process, (see <a href="http://www.medicalhomeimprovement.org/pdf/MHPracticeBasedCC-Workbook_7-16-07.pdf">www.medicalhomeimprovement.org/pdf/MHPracticeBasedCC-Workbook_7-16-07.pdf</a> for information on the Plan-Do-Study-Act quality improvement method). We strongly encourage office staff to invite parents of CYSHN or youth to participate on the QI team.</td>
<td>5.C.2</td>
</tr>
</tbody>
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### Care Coordination in the Primary Care Setting

(Staff = Office Staff, C/C = Care Coordinator, CYSNH = Children & Youth with Special Health Needs)

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</table>
|                        | Develop list of community resources | Build relationships with different agencies. Identify external care coordination resources, including:  
- Early Intervention/Early Childhood Special Education (EI/ECSE) [www.ode.state.or.us/search/results/?id=252](http://www.ode.state.or.us/search/results/?id=252)  
- CaCoon Care Coordination/public health [www.ohsu.edu/xd/outreach/occyshn/programs-projects/cacoon.cfm](http://www.ohsu.edu/xd/outreach/occyshn/programs-projects/cacoon.cfm)  
- Community Connections Network, a program of OCCYSHN [www.ohsu.edu/xd/outreach/occyshn/programs-projects/community.cfm](http://www.ohsu.edu/xd/outreach/occyshn/programs-projects/community.cfm)  
- Developmental Disability services [www.oregon.gov/DHS/dd/](http://www.oregon.gov/DHS/dd/)  
- Department of Vocational Rehabilitation [www.oregon.gov/DHS/vr/](http://www.oregon.gov/DHS/vr/)  
# Care Coordination in the Primary Care Setting

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| Develop list of community resources *(continued)*                        | • Inclusive Child Care Program [oregoninclusivecc.org](http://oregoninclusivecc.org)  
• Child Care Resource & Referral Network [www.oregonchildcare.org](http://www.oregonchildcare.org)  
• Family 2 Family Health Information Center [www.oregonfamilytofamily.org](http://www.oregonfamilytofamily.org)  
• Swindell’s Resource Center [oregon.providence.org/patients/programs/swindells-child-disability-resource-cent/Pages/default.aspx](http://oregon.providence.org/patients/programs/swindells-child-disability-resource-cent/Pages/default.aspx)  
Utilize existing community resource guides such as  
• 211 [www.211info.org](http://www.211info.org)  
• Parent Help Line in Lane County [birhto3.org/parents](http://birhto3.org/parents) |                                                                       |                                           |                 |
<p>| Identify external care coordination support for the office care coordinator and families | CaCoon Program/local public health nurses <a href="http://www.ohsu.edu/xd/outreach/occyshn/programs-projects/cacoon.cfm">www.ohsu.edu/xd/outreach/occyshn/programs-projects/cacoon.cfm</a> | 5.E.3                                    |                 |
| Promote and “market” office care coordination services                    | <strong>Medical Home Practice Brochure for Parents</strong>                         | 5.C.1                                    |                 |</p>
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<td></td>
<td>Identify individuals with special health care needs in the practice and create a special health needs registry</td>
<td>Recommended tool: CAHMI Screener for Children with Special Health Care Needs</td>
<td>The CAHMI Screener is a 5 item parent-completed tool that can be completed online, over the phone or when the family checks in for a well-child appointment. It asks about use of medications, service utilization and functional limitations. Some practices may choose to start with a short list of ICD-9 codes or a brief checklist based on high service needs. For more information, see Identification of Children and Youth with Special Health Needs (CYSNH).</td>
<td>5.A.1b</td>
</tr>
<tr>
<td></td>
<td>Conduct regular care coordination “rounds” (team meetings)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Code and bill appropriately</td>
<td>Building Your Medical Home and Getting Paid Appropriately</td>
<td></td>
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## Care Coordination in the Primary Care Setting

