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.

Brainstorm Worksheet

Care Coordination Implementation

Now that you've identified areas of improvement you'd like to work on, think through what will be needed to implement a change in your clinic. Take the most doable element(s) identified from the **Care Coordination Capacity Checklist** and write it below. Answer the questions to determine if your clinic would be ready to work on it and break it down into actionable steps. You can run as many elements from the checklist through these questions as needed. Once you identify the one you would like to implement, it will become your priority task.

Element to Brainstorm: _____

Brainstorm Questions

What changes would you like to see?

Who will be involved in these changes? Will you need to hire additional staff?

How will this change the workflow at your clinic? What will be needed to get staff to follow a new protocol?

What else will you need to make this change successful - technology, equipment, etc?

Is this a feasible option for the clinic at this time?

What would the next steps be in order to implement this change? What needs to be approved by leadership?

Priority Task: _____

Project Planning Worksheet

Care Coordination Implementation

Now that you have decided on your priority task, you can start to plan out in detail what needs to happen for changes to occur. You will need to either modify a current process to include these changes or create a new one. Identify the staff you have available and plot out the steps that will need to occur in order to reach your goal. Identify who will fill each roles, what training staff should receive, and if you need any additional resources or support.

Planning Your Next Steps

Use the table below to identify what your next steps are, who will carry them out, who will be involved in implementation, what kind of training will be needed, etc.

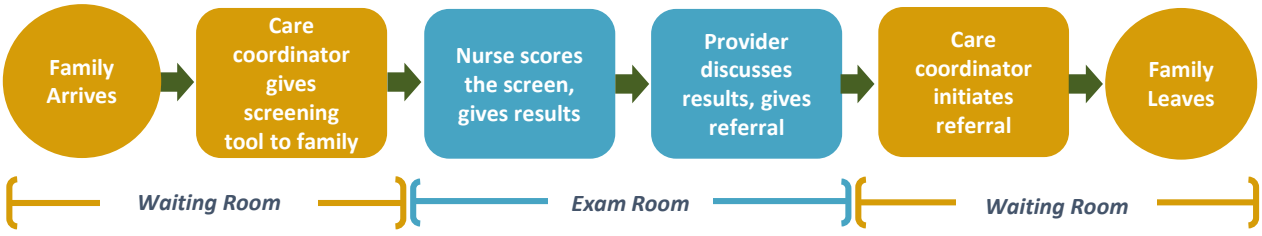
Next Steps	Person (s) Assigned	Notes

Planning Tool: Process Mapping

Process mapping may be a helpful tool to use as you plan out your project. Process mapping is exactly what it sounds like – mapping out each step of a specific process to show how it works in a given setting. They can help your implementation team identify problems, solutions, and improvement opportunities within current systems. They can also be helpful for creating processes and explaining them to others

A process map illustrates the sequence of activities and flow of work. Consider staff you have available to do each step you identify. Use different colors and shapes to help distinguish between categories. Grab a blank piece of paper and create a process map for the priority task you identified. Check out the example below, additional examples in the Appendix, and this video on how to use a process map to help guide you.

For each step of the process, be sure to include: **What** happens, **Who** is involved, and **Where** the step will take place. Once you have that, you can being to identify specific people who will be involved and what training they will need.



Plan-Do-Study-Act (PDSA) Worksheet

Care Coordination Implementation

Use this worksheet for Step 3 to implement your priority task. A Plan-Do-Study-Act (PDSA) cycle is a simple scientific method for accelerating quality improvement (QI). Use this worksheet to test a change you wish to implement or improve in your facility.

Title: _____

Planned Test Date(s): _____ **Today's Date:** _____

1: PLAN Develop a test and make a prediction

DESCRIPTION OF TEST/TASK

Who:_____

What: _____

Where: _____

When: _____

PREDICTION

2: DO Conduct the test and collect data

STEPS TAKEN

COLLECT DATA

3: STUDY Analyze the data and summarize results

ANALYZE DATA

RESULTS

COMPARE RESULTS TO PREDICTED OUTCOME

4: ACT Refine changes for the next cycle

❑ **ADAPT** (write out changes to be made next time)

❑ **ADOPT** (create a timeline for full implementation)

❑ **ABANDON**

Louisiana Department of Health ● Office of Public Health ● Bureau of Family Health

Implementation Training & Support

The Bureau of Family Health offers trainings and resources to Louisiana providers that can help enhance and expand their clinical services. Our team of experts is available to develop a tailored plan to fulfill your clinic's needs, and can meet in-person or virtually to provide technical assistance. We use a quality improvement framework that helps embed continuous improvement into your practice. We provide trainings on the following topics:

- Developmental screening
- Care coordination
- Youth health transition
- Pediatric and Perinatal Mental Health

These trainings and resources are available at no cost. If you're interested in learning more, please complete the information below and email it to DevScreen@la.gov. We will contact you to provide more information and schedule a training. For more information about each of these topics, visit PartnersForFamilyHealth.org/medical-home.

Step 1: Tell Us Your Interests

Check the following services you are interested in for each of the topic areas.

	Referral Resources	Tools to Use in Clinic	Implementation Training*
Developmental Screening			
Care Coordination			
Youth Health Transition			

*Implementation Training can be done in-person or virtually. Training includes:

- Project planning
- Staff training
- Process mapping
- Implementation Assistance

Step 2: Tell Us About Your Practice

Provide the following information about your clinic. We will contact you using your preferred method of communication.

Clinic: _____ Contact Name: _____

Address: _____ Contact's Role: _____

City: _____ Phone: _____

EHR System: _____ Email: _____

Clinic Owner: _____ Preference: ☐ Phone ☐ Email

LOUISIANA DEPARTMENT OF HEALTH

For more information, please contact the Developmental Screening Coordinator at 504-568-3504 or at DevScreen@la.gov