Section 0.4 Overview

CCC Program Workflow and Tools

Tools in the Community-Based Care Coordination (CCC) Toolkit are organized around general phases that an organization or community would likely follow to plan, implement, and maintain a CCC program. The phases are logical and sequential. Most processes within the phase are supported by one or more tools in the CCC Toolkit.

Outlined below and in the following pages is a description of each phase in CCC program development, a list of tools that support the processes in each phase, and a process flow diagram for each phase.

Phases in CCC program development

Phase 0 – OVERVIEW. Familiarization with basic concepts, terminology, and resources for communities contemplating development of a CCC program.

Phase 1 – ASSESS. Documentation of the current environment, assessment of community readiness for a CCC program, and engagement of physicians and key community leaders.

Phase 2 – PLAN. Planning various models, program goals, and components required for a successful CCC program, including organizational and program management activities.

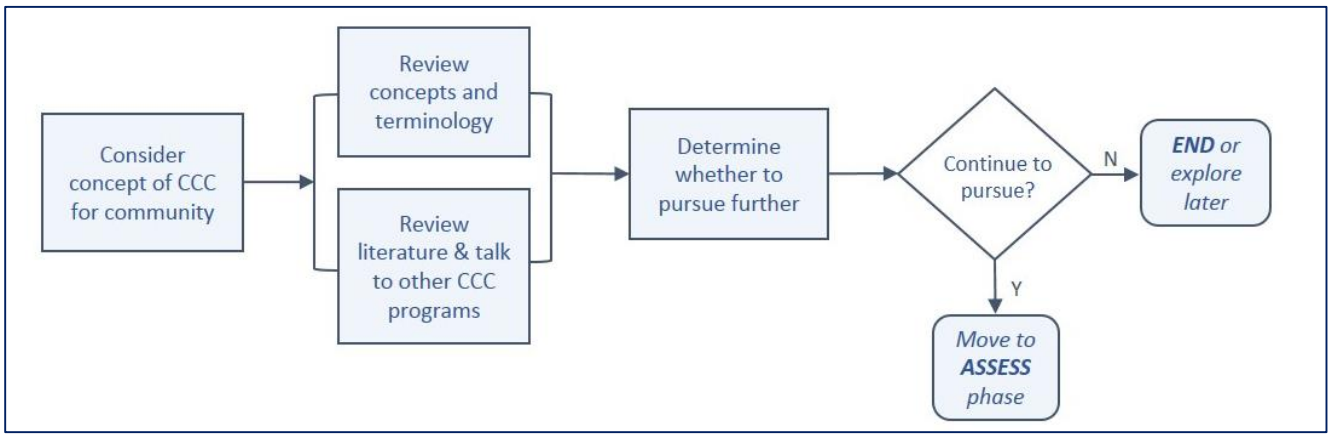
Phase 3 – DESIGN. Design of the structural components of a CCC program, such as support resources, staffing and care team, workflow and processes, information and technology, clinical guidelines and quality measures, and new approaches to patient communications.

Phase 4 – IMPLEMENT. Implementation of the essential components of a CCC program, and re-design of workflow and processes.

