Section 1.2 Assess

Community Data Collection Form

This tool facilitates the collection of community data as part of an initial assessment in the planning and development of a community-based care coordination (CCC) program. Each organization that participates, or anticipates participating, in the CCC program must complete this community data collection form. It identifies the resources, needs, and opportunities in the community in order to develop, implement, and sustain successful care coordination services.

|  |
| --- |
| **Time needed**: 20 hours  **Suggested other tools**: CCC Glossary of Terms; CCC Maturity Assessment |

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How to Use

1. **Complete** this Community Data Collection Form and return to <organization> by <date>.
2. **Send** completed form via email to: <name> at <email address>*.* If you have any questions or need clarification on any item, please contact <name> at <phone number>. **Note:** It is to be expected that there will be a number of items on this assessment for which you have no answer, the answer is “no” because something has not yet been deployed, or is “not applicable” to the community or organization.
3. **Review** the assessment. Once you have returned the form and it is further discussed during the site visit on <date>, a summary of the findings and opportunities will be provided to you within <two weeks> and will be discussed in a conference call thereafter.
4. **See** *Glossary of Terms for CCC* for definitions of terminology used in this assessment.

**Community Data Form**

Form completed for:

|  |  |
| --- | --- |
| Community: |  |
| Date: |  |

|  |  |
| --- | --- |
| Team members/organizations participating in completion of this survey: | |
| Name | Organization |
|  |  |
|  |  |
|  |  |
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|  |  |
|  |  |

# Patient Panel Understanding

The following information will ensure that key characteristics of the community’s providers and patient population are identified and available as needed throughout the project.

1. **Describe the health care providers in your community**

|  |  |  |
| --- | --- | --- |
| **HOSPITAL\*** | | |
| Lead hospital name: |  | |
| CEO name: |  | |
| CMO name: |  | |
| Hospital type: | ❑ Fee for service ❑ Critical access | |
| Number of beds: |  | |
| Number of annual admissions: |  | |
| Average daily census: |  | |
| Average length of stay: |  | |
| Annual number of visits to ED: |  | |
| Annual number of visits of out-patient departments of hospital for each department: | Department: | # annual visits: |
| Department: | # annual visits: |
| Department: | # annual visits: |
| Department: | # annual visits: |
| Does hospital have 24x7 pharmacist coverage: | ❑ Yes  ❑ No | |
| Nearest tertiary care hospital and miles from hospital: | Hospital name:  # miles: | |
| Percent of patients in the community with an identifiable primary care provider: | \_\_% | |
| \* If there is more than one hospital in the community, provide data for the lead hospital on the community team first, then copy and populate the table of information for each additional hospital. | | |
|  | | |
| **NURSING HOME\*\*** | | |
|  |  | |
| Facility name: |  | |
| Number of beds: |  | |
| Number of annual admissions: |  | |
| Average daily census: |  | |
| Average length of stay: |  | |
| **HOME HEALTH** | | |
| Facility name: |  | |
| Number of nursing staff: | # of CNAs/LPNs:\_\_\_ # of RNs:\_\_\_ | |
| Annual number of clients: |  | |
| **HOSPICE** | | |
| Facility name: |  | |
| Annual number of patients: |  | |
| **INPATIENT REHABILITIATION FACILITY** | | |
| Facility name: |  | |
| Number of nursing staff: | # of CNAs/LPNs:\_\_\_ # of RNs:\_\_\_ | |
| Annual number of patients: |  | |
| Average daily census: |  | |
| Average length of stay: |  | |
| \*\* If there is more than one of each facility/organization above, copy and populate the table of information for each additional facility/organization. | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **OTHER PROVIDER FACILITIES IN COMMUNUNITY** (Add lines as needed; if not available or not applicable, record N/A.) | | | | | |
| **Type of Provider** | **Name of Facility** | **# Physicians /**  **# PAs / NPs** | **# Annual Visits** | **# Patients per Day per Provider** | **Specify if FQHC, RHC, CMC, CMHC** |
| Primary care |  |  |  |  |  |
| Multi-specialty |  |  |  |  |  |
| Behavioral health |  |  |  |  |  |
| Psychiatrist |  |  |  |  |  |
| Dental |  |  |  |  |  |
| Chiropractic |  |  |  |  |  |
| Podiatrist |  |  |  |  |  |
| Optometrist |  |  |  |  |  |
| Commercial lab |  |  |  |  |  |
| Imaging center |  |  |  |  |  |
| Retail pharmacy |  |  |  |  |  |
| Respiratory therapy |  |  |  |  |  |
| Physical therapy |  |  |  |  |  |
| Occupational therapy |  |  |  |  |  |
| Music therapy |  |  |  |  |  |
| Dietician |  |  |  |  |  |
| Behavioral health |  |  |  |  |  |
| Durable medical equipment |  |  |  |  |  |
| Local public health provider |  |  |  |  |  |
| Other (specify) |  |  |  |  |  |
| Other (specify) |  |  |  |  |  |

