

## Health Care Provider Agency Integrated Care Coordination Worksheet

**Instructions: Each member of your team should fill out this worksheet on their own. As you are completing the form be sure to reference your agency's integration work plan. Once all team members have completed the worksheet meet as a team and discuss your findings. As a team, agree on one or more activities you would like to target for improvement.**

Care Coordination Domains	Care Coordination Activities	How well is your agency accomplishing this activity?  1=Poor 2= OK 3=Great Job	If you scored this item as "OK" or "Great Job" what data/evidence can your agency produce for this?	Is this activity currently in your agency's IH Work Plan as a Goal?  (Yes/No)	If No, should this be added to the integration work plan at this time?  (Yes/No)
<b>Accountability</b>	1. All medical home team members work within the same plan of care & are measurably co-accountable for their contributions to the shared plan & achieving the pt's goals.				
	2. Our agency supports the pt./family to understand their role in the coordination of care (e.g. physical & behavioral health crisis plans, orientation provided to help explain how to navigate between providers, etc.).				
<b>Patient &amp; Family Centered Support</b>	3. Our agency provides referral & related activities (such as scheduling appointments for pts.) to help an individual obtain needed services, including medical, social, educational, childcare, nutritional, transportation, home repair, prescription assistance, home healthcare, employment services, utilities, etc.				
	4. Our agency provides pt./family skills training needed to improve physical/beh health condition(s) & navigate the social welfare/healthcare system.				
	5. Our agency has a racial, ethnic, & sexual orientation disparities of care plan in place to address how the health care needs of these populations will be addressed.				
	6. Our agency routinely assesses inter & intra-agency care flow processes to insure they are pt./family oriented (e.g., conduct "secret shopper" assessments).				
	7. Our agency pt. care plans are proactive updated based on anticipated pt. needs based on history of the illness, age, &/or cognitive abilities.				
	8. Staff duties related to care coor. are clearly articulated to & understood by staff as evidenced by ongoing training in care coor., care coor. in job descriptions, care coor. policy/procedures, etc.				

<b>Communication, Connectivity, &amp; Care Flow</b>	9. WITHIN agency communication regarding care coor. is robust & facilitated by regular care coor. meetings, dashboard reports describing care coor. outcomes &/or resource use, alert notifications, etc.				
	10. BETWEEN agency communication regarding care coor. is robust & facilitated by regular care coor. meetings, dashboard reports describing care outcomes &/or resource use, coor. of care documentation sharing, alert notifications, cross training, etc.				
	11. Pt. care transfers are well coordinated as evidenced by timely alerts of pt. presentation & d/c from facilities & transmission of pt. transition documentation.				
	12. Medication reconciliation occurs across all providers & with pt./family following medication changes.				
	13. Our agency senior leadership & frontline staff regularly meet with providers with whom we engage in the most coor. of care/with whom we share patients.				
	14. Our agency routinely assesses inter & intra-agency care flow processes to insure staff have the resources needed to be efficient & effective (e.g., clinical decision support tools, communication gap analysis, etc.).				
<b>Cross Agency Relationships &amp; Agreements</b>	15. Our agency has formal agreements (i.e., contracts or MOU's) with all agencies in our pt's network of care.				
	16. Electronic transfer of data between provider agencies occurs as needed to support & monitor the needs of pts./pt. populations.				
	17. Our agency has streamlined admission processes between agencies with whom we frequently refer pts.				
<b>Total/Add up your ratings/numbers!</b>					
<b>High Care Coordination = 35-51</b> <b>Moderate Care Coordination = 18-34</b> <b>Low Care Coordination = 1-17</b>					