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| Create a mechanism for tracking, monitoring and following up on referrals, lab tests, procedures, and hospitalizations. Make sure that clinicians and families are aware of results. Create a mechanism for follow-up of care management and care coordination activities. | Measure success | Measure changes in your practice: use the Medical Home Index: Pediatric:  
Measure changes in child outcomes: For example, track data on # of CYSHN in general, # of children with written care plan or care summary and # of children with specific conditions in addition to # of office or ER visits and hospital days. | For information on creation of a patient registry, see *Identification of Children and Youth with Special Health Needs (CYSHN)*. Also review the Centers for Medicaid and Medicare Services (CMS) overview of meaningful use of Electronic Health Record (EHR), [www.cms.gov/ehrincentiveprograms/30_Meaningful_Use.aspx#BOOKMARK2](http://www.cms.gov/ehrincentiveprograms/30_Meaningful_Use.aspx#BOOKMARK2) | 5.B.3 5.E.3 5.A.1a 5.B.3 6.C.1 6.C.2 6.C.3 |
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<td></td>
<td>Measure success (continued)</td>
<td>Use your office’s EHR to track and monitor a specific quality indicator as part of the office’s quality improvement program (PCPCH standard).</td>
<td>Measure the patient’s and family’s experience of care; for example:</td>
<td></td>
</tr>
</tbody>
</table>
## Care Coordination in the Primary Care Setting

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<tr>
<td></td>
<td></td>
<td>Basic Care Coordination/Care Management Services:</td>
<td></td>
<td>Basic care coordination services are available to all children and families in the practice.</td>
<td></td>
</tr>
<tr>
<td>X</td>
<td></td>
<td>Determine the need for time of service in-person or telephone trained interpreter to communicate with the child and family in their own language</td>
<td></td>
<td>Alert office staff to the family’s language requirements, schedule with the appropriate health care provider (one who speaks the family’s language) or arrange for interpreter services.</td>
<td>6A.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Inform all individuals and families about the office’s care coordination services; set expectations through the use of an office brochure/poster and face-to-face discussion at the appointment</td>
<td>Medical Home Practice Brochure for Parents</td>
<td></td>
<td>5C.1</td>
</tr>
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## Care Coordination in the Primary Care Setting

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</table>
| Basic Care Coordination / Case Management Services | X | Conduct pre-visit planning | Family-Centered Care Coordination Tool  
Also, complete the CAHMI CSHCN Screener,  
For return patients, see the Pre-visit Contact form | Review the handout Tips for a Successful Healthcare Visit for CYSHN and their Families as part of new patient registration. For specific strategies to use with children with autism and other developmental disorders, see physicians toolkit at www.handsinautism.org  
Also review the Bright Futures Tool and Resource Kit for health professionals, brightfutures.aap.org/tool_and_resource_kit.html | |
| | X | Conduct limited individual/family needs assessment | Family-Centered Care Coordination Tool  
For further information on cultural issues and health, review ethnomed.org, a website developed by staff at the University of Washington that provides comprehensive information about a number of different health care topics and a number of different cultures | The needs assessment is one way for the office to begin to build a relationship with the child and family. The needs assessment invites the family to share information about their cultural background, their understanding of health care issues and treatments, their goals for upcoming appointments, their support needs and how best to share information with them. | |
### Care Coordination in the Primary Care Setting

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<tr>
<td></td>
<td></td>
<td><strong>Conduct limited individual/family needs assessment (continued)</strong></td>
<td></td>
<td>As needed, supplement the Family-Centered Care Coordination form with the Brief Interview to Elicit Health Care Beliefs, the Brief Assessment of the family’s cultural and religious practices and other health literacy tools. For more information, see Health Literacy.</td>
<td></td>
</tr>
<tr>
<td><strong>X</strong></td>
<td></td>
<td><strong>Provide resources and referral information as needed at appointments (include medical, financial, developmental/educational, behavioral/mental health, social, transportation, family-to-family/parent group resources</strong></td>
<td><strong>Community Resources Rx</strong></td>
<td>The Community Resources Rx may be used as hard copy in a prescription pad format or online by the primary care provider to communicate with the front office. For example, post the Community Resources Rx template in the patient education section of EPIC. Office staff will help the child’s family access needed resources.</td>
<td></td>
</tr>
</tbody>
</table>

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**Basic Care Coordination / Care Management Services**