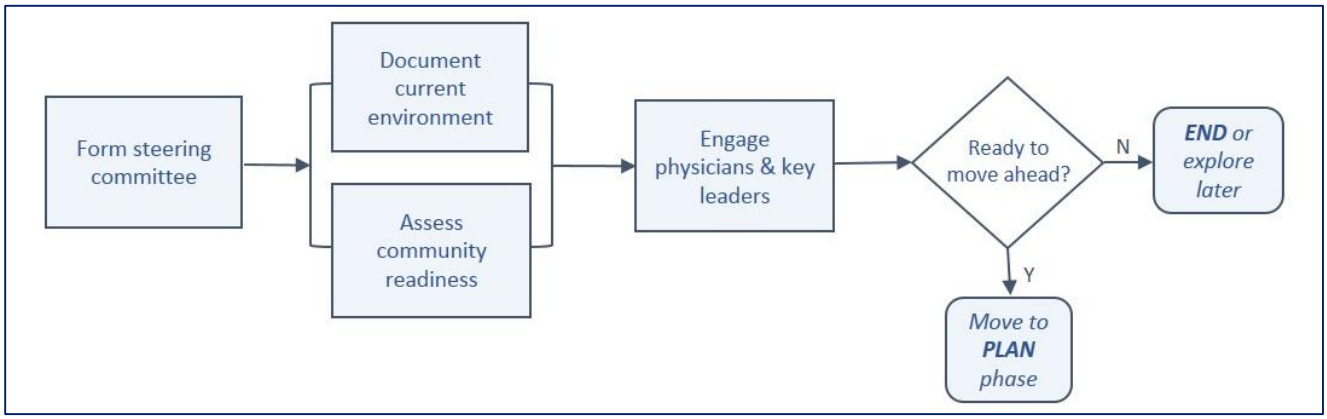
Phase 5 – MAINTAIN. Monitoring goal achievement, evaluation of program effectiveness, and implementing program changes.

Phase 6 – OPTIMIZE. Implementation of more advanced components of a CCC program, and optimization of workflow and processes.

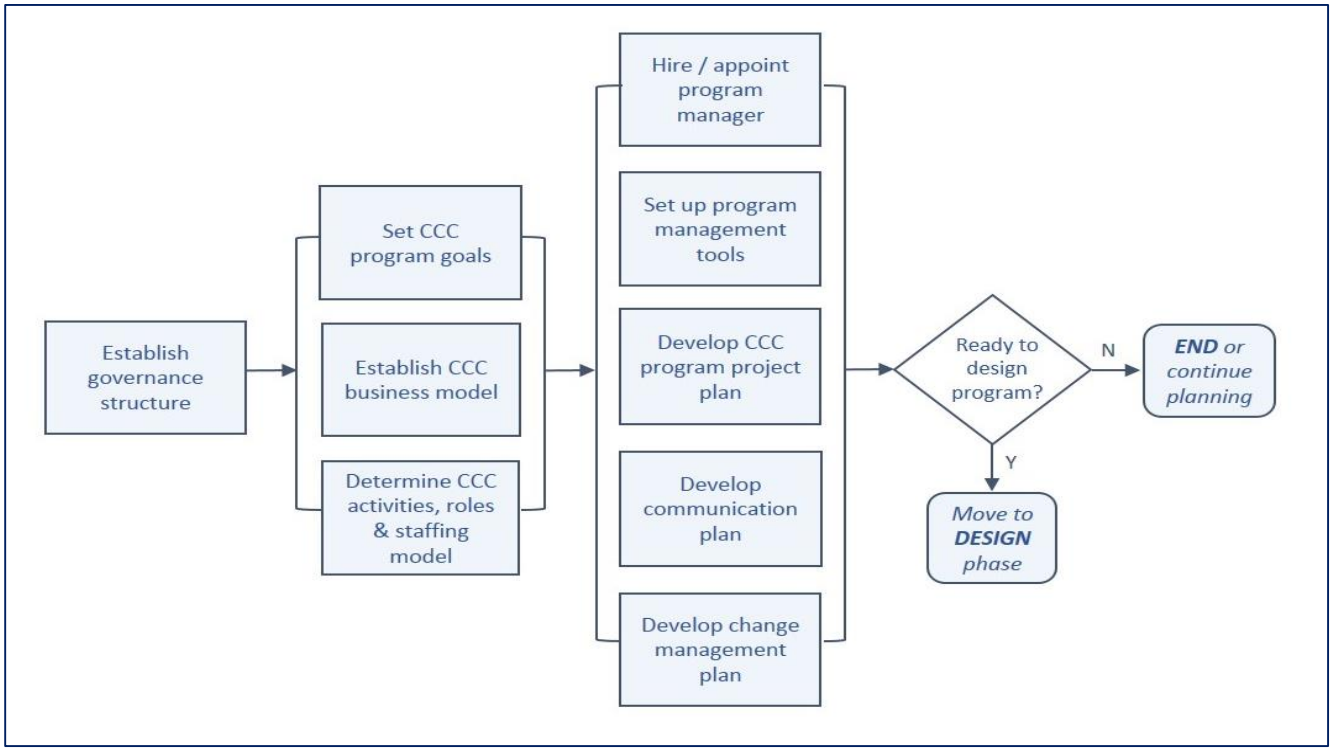
PHASE 0	OVERVIEW
Description	The OVERVIEW section provides tools that introduce basic concepts, terminology, and resources for communities contemplating development of a CCC program.
Tools	▪ How to Use The CCC Toolkit ▪ Table of Contents for CCC Toolkit ▪ CCC Program Workflow Diagram ▪ CCC Program Workflow and Tools ▪ Glossary of Terms for CCC ▪ Resource Library (and links to resources)