**Comments:**

# Community Support Resources

1. **Describe the community support resources in your community.** In addition to the providers listed above, describe other health support services available in your community and whether they are represented on your CCC program team.(Add lines as needed; if any are not available, record N/A.)

|  |  |  |  |
| --- | --- | --- | --- |
| **Community Resource** | **Name of Resource(s)** | **CCC Program Team Member? (Y/N)** | **Plan to include on CCC Team (Y/N)** |
| Case management |  |  |  |
| Aging services |  |  |  |
| ADL services |  |  |  |
| Social services |  |  |  |
| Local public health services |  |  |  |
| Transportation services |  |  |  |
| Emergency response services |  |  |  |
| Support groups (e.g., Alcoholics Anonymous, tobacco cessation) |  |  |  |
| Nutrition services  (e.g., Meals on Wheels) |  |  |  |
| Weight management |  |  |  |
| Physical activity services |  |  |  |
| Community health workers |  |  |  |
| Parish nursing |  |  |  |
| Pastoral care |  |  |  |
| Respite care |  |  |  |
| Homeless shelter |  |  |  |
| Crisis line |  |  |  |
| Assisted living facilities |  |  |  |
| Food pantries |  |  |  |
| Homemaker services |  |  |  |
| Other (specify) |  |  |  |
| Other (specify) |  |  |  |
| Other (specify) |  |  |  |

**Comments**:

# Community / Health Census

1. Describe the population of the community

|  |  |
| --- | --- |
| Age (in years) of persons in the community: | \_\_\_\_% Infants (0-1)  \_\_\_\_% Children (2-11)  \_\_\_\_% Adolescents (12-20)  \_\_\_\_% Adults (21-64)  \_\_\_\_% Elderly (65+) |
| Median household income for the community: | **$** |
| Unemployment rate in community: | \_\_\_\_% |
| Major industry(s) in the community (e.g., farming, manufacturing): |  |
| Payer mix: | \_\_\_\_% Medicare  \_\_\_\_% Medicaid  \_\_\_\_% BCBS  \_\_\_\_% Other commercial insurer(s)  \_\_\_\_% Self-pay |
| Population risk stratification: | **Low risk:** \_\_\_\_\_% (healthy persons or persons with only one medical condition that is well managed)  **Moderate risk:** \_\_\_\_\_% (persons who have a single, severe condition; or persons with multiple well-managed conditions)  **High risk:** \_\_\_\_\_% (medically fragile persons with multiple  conditions needing complex care) |
| Number of patients within  community in high risk, high  cost focus categories: | CHF: \_\_\_\_ representing \_\_\_\_% of population  COPD: \_\_\_\_ representing \_\_\_\_% of population  Stroke: \_\_\_\_ representing \_\_\_\_% of population |
| Identify 3 conditions other  than those listed above that are in the top 10th percentile of  spend in prior year: | 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_: \_\_\_\_ representing \_\_\_\_% of pop 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_: \_\_\_\_ representing \_\_\_\_% of pop 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_: \_\_\_\_ representing \_\_\_\_% of pop |
| Number of patients who have had one or more emergency department visits in prior year: | \_\_\_\_ representing \_\_\_\_% of population |
| Number of patients who have had one or more  hospitalizations in prior year: | \_\_\_\_ representing \_\_\_\_% of population |
| Number of 30-day  readmissions: | \_\_\_\_ representing \_\_\_\_% of population |