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*Oregon Center for Children and Youth with Special Health Needs • 503-494-8303 • 1-877-307-7070 • occyshn@ohsu.edu • www.occyshn.org*
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</tr>
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</table>
| X   |       | Determine the need for enhanced care coordination services | Recommended Complexity Tools:  
1. The CAHMI CSHCN Screener, for example, 3 or more items positive  
2. Hirsch Complexity Index, internet.dsrc.uic.edu/forms/medicalhome/HirschComplexityIndex.pdf  
3. Exeter Pediatric “HOMES” complexity index, internet.dsrc.uic.edu/forms/medicalhome/ExeterComplexityIndexScale.pdf  
4. Bob’s Levels of Support Scale (for example, BLSS) | The office may offer enhanced care coordination to all CYSHN or to selected CYSHN. That decision may be based on professional judgment, parent request, or use of a formal checklist or a complexity scale. Another strategy is to use administrative data from the health plan or Medicaid (e.g., # of office or ER visits and hospital days). The Clinical Risk Group (CRG) software developed by NACHRI is one example of this approach.  
Please note: if you use the number of positive responses on the CAHMI Screener as a complexity tool, it does not directly address social and family factors. For more information, see Identification of Children and Youth with Special Health Needs (CYSHN). |  |
## Enhanced Care Coordination Services:

Many CYSHN require an enhanced level of care coordination. Office staff work to build the family's/child's knowledge of the chronic condition and its treatment and their skills in searching for and interpreting health information (health literacy); encourage self-advocacy (for example, for youth with developmental disabilities, see Speaking Up in the Doctor’s Office at [www.healthytransitionsny.org](http://www.healthytransitionsny.org)) and shared decision making (self-determination), and support the family and child in building self care skills and independence.

<table>
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<tr>
<th>Enhanced Care Coordination Services</th>
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</thead>
</table>
| X                                  | Conduct comprehensive individual/family needs assessment (see discussion on limited individual/family assessment) or refer to external care coordination resources. | Consider supplementing the Family-Centered Care Coordination Tool with  
- [Family Needs Survey](https://www.healthytransitionsny.org)  
- [Family Concerns Checklist](https://www.healthytransitionsny.org) | Refer to community care coordination services such as the CaCoon (Care Coordination) program as needed [www.ohsu.edu/xd/outreach/occyshn/programs-projects/cacoon.cfm](http://www.ohsu.edu/xd/outreach/occyshn/programs-projects/cacoon.cfm) |
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<tr>
<td>X</td>
<td></td>
<td>Review pre-visit planning worksheet by phone or email for upcoming appointment including update on individual/family needs as well as goals.</td>
<td>Use the Pre-visit Contact form</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X</td>
<td></td>
<td>Participate in office appointment as needed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X</td>
<td></td>
<td>Provide resource and referral information; conduct research as needed to identify recommended services</td>
<td>Community Resources Rx</td>
<td>The Community Resources Rx may be used as hard copy in a prescription pad format or online by the primary care provider to communicate with the front office. For example, post the Community Resources Rx template in the patient education section of EPIC. Office staff will help the child’s family access needed resources.</td>
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<tr>
<td>X</td>
<td></td>
<td>Review the <strong>Care Management Rx</strong> completed by primary care provider; assist with navigating the service system as needed</td>
<td><strong>Care Management Rx</strong></td>
<td>The Care Management Rx may be used as hard copy in a prescription pad format or online by the primary care provider to communicate with the front office. For example, post the Care Management Rx template in the patient education section of EPIC. The Care Coordinator will assist families in navigating the service system and provide self-management supports as needed.</td>
<td></td>
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For further information on building the capacity of the child and family to manage their own care, see [Health Literacy](#) and [Goal-Setting](#).
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<tbody>
<tr>
<td>X</td>
<td></td>
<td>Provide supports for self-management of the special health condition, as needed</td>
<td><strong>Care Management Rx</strong>&lt;br&gt;• Information on specific conditions: <a href="http://www.medicalhomeportal.org">www.medicalhomeportal.org</a> and <a href="http://depts.washington.edu/healthtr/hcp/diat.html">depts.washington.edu/healthtr/hcp/diat.html</a>&lt;br&gt;• Gene Tests, <a href="http://www.ncbi.nlm.nih.gov/sites/GeneTests/?db=GeneTests">www.ncbi.nlm.nih.gov/sites/GeneTests/?db=GeneTests</a>&lt;br&gt;• National Organization for Rare Disorders (NORD), <a href="http://www.rarediseases.org">www.rarediseases.org</a>&lt;br&gt;• NIH Office for Rare Diseases Research, information on current NIH-funded research studies, <a href="http://rarediseases.info.nih.gov">rarediseases.info.nih.gov</a></td>
<td>Based on the completed Care Management Rx, the office Care Coordinator will provide self-management supports. Examples include education on the condition, review of medication management, training on procedures, discussion of behavior management strategies, and motivational interviewing and coaching of youth and adults on behavioral change. Refer to external resources as needed, for example, home health nursing.&lt;br&gt;&lt;br&gt;For further information on building the capacity of the child and family to manage their own care, see <a href="http://www.healthyamericans.org">Health Literacy</a> and <a href="http://www.healthyamericans.org">Goal-Setting</a>.</td>
<td>6.8.1</td>
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</table>
| X   |       | Provide supports for self-management of the special health condition, as needed *(continued)* | **Guidelines of Care for select conditions**  
- Autism  
- Cerebral Palsy  
- Cleft Lip & Palate  
- Developmental Delay or Intellectual Disability  
- Seizure Disorder  