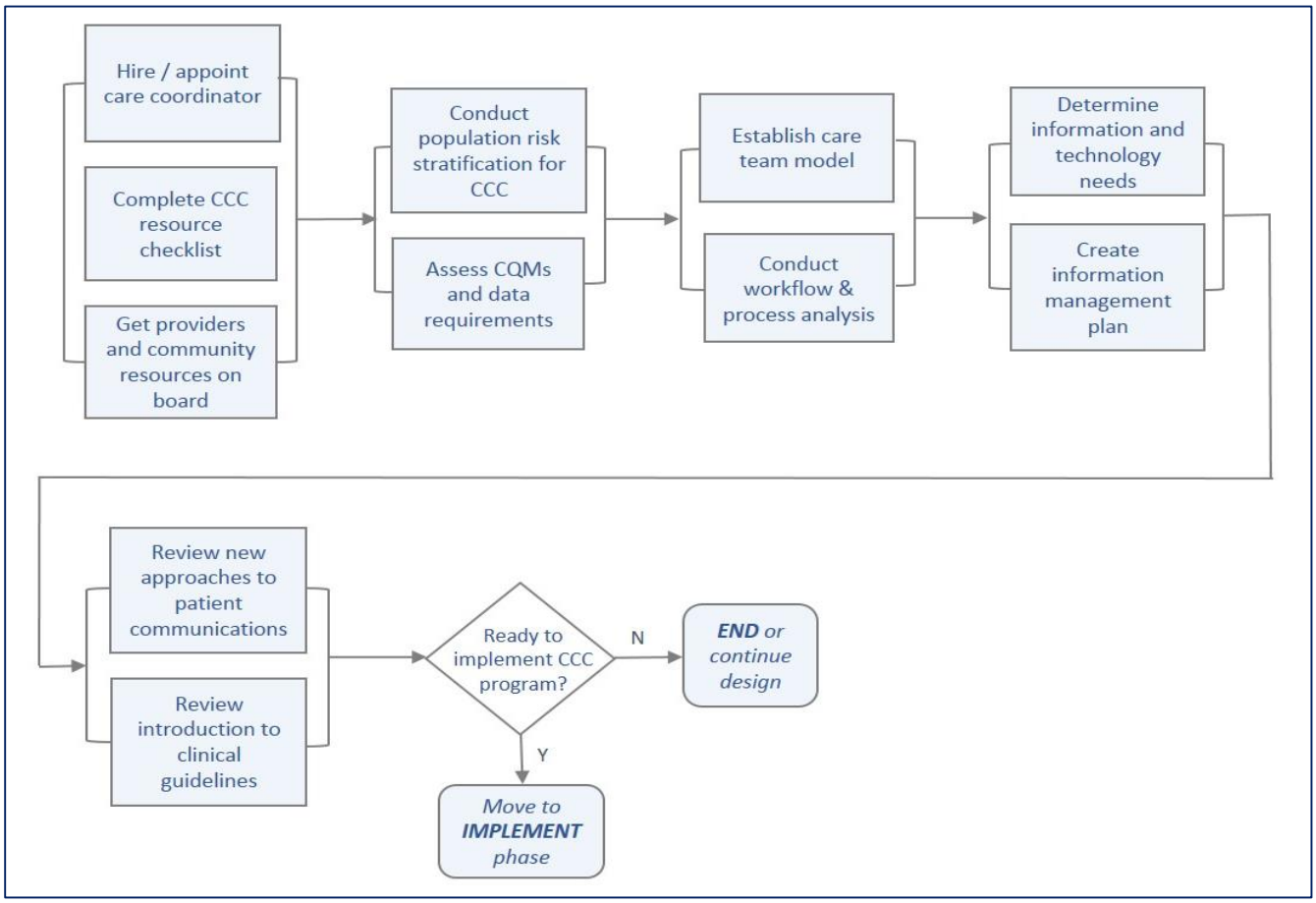
PHASE 1	ASSESS
Description	The ASSESS section includes surveys and other types of assessments that assist in determining the readiness of a community to implement a CCC program. Also included in this section is a tool to help establish a steering committee that represents the community and its needs in a CCC program, as well as tools to help engage physicians in CCC.
Tools	▪ Steering Committee for CCC ▪ Community Data Collection Form ▪ CCC Maturity Assessment / assessment template / example reports ▪ Physician Engagement in CCC / template ▪ CCC Fact Sheet for Providers



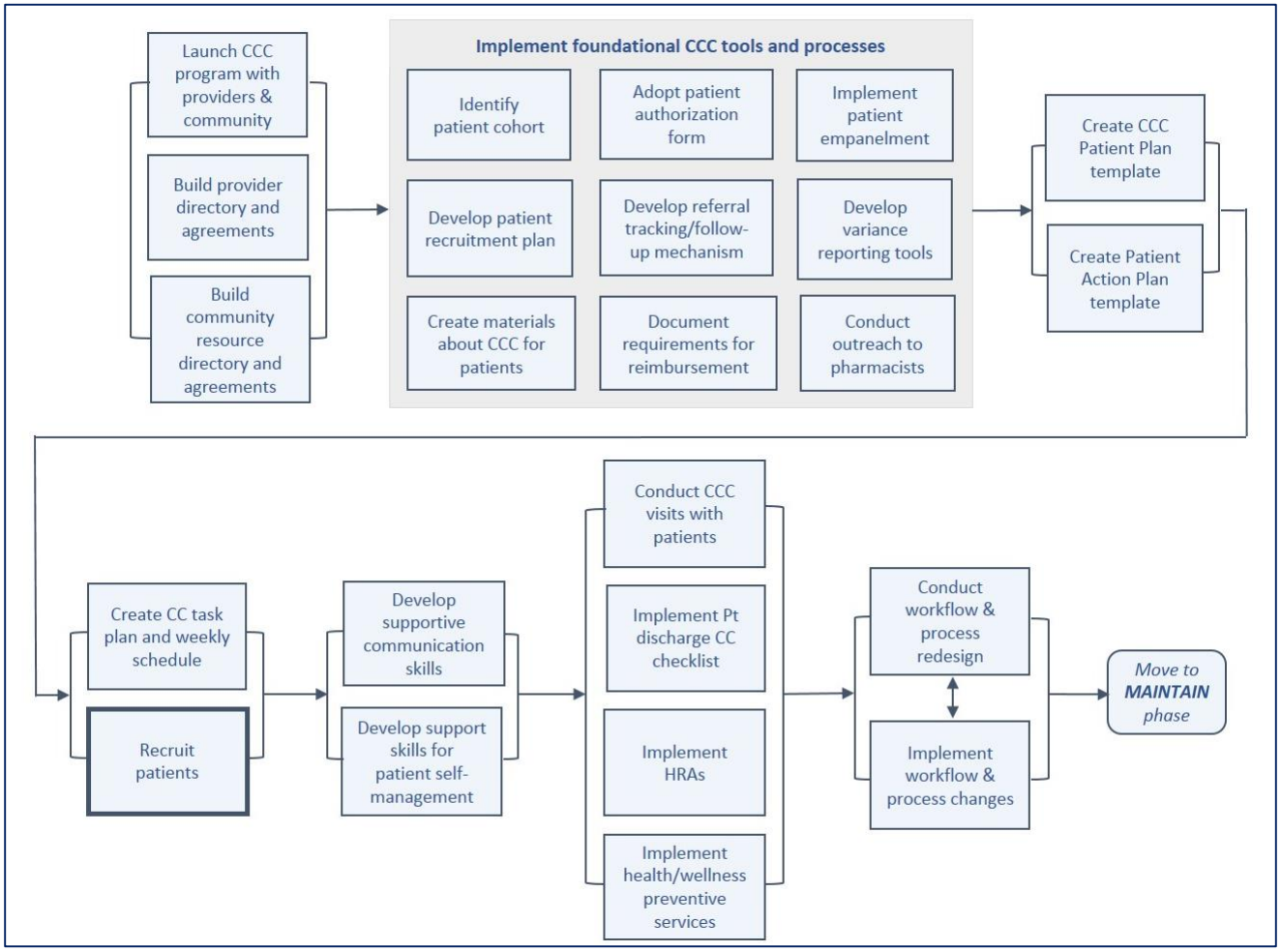
PHASE 2	PLAN
Description	The PLAN section includes tools to help identify the various components needed to implement a CCC program. This set of tools provides: suggestions for governing a CCC program; tips for understanding different reimbursement models for CCC programs and establishing appropriate goals for the chosen model; a project plan to build the program step-by-step; a communication plan to help ensure communications are on target; various tools to help organize the work and program team; and an overview of program change management concepts.
Tools	▪ CCC Governance ▪ Setting and Monitoring Goals for CCC ▪ Business and Reimbursement Models for CCC ▪ CCC Program Staffing Models ▪ Planning Matrix for Care Coordination-Related Activities and Staff Roles / template ▪ CCC Program Project Plan / template ▪ CCC Program Change Management ▪ Communication Plan / template ▪ Issues Log / template ▪ Meeting Agenda and Minutes Template