# Leadership

“Leaders inspire providers and care teams to re-imagine care delivery and reconsider how the organization interacts with patients to ensure continuity of care.”[[1]](#footnote-1)

Describe the leaders within your Community Team by identifying (✓) the activities in which they are currently engaged in each of the leadership categories below:

1. Ensure that the importance of care coordination (CC) is reflected in your community’s/practice’s mission, vision, values, and strategic plan
   * Promote the organization’s commitment to CC at staff meetings
   * Describe CC practices in employee job descriptions, recruitment documents, and interview questions for potential staff
   * Recognize and reward those who demonstrate CC progress across the continuum of care
2. Use a communication strategy to spread the message about the importance of CC
   * Frequent topic on staff meeting agendas
   * Employ multiple communication strategies
   * Forming a community steering team, including providers, representatives of other community resources, and patients/family/caregivers
   * Solicit change ideas and strategies from staff and members of the community to personalize CC
3. Identify and mentor champions for CC who are respected and who have regular interaction with staff, providers, community team members, patients, and families/caregivers
   * Meet regularly with staff to address areas of concern and refine CC processes
   * Engage providers in assuring care is coordinated across provider organizations and other community resources
   * Provide training in communication, coaching, and continuous improvement for staff, providers, and community team members to empower patients and ensure continuity of care
4. Develop a system for integrating quality improvement (QI) data into the care coordination implementation process
   * Stratify the patient population in the community by categorizing their health status by risk level
   * Conduct predictive modeling to anticipate consequences of a change in a focused population
   * Sustain change by ensuring that evidence-based practices are adopted in preventing chronic disease, stabilizing current chronic conditions, and preventing acceleration to higher risk categories with higher costs
5. Report regularly on quality improvement initiatives and outcomes
   * Report regularly to staff, providers, and board of directors on the quality of care being provided within the community for specific high-risk conditions
   * Report regularly to staff, providers, and board of directors on the cost of care for specific high-risk conditions
   * Report regularly to the public within the community on the quality and cost of care for specific high-risk conditions
6. Identify and allocate resources including time, dollars, staffing, equipment, technology, and other types of support that help staff implement or sustain CC
   * Ensure that all staff transitioning into a new role or taking on a new responsibility are trained and prepared in CC
   * Consider the long-term developmental needs of staff and develop a budget to support high-priority training on CC
   * Ensure effective change management by providing time to understand and embrace the transformative nature of CC
   * Address limitations frankly and honestly to find ways to reduce resistance to change
7. Make the chief financial officer a quality champion
   * Utilize data and advanced analytics to identify costs and compare outcomes with various CC and other interventions
   * Support workflow and process management that focuses on elimination of waste rather than cutting services
   * Apply a macro-economic approach to valuing investments in CC
8. Specify evaluation and reporting measure(s) used:
   * HEDIS
   * CAHPS
   * HCAHPS
   * State-specific measures (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   * Other measures (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. Other leadership traits unique to your community team:

# Care Management

Care coordination begins with triaging patients to the appropriate level of care and ensuring that each patient has a plan of care based on the patient’s needs and preferences that will help maintain health and wellness, prevent chronic disease, stabilize current chronic conditions, or prevent acceleration to higher risk categories with higher costs.

Identify (✓) the specific care management functions *currently* performed, *planned* to be performed with the care coordinator, or considered a potential *future* initiative.