Clinical reviews from UpToDate (proprietary)  
[www.uptodate.com](http://www.uptodate.com)

Medication Review and other health literacy tools:  
- Checklist for Caregiver Understanding  
  (adapted from Florida HATS)  
- Health Literacy Tools and Strategies (AMA) |
## Care Coordination in the Primary Care Setting

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| X         | Provide supports for self-management of the special health condition, as needed (continued) | **Other Resources for Providers and Parents:**
National organizations and advocacy groups on specific conditions. For example,
- National Down Syndrome Society, [www.ndss.org](http://www.ndss.org)
- Children and Adults with Attention Deficit/Hyperactivity Disorders, [www.chadd.org](http://www.chadd.org)
- LD Online, website on learning disabilities and ADHD, [www.ldonline.org](http://www.ldonline.org)
- Autism Speaks, national advocacy group on Autism Spectrum Disorder, [www.autismspeaks.org](http://www.autismspeaks.org)
- The Arc, for people with developmental disabilities, [www.thearc.org](http://www.thearc.org)
- Other national parent associations and advocacy groups can often be found by conducting a “Google search” for that condition, for example, Williams Syndrome Association, [www.williams-syndrome.org](http://www.williams-syndrome.org) |
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<th>Tools</th>
<th>Examples, Descriptions and/or Strategies</th>
<th>PCPCH Standards</th>
</tr>
</thead>
</table>
| X   |       | Encourage adaptive skills and independence at all visits | Use a general developmental questionnaire that includes a personal-social domain for children up to 5 years of age  
  - For example, Ages and Stages Questionnaires*, online access for families at [www.asgoregon.com](http://www.asgoregon.com)  
  - Dr. Nickel, the primary author of the OCCYSHN Care Coordination Toolkit, is co-author of the Ages and Stages Questionnaires  

Use handouts for youth and their parents, for example,  
- Healthcare Transition Planning Guides for youth 12-14 years, 15-17 years and 18 years and older at [www.floridahats.org](http://www.floridahats.org)  
- Handout on Goal Setting for youth with developmental disabilities, go to Healthy Transitions NY, [www.healthytransitionsny.org/skills_media/tool_show/9](http://www.healthytransitionsny.org/skills_media/tool_show/9)  

Also review the Bright Futures Tool and Resource Kit for health professionals, [brightfutures.aap.org/tool_and_resource_kit.html](http://brightfutures.aap.org/tool_and_resource_kit.html)  
For further information, see Goal-Setting and Transitioning to Adult Services. |

Enhanced Care Coordination Services
# Care Coordination in the Primary Care Setting

(Key: Staff = Office Staff, C/C = Care Coordinator, CYSHN = Children & Youth with Special Health Needs)

<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>X</td>
<td></td>
<td><em>Create and update a detailed written care plan</em> that incorporates care coordination and transition activities. Review the plan at least annually and as needed. Develop an emergency care plan as needed. Develop a transition summary as needed.</td>
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</table>
|     |       |            | • **Pediatric Care Plan**  
• **Action Plan**  
• **Emergency Care Plan**  
• Transition summary: [www.floridahats.org/wp-content/uploads/2010/03/HCT-Summary.pdf](http://www.floridahats.org/wp-content/uploads/2010/03/HCT-Summary.pdf) | Ideally the care plan is a “shared” care plan, an action plan that is developed in collaboration with the individual and family. Also consider the need to collaborate with educational staff to develop an emergency management plan for the school. | 5.F.2 |