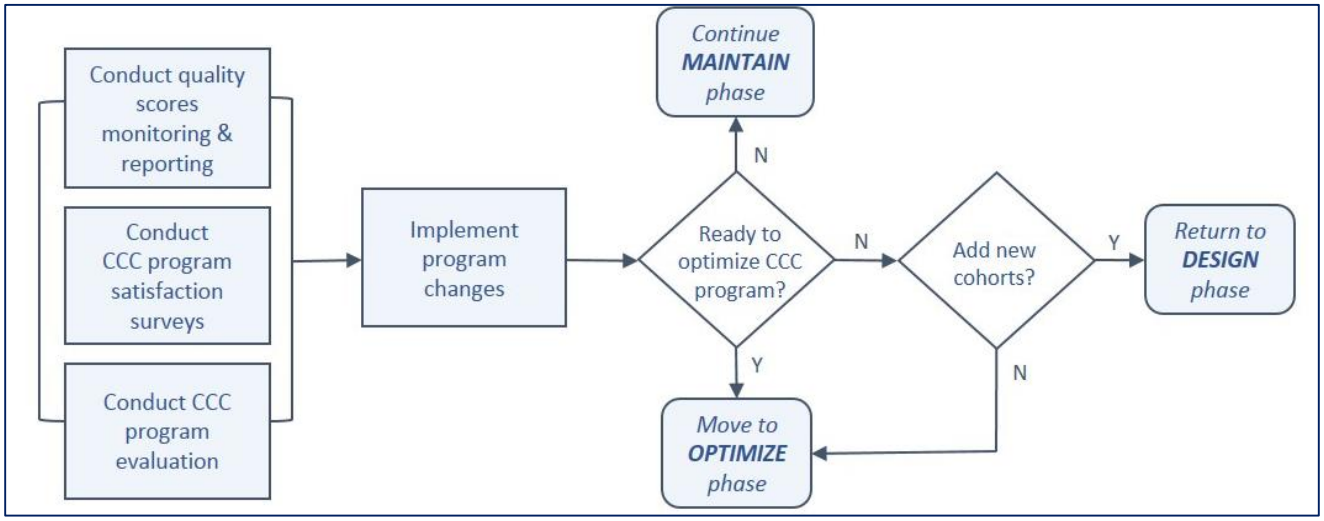
PHASE 3	DESIGN
Description	The DESIGN section provides tools for helping to structure the various components of a CCC program. These include staffing considerations, ensuring that support resources are in place, population risk stratification, and identification of information and technology needs. A workflow and process analysis tool also is provided in this section. Data are also critical to the success of a CCC program, and in particular, the assessment of data needs for clinical quality measures and an understanding of clinical guidelines. This section of the toolkit emphasizes new approaches to patient communications, which is then developed further in other tools in later sections of the toolkit.
Tools	▪ Care Coordinator Sample Job Description ▪ Resource Checklist for CCC ▪ Population Risk Stratification and Patient Cohort Identification ▪ Assessment of Data Needs for CQMs ▪ Establishing the Care Team: Roles and Communications ▪ Workflow and Process Analysis for CCC / template ▪ Technology Tools and Optimization for CCC ▪ Approaches to Patient Communications ▪ Introduction to Clinical Guidelines