| **Care Management Activity** | **Currently Performed** | **Task of Care Coordinator** | **Future Initiative** |
| --- | --- | --- | --- |
| 1. Assess patient’s clinical, insurance, and logistical needs so patient is provided services at appropriate level of care |  |  |  |
| 1. Ensure patient has a current medication list |  |  |  |
| 1. Review patient compliance with medications |  |  |  |
| 1. Utilize technology and pharmacist support for medication safety risk identification |  |  |  |
| 1. Track lab tests; flag and follow up on overdue results |  |  |  |
| 1. Track imaging studies; flag and follow up overdue results |  |  |  |
| 1. Ensure patient/family is notified of lab and imaging results in a timely manner |  |  |  |
| 1. Conduct case review to assess whether patient needs and support systems are addressed |  |  |  |
| 1. Perform disease management to assess whether the patient is getting the most cost effective care |  |  |  |
| 1. Serve as patient advocate during a health care event to ensure that the patient’s care plan is being followed |  |  |  |
| 1. Identify and promote use of evidence-based practices in the immediate and planned care of the patient |  |  |  |
| 1. Analyze and redesign workflows and processes to support improvements in care, experience of care, and cost of care |  |  |  |
| 1. Provide support for patient/family health literacy |  |  |  |
| 1. Engage patient/family in care planning: |  |  |  |
| 1. Apply motivational interviewing/patient self-management techniques to support patient engagement in care planning with the provider |  |  |  |
| 1. Focus on specific, realistic, and measurable goals for health status and quality of life |  |  |  |
| 1. Educate patient/family on monitoring signs and symptoms and seeking solutions to problems |  |  |  |
| 1. Ensure care plan reflects patient/family barriers and preferences |  |  |  |
| 1. Ensure care plan reflects shared decision making |  |  |  |
| 1. Track that patients are receiving appropriate screenings and preventive services for their age group |  |  |  |
| 1. Perform population health management to continuously monitor quality of care processes and outcomes for improvement in the community served |  |  |  |

# Care Coordination

Care coordination adds the specific dimensions of identifying those at risk and coordinating their care plans, arranging and tracking appointments, providing education, monitoring health status, referral management and follow up, transitional care management, community resource utilization and facilitating other aspects health care.

Identify (✓) the specific care coordination functions *currently* performed, *planned* to be performed with the care coordinator, or considered a potential *future* initiative.

| **Care Coordination Activity** | **Currently Performed** | **Task of Care Coordinator** | **Future Initiative** |
| --- | --- | --- | --- |
| 1. Track referrals to specialists and community services; flag and follow up on appointments/arrangements not made or not kept |  |  |  |
| 1. Ensure that clinical summary information is available, as applicable, for all referrals to specialists and community services |  |  |  |
| 1. Obtain specialists and community services results/reports |  |  |  |
| 1. Conduct admission planning to hospital to ensure: |  |  |  |
| 1. Primary care provider is notified |  |  |  |
| 1. Clinical summaries are received from other providers as applicable |  |  |  |
| 1. Advance directives are reconciled |  |  |  |
| 1. Conduct discharge planning in advance of anticipated discharge date for transfer to other level of hospitalization or nursing home to ensure : |  |  |  |
| 1. A plan of care exists |  |  |  |
| 1. Patient/family is prepared and agrees to transfer |  |  |  |
| 1. Advance directives are reconciled |  |  |  |
| 1. Recipient provider receives summary of care |  |  |  |
| 1. Patient’s primary care provider is notified of transfer |  |  |  |
| 1. Manage transitions of care (ToC) for patients with moderate or high complexity of medical decision making between the date a patient is discharged from a hospital or nursing home to the patient’s community and continuing for the next 30 days: |  |  |  |
| 1. Communicate with patient/family within 2 days post-discharge, **and** |  |  |  |
| 1. Face-to-face visit with patient within two weeks of discharge, ***or*** |  |  |  |
| 1. Face-to-face visit with patient within one week of discharge |  |  |  |
| 1. Ensure care coordinator bills appropriately once within the 30 day period following discharge for applicable ToC services |  |  |  |
| 1. Conduct the following activities during ToC: |  |  |  |
| 1. Ensure patient/family has current plan of care |  |  |  |
| 1. Monitor adherence to care plan, evaluate effectiveness, monitor patient progress, and facilitate changes as needed |  |  |  |
| 1. Ensure patient has, or arrange for, applicable community services based on patient needs |  |  |  |
| 1. Ensure patient has, is using, and understands any home monitoring devices and results as applicable |  |  |  |
| 1. Work with patient/family to plan for and monitor any unmet health and social needs |  |  |  |
| 1. Develop an ongoing action plan as applicable |  |  |  |
| 1. Create ongoing process for patients/families to determine and request the level of care coordination support they desire at any given point in time |  |  |  |
| 1. Serve as contact point, advocate, and informational resource for patient/family, care team, payers, and community resources |  |  |  |
| 1. Cultivate and support primary care and subspecialty co-management with timely communication, inquiry, follow-up, and integration of information into the care plan regarding ToC and referrals |  |  |  |
| 1. Facilitate patient access to appropriate medical and specialty providers |  |  |  |
| 1. Facilitate and attend meetings between patient, family, care team, payers, and community resources as needed |  |  |  |
| 1. Assess current community service offerings and recommend opportunities for enhancement |  |  |  |
| 1. Contribute to the evaluation of the quality of care, experience of care, and cost of care provided in the community |  |  |  |
| 1. Identify other quality/performance improvement initiatives in your community that may relate to care management or care coordination services (e.g. chronic disease management, medical home, reducing hospital readmissions) |  |  |  |
| 1. Identify perceptions of potential barriers to care coordination, the degree of impact these barriers may pose in developing a care coordination program, and the factors that drive decisions within your community related to care coordination |  |  |  |