## Enhanced Care Coordination Services

| X   |       | *Systematically track and follow-up referrals, results of laboratory tests, procedures and hospitalizations.* | | | 5.E.3 |
Care Coordination in the Primary Care Setting
(Key: Staff = Office Staff, C/C = Care Coordinator, CYSHN = Children & Youth with Special Health Needs)

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</thead>
<tbody>
<tr>
<td>Coordinate care with other community providers, including dental, mental health, public health, educational staff and social services providers.</td>
<td></td>
<td>Attend care conferences with school staff and other community providers as needed.</td>
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<tr>
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<td>Consider the need to refer the child and family to external care coordination supports such as the CaCoon (Care Coordination) program, public health nurses in each county <a href="http://www.ohsu.edu/xd/outreach/occyshn/programs-projects/cacoon.cfm">www.ohsu.edu/xd/outreach/occyshn/programs-projects/cacoon.cfm</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Also consider the need to refer to external supports such as a home health nurse to build the child’s or family’s self-management skills.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Participate in community planning groups such as Local Inter-Agency Coordinating Councils.</td>
</tr>
</tbody>
</table>
Other Resources

Care Coordination Atlas: www.ahrq.gov/qual/careatlas/careatlas3.htm

Health Literacy Universal Precautions Toolkit: www.ahrq.gov/qual/literacy

American Academy of Pediatrics’ (AAP) culturally effective care toolkit: practice.aap.org/culturallyeffective.aspx

American Medical Association’s health literacy program which includes a video and manual for clinicians: www.ama-assn.org/ama/pub/about-ama/ama-foundation/our-programs/public-health/health-literacy-program/health-literacy-kit.page

Ethnomed: ethnomed.org; website developed by staff from the University of Washington. It provides comprehensive information about a variety of health care topics and a number of different cultures.
Resources on the transition of youth to adult services:

The National Health Care Transition Center, [www.gotttransition.org](http://www.gotttransition.org), supported by a cooperative agreement between the US Maternal and Child Bureau and the Center for Medical Home Improvement, includes link to Clinical Practice Guidance and Algorithm on transition jointly developed by the AAP, the American Association of Family Physicians and the American College of Physicians.

Adolescent Health Transition Project at University of Washington, [depts.washington.edu/healthtr](http://depts.washington.edu/healthtr), includes the Adolescent Autonomy Checklist, a transition timeline and a guide to Parent-Child Self Management

Florida Health and Transition Services (HATS), a comprehensive transition resource site that links to documents from a number of other transition sites, [www.floridaHATS.org](http://www.floridaHATS.org)


Healthy and Ready to Work (HRTW) National Center, variety of tools and checklists for providers including transition checklist and templates for care plan, medical summary and emergency management plan [syntiro.org/hrtw/tools/index.html](http://syntiro.org/hrtw/tools/index.html)

Healthy Transition NY, a comprehensive transition resource site for youth with developmental disabilities that includes tools for scheduling an appointment, managing medications, speaking up at the doctor’s office and setting health goals [www.healthytransitionsNY.org](http://www.healthytransitionsNY.org)

Transition resources from the Waisman Center, Transition to Adult Health Care: Training Guide in Three Parts [www.waisman.wisc.edu/cedd/pdfs/products/health/TAHCT_2.pdf](http://www.waisman.wisc.edu/cedd/pdfs/products/health/TAHCT_2.pdf)


The AHRQ also discusses the “medical neighborhood,” a recent concept that highlights the importance of coordination of care between the primary care office and hospital, and among all health and mental health care providers in the community, [pcmh.ahrq.gov/portal/server.pt/community/pcmh_home/1483/federal_pcmh_activities](http://pcmh.ahrq.gov/portal/server.pt/community/pcmh_home/1483/federal_pcmh_activities)

The Centers for Medicaid and Medicare Services (CMS) provide an overview of “meaningful use” of an EHR; for example, use for e-prescribing, to exchange health information and to track quality indicators to improve care, [www.cms.gov/ehrincentivprograms/30_MeaningfulUse.asp#BOOKMARK2](http://www.cms.gov/ehrincentivprograms/30_MeaningfulUse.asp#BOOKMARK2)

