



Care Coordinator to PCP Conversation Tool

Use this tool as needed to engage clinicians in a conversation about patient identification & engagement

“This is a patient who had high intensity health care 3 months ago. I need to find out if this is someone who needs care coordination and if they might engage with my outreach.

- 1) Would you be surprised if this patient were hospitalized or had an ER visit in the next 6 months? Why or why not?
- 2) Do you feel that, with your backing, this patient will engage in care management (assuming they are not already in it)? What might help them engage?
- 3) Given your knowledge of this patient longitudinally, what do you think is the most critical area to focus on? (Medical: What? Social: What? Support, Financial, Behavioral Health, etc.?)”

Data Collection Sheet:

For PCP:

Patient	Surprised if Hospital or ER?	Likely to engage?	What would help engage?	Critical focus?

Notes: