Care Coordination Capacity Checklist

Care Coordination Implementation

The table below lists key care coordination elements based on the National Standards for Systems of Care for Children and Youth with Special Health Care Needs (CYSHCN) domains.[4] Each element is broken up into three different levels of implementation based on clinic capacity.

- **Basic** refers to clinic structures that may limit or restrict service provision due to a small number of staff, lack of technological tools and data system, spatial restrictions, etc.
- **Intermediate** refers to practices that have the staff and physical space to support comprehensive care coordination services. Level 2 practices have a functional data system/EHR and mechanisms to modify the system.
- **Advanced** refers to practices that have at least one designated care coordinator on staff who works to develop, implement, and ensure follow-up for the patient plan of care. The care coordinator tracks outcomes and drives quality improvement efforts.

For each care coordination element, move across the row and put a check next to the elements that best describe your current clinic activities. For some elements, you may fall into the Basic level, for others you may be Advanced. After you go through all the elements listed on this page and the next, take a look at the checklist as a whole. Focus in on the elements where your clinic is at the basic or intermediate level. These are likely areas for improvement. Circle 1-3 elements that would be most feasible to improve on at this time. You will use those in the next step.

Screening, Identification, and Assessment

Care Coordination Elements	Basic	Intermediate	Advanced
Screening processes	❑ Basic screening/needs assessments in place for identifying unmet child/family needs.	❑ Systematic and timely screening services are provided per Bright Futures Preventative Health Periodicity Table ❑ Systematic screening for special health care needs.	❑ Information and data from multiple data sources are built into screening and assessment processes (including complexity of child's health status, health/social inequities, etc.)
Identification of clinic's CYSHCN (high need patients)	❑ A definition and mechanism for identification of CYSHCN is in place and used to enhance care (pre-visit planning, additional visit time, safe-wait space, etc.)	❑ Systematic and universal method is used to identify CYSHCN patient charts to ensure consistency and efficiency of supports and services.	❑ CYSHCN patients are assigned a complexity level, diagnostic codes are documented, and there is a plan of care for ongoing monitoring and referral tracking.
Assessment of needs	❑ Care coordination assessment is conducted in addition to, or in alignment with, other initial screens.	❑ Care coordination assessment (including social related needs) findings are consistently documented and incorporated within the plan of care.	❑ Action items identified through care coordination assessments are used for goal-setting based on family needs, priorities. ❑ Reassessments and follow-up protocols are in place.

	Care Coordination Elements	Basic	Intermediate	Advanced
Care Planning and Continuity	**Shared Plan of Care**	❑ Written plan of care is collaboratively developed and shared with family - addresses clinical, functional, and social needs.	❑ Clinic team implements, monitors and updates the plan of care that includes social related health needs during the course of patient visits and phone encounters.	❑ A designated care coordinator conducts ongoing plan updates and monitors the plan of care within/across systems.
	Resource Linkage	❑ Basic community resource referral/linkage without follow up.	❑ Linkage to community resources with follow up (closed referral loops). ❑ Ready access public health and community program materials/resources.	❑ Designated care coordinator provides ongoing coordination support and community referrals with follow-up based on patient/family needs.
Systems and Workforce	**Appointment Scheduling**	❑ Basic scheduling and pre-visit processes in place.	❑ Policies implemented that address special accommodations and/or visit supports for CYSHCN.	❑ Detailed communication strategies in place that support effective CYSHCN services; easy access clinic contact for families, such as designated care coordinator or nurse.
	Staff Roles and Policies	❑ Loosely defined staff roles, clinic lacks fully adopted care coordination definition with assigned staff roles.	❑ Clear practice-based care coordination definition with staff assigned to specific care coordination activities.	❑ Designated care coordinator with clearly defined role and fluid level of involvement based on a patient/family needs.
Transition to Adulthood	**Youth Transition Processes**	❑ Typical adolescent anticipatory guidance provided.	❑ Providers use a transition checklist and developmental approach. ❑ Transition needs assessment and guidance is offered related to wellness, vocational planning, community supports, etc.	❑ Practice implemented a youth transition policy. ❑ Transition progression is outlined/tracked in the EHR. ❑ Adolescents receive practice support to link their health and transition plans with other relevant providers, services, and agencies.
Quality Standards	**Continuous Quality Improvement (QI)**	❑ Practice conducts family satisfaction surveys and uses feedback to guide practice improvements. ❑ Practice has scheduled monthly/quarterly staff meetings.	❑ Practice has a quality improvement (QI) team. ❑ Practice uses continuous quality improvement (CQI) to ensure current best practices are implemented and processes remain effective and efficient.	❑ Staff and families of CYSHCN are supported to participate in CQI activities. ❑ Policies, procedures, and mechanisms are in place to review care team activities on a regular basis to assess quality and outcomes.