Oregon Patient-Centered Primary Care Program

The Oregon Health Authority (OHA) has launched its Patient-Centered Primary Care Home (PCPCH) Program. This program is part of Oregon’s health system transformation efforts that put forward a vision for better health, better care and lower costs. Although this work initially will provide access to a PCPCH to individuals covered by Medicaid, state employees and Oregon educators, the intent is to move toward statewide adoption of the PCPCH model across all payers. The PCPCH Program’s website, www.primarycarehome.oregon.gov provides links to an implementation guide, reporting guidelines, a self-assessment tool, and the application to be recognized as a PCPCH.

“The PCPCH measures are divided into “Must-Pass” measures and other measures that place the practice on a scale of maturity or ‘tier’ that reflect basic to more advanced PCPCH functions. Must-Pass and Tier 1 measures focus on foundational PCPCH elements that should be achievable by most practices in Oregon with significant effort, but without significant financial outlay. Tier 2 and Tier 3 measures reflect intermediate and advanced functions. Except for the 10 Must-Pass measures, each measure is assigned a point value corresponding to the Tier. For a practice to be recognized as a PCPCH, it must meet the following point allocation criteria:

- Tier 1: 30 – 60 points and all 10 Must-Pass Measures
- Tier 2: 65 – 125 points and all 10 Must-Pass Measures
- Tier 3: 130 points or more and all 10 Must-Pass Measures”

In order to be recognized as a PCPCH, a practice must contractually attest to meeting certain standards as well as submit data elements which will include a patient experience of care survey. The Oregon PCPCH Program will score PCPCHs by combining the contractual attestation information with the data requirements received. The OHA will develop a web-based reporting system.
Implementation Measures for Core Attribute #5: Coordination & Integration

Tier 1 (5 points each): The PCPCH

5.A.1a identifies, aggregates, and displays data regarding its patient population.
5.A.1b identifies, tracks and proactively manages the care needs of a subpopulation of its patients.
5.C.1 assigns individual responsibility for care coordination and tells each patient of family the name of the team member responsible for coordinating his or her care.
5.D.1 tracks ordered tests and ensures timely and confidential notification or availability of results to patients and families and ordering clinicians.
5.E.1a tracks referrals ordered by its clinicians, including referral status and whether consultation results have been communicated to patients and clinicians.
5.E.1b coordinates care when its patients receive care in specialized settings, e.g., hospitals or skilled nursing facility.

Tier 2 (10 points each): The PCPCH

5.C.2 describes and demonstrates its process for identifying and coordinating the care of patients with complex care needs.
5.F.2 demonstrates the ability to identify patients with high-risk environmental or medical factors, including patients with special health care needs, who will benefit from additional care planning. PCPCH demonstrates it can provide these patients and families with written care plan that includes: self-management goals; goals of preventive and chronic illness care; action plan for exacerbations of chronic illness (when appropriate); end of life care plans (when appropriate).

Tier 3 (15 points each): The PCPCH

5.B.3 has an electronic health record and demonstrates “meaningful use” of the electronic record, according to CMS rules.
5.E.3 tracks referrals and coordinates care where appropriate for community settings outside the PCH (such as dental, educational, social service, foster care, public health, or long term care settings).
Implementation Measures for Core Attribute #6: Person- and Family-Centered Care

Must-Pass: The PCPCH

6.A.0 documents the offer and/or use of either providers who speak a patient and family’s language or time of service in-person or telephone trained interpreters to communicate with patients and families in their language of choice.

Tier 1 (5 points each): The PCPCH

6.B.1 documents patient and family education, health promotion and prevention, and self-management support efforts, including available community resources.

6.C.1 surveys a sample of its patients and families at least annually on their experience of care. The survey must include questions on access to care, comprehensive whole person care, continuity, coordination and integration, and person or family centered care. The recommended patient experience of care survey is one of the CAHPS survey tools.

Tier 2 (10 points each): The PCPCH

6.C.2 surveys a sample of its population using one of the CAHPS survey tools and reports results on the access of care domain.

Tier 3 (15 points each): The PCPCH

6.C.3 surveys a sample of its population using one of the CAHPS survey tools and demonstrates or meets benchmarks on the majority of domains.