# Potential Barriers

# Identify potential barriers to community-based care coordination and assess the affect of each barrier on your community using a scale from 0 to 4, with 4 being the highest. Add additional lines as needed.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Potential barrier** | **Identify affect of barrier on your community** | | | | |
| None |  | Moderate |  | High |
| Community awareness of care coordination | 0 | 1 | 2 | 3 | 4 |
| Health care staff/resources to provide services | 0 | 1 | 2 | 3 | 4 |
| Community resources to provide services | 0 | 1 | 2 | 3 | 4 |
| Clinician knowledge about care coordination | 0 | 1 | 2 | 3 | 4 |
| Clinician experience in care coordination | 0 | 1 | 2 | 3 | 4 |
| Coordination of care between provider settings | 0 | 1 | 2 | 3 | 4 |
| Medical staff commitment to care coordination | 0 | 1 | 2 | 3 | 4 |
| Reimbursement | 0 | 1 | 2 | 3 | 4 |
| Health information exchange | 0 | 1 | 2 | 3 | 4 |
| Health information technology | 0 | 1 | 2 | 3 | 4 |
| Technical infrastructure | 0 | 1 | 2 | 3 | 4 |
| Other (specify) | 0 | 1 | 2 | 3 | 4 |
| Other (specify) | 0 | 1 | 2 | 3 | 4 |
| Other (specify) | 0 | 1 | 2 | 3 | 4 |

# 

# Data and Processes

Data and processes are critical to effective and efficient care coordination. Describe the use of health information technology and other strategies to collect, manage, and use data and process improvement to support care coordination.

|  |  |
| --- | --- |
| **Data collection by health care facilities/members in the community**. Includes (✓): | |
| Hospital using certified EHR | ❑ Earning meaningful use incentives  ❑ Expect to first attest by (specify date): |
| Primary care providers (PCPs) using certified EHR | \_\_\_\_# PCPs using EHR out of possible \_\_\_\_#  \_\_\_\_% PCPs earning meaningful use incentives  ❑ Expect to first attest by (specify date): |
| Specialists using certified EHR | \_\_\_\_# Specialists using EHR out of possible \_\_\_\_#  \_\_\_\_% Specialists earning meaningful use incentives  ❑ Expect to first attest by (specify date): |
| Presence of EHR in other facilities | ❑ Nursing home uses an EHR  ❑ Behavioral/mental health uses an EHR  ❑ Home health uses an EHR  ❑ Local public health uses an EHR  ❑ Other providers use an EHR  specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Retail pharmacies accept  e-prescribing | \_\_\_\_# Pharmacies out of possible \_\_\_\_# |
| Other (specify): |  |

**Overall optimal utilization of EHR.** Rate on a scale of 1 (low) to 5 (high) compliance with:

|  |  |  |  |
| --- | --- | --- | --- |
| \_\_\_ Point of care charting  \_\_\_ Structured data entry requirements  \_\_\_ Clinical decision support alerts and reminders  \_\_\_ Standard terminologies (ICD-9-CM, CPT, SNOMED, LOINC, RxNorm, DSM-5, nursing)  \_\_\_ Technical interoperability standards and operating rules (HL7, X12/CORE, NCPDP, DICOM)  \_\_\_ Security risk analysis | | | |
| **Data analytics and public reporting available to the community** | | | |
| * Local or state-based data registry/warehouse | Community participants *contributing* data #\_\_\_\_\_ out of possible #\_\_\_\_  Community participants *retrieving* data #\_\_\_\_\_ out of possible #\_\_\_\_\_  ❑ Public reporting by provider  ❑ Plans for enhanced data warehouse (specify start date): \_\_\_\_\_\_\_\_\_\_\_  ❑ Uses of data registry/warehouse (specify uses): | | |
|  | |  |  |

|  |  |  |
| --- | --- | --- |
| **Use of Data** | CURRENT | PLANNED |
| Quality measure collection and reporting | ❑ | ❑ |
| Compliance with EBM analysis | ❑ | ❑ |
| Gaps in care by patient (e.g., follow-up list of Pts with Hg A1C) | ❑ | ❑ |
| Gaps in care by provider | ❑ | ❑ |
| Diagnostic cost groups (DxCG) | ❑ | ❑ |
| Medical Episode Grouper (MEG) | ❑ | ❑ |
| Other (specify): | ❑ | ❑ |

|  |  |
| --- | --- |
| **Other Technology Resources** | |
| * Community services resource directory available | \_\_\_\_# Community participants listed in directory out of possible #\_\_\_  \_\_\_\_# Community participants using directory out of possible #\_\_\_ |
| * Telehealth services in use (specify types): | ❑ Teleradiology  ❑ Telepsychiatry/telepsychology  ❑ Other (specify): **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  ❑ Other (specify): **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| * Personal health record offered by one or more providers | Estimated patient use: \_\_\_\_% |
| * Blue Button in use | Estimated patient use: \_\_\_\_% |
| * Clinical summary format in use | ❑ Continuity of care document (CCD)  ❑ Consolidated Clinical Document Architecture (C-CDA) |
| * Health information exchange (HIE) in use | Check all used in community:  ❑ Direct ecosystem community participant  ❑ State-certified health information exchange service provider (HISP)  ❑ Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Data are exchanged through HIE (specify types): | * Immunizations * Syndromic surveillance * Lab results * PACS * Medication lists * Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

# Workflow Analysis

Workflow analysis is the purposeful mapping of processes within the community. Place an **X** in each of the boxes where workflow across settings has been mapped.

*Example 1:* If the hospital has mapped medication reconciliation with a primary care provider (PCP), check hospital and PCP.

*Example 2*: If the PCP has mapped clinical summary exchange with hospital and specialists, check PCP, hospital, and specialist.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Hospital** | **PCP** | **Specialist** | **Local PH** | **Nursing Home** | **Home Health** | **Behavioral Health** |
| Medication reconciliation |  |  |  |  |  |  |  |
| Clinical summary exchange |  |  |  |  |  |  |  |
| Patient/family follow up |  |  |  |  |  |  |  |
| Transitions of care |  |  |  |  |  |  |  |
| Appointments/ tracking/ follow up |  |  |  |  |  |  |  |
| Referrals/ tracking/follow up |  |  |  |  |  |  |  |
| Other (specify): |  |  |  |  |  |  |  |
| Other (specify): |  |  |  |  |  |  |  |
| Other (specify): |  |  |  |  |  |  |  |
| Other (specify): |  |  |  |  |  |  |  |

# Additional Information

## Provide any additional information below about the community that would be helpful to know in developing a community-based care coordination program.

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## C:\Users\nmiller\Dropbox\Screenshots\Screenshot 2014-12-11 16.36.15.png

1. Qualis Health, The Commonwealth Fund, and GroupHealth. Quotation is taken from a work on leadership engaged in transformative change in health care. May 2013. [↑](#footnote-ref-1)