## Medical Home Care Coordination Measurement Tool

### Site Code: ___  Form # ___ of ___

<table>
<thead>
<tr>
<th>Date</th>
<th>Patient Study Code And Age</th>
<th>Patient Level</th>
<th>Focus</th>
<th>Care Coordination Needs</th>
<th>Activity Code(s)</th>
<th>Outcome(s) Prevented Occurred</th>
<th>Time Spent*</th>
<th>Staff</th>
<th>Clinical Comp.</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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.)

### Activity Code(s)

#### 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
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)

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

---

**Supported by grant HRSA-02-MCHB-25A-AB**

---

©The Children’s Hospital Corporation, Richard Antonelli, MD, FAAP, [2009, for permission to use contact: Richard.Antonelli@childrens.harvard.edu]  

---

Boston Children’s Hospital