

## Integration Model Checklist

Integrated care requires smart design in order to deliver clinical benefits to patients. Community Health Solutions developed the Population Health Design Framework<sup>1</sup> to help clinical organizations develop more integrated approaches for patient care. The framework is grounded in experience and closely aligned with the Patient Centered Medical Home and the Chronic Care Model.

We encourage practices to use the checklist below to assess where you stand currently, and identify areas for action. Please note that the checklist does not assume that every integrated care project will require every element on the list. First, we recommend that you convene your team and scan the list to identify the elements that are necessary for your project. Then, for the elements that are necessary, determine the ones that are already in place and the ones that need work. We recommend focus your efforts on one or two priorities at a time.

#	Design Element	Is it Necessary?	Is it in Place?	Does it Need Work?
<b>Identify Population Health Needs</b>				
1	Define the population of interest (e.g. age, gender, health condition, payer)			
2	Identify the population in the record system			
3	Place the defined population in a registry			
4	Conduct additional patient health assessment as needed			
5	Define objectives for access, quality, patient engagement, utilization, and health outcomes			
<b>Optimize Service Delivery</b>				
1	Organize patient and population data to facilitate efficient and effective care			
2	Define the scope of services			
3	Embed evidence-based guidelines into daily clinical practice			
5	Facilitate continuity with a chosen or assigned clinician for each patient			
4	Define roles and distribute tasks that utilize team members to the top of their credential			
6	Use planned interactions to support evidence-based care			
7	Share information with providers and patients to coordinate care			
8	Provide clinical case management services for complex patients			
9	Ensure regular follow-up by the care team			
10	Provide timely reminders for providers and patients			
11	Give care that patients understand and that fits with their cultural background			
12	Empower and prepare patients to manage their health and health care			
13	Provide access to appointments and clinical advice during office hours			
14	Provide access to appointments and clinical advice after hours			
15	Provide electronic access to patient information			
16	Use an electronic prescribing system			
<b>Collaborate for Impact</b>				
1	Integrate specialist expertise into the primary care setting			
2	Develop agreements that facilitate care coordination within and across organizations			
3	Coordinate care transitions			
4	Track and follow up on tests			
5	Track and follow up on referrals			
6	Organize internal and community resources to provide ongoing self-management support			
7	Form partnerships with community organizations to fill gaps in needed services			
8	Encourage patients to participate in effective community programs			
9	Advocate for policies to improve patient care			

<sup>1</sup> The Population Health Design Framework is © 2015 Community Health Solutions, all rights reserved. This framework may be copied and distributed for non-commercial educational purposes only.

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<b>Manage Quality</b>				
1	Visibly support improvement at all levels of the organization, beginning with the senior leader			
2	Encourage open and systematic handling of errors and quality problems to improve care			
3	Use proven provider education methods			
4	Promote effective improvement strategies aimed at comprehensive system change			
5	Continuously monitor performance of practice team and care system			
6	Continuously measure clinical performance			
7	Continuously measure patient/family experience			
8	Provide incentives based on quality of care			
9	Use certified electronic health record technology			
10	Study performance to drive internal quality improvement			
11	Report performance data to external stakeholders			
<b>Evaluate Impact</b>				
1	Define measures for access, quality, patient engagement, utilization, health outcomes, and cost			
2	Identify benchmark measures (external or internal) as applicable			
3	Produce baseline measures for the defined population			
4	Produce follow-up measures for the defined population			
5	Analyze results and identify key findings			
<b>Demonstrate Value</b>				
1	Define payer value objectives			
2	Define funder value objectives			
3	Define community value objectives			
4	Define value indicators (including but not limited to outcome and cost measures)			
5	Produce value indicators			
6	Produce value reports			
7	Use value reports to educate team members and external stakeholders			