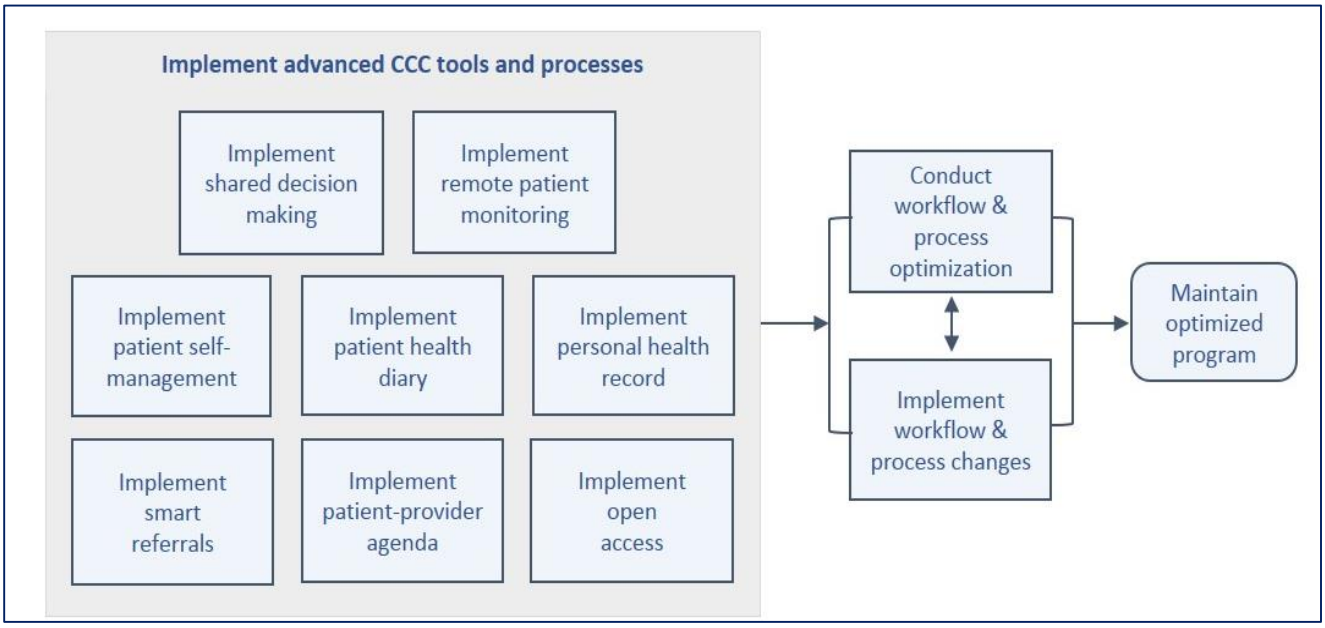
PHASE 4	IMPLEMENT	
Description	The IMPLEMENT section builds upon the structure designed for the CCC program. Tools in this section can help put the essential components of a CCC program into place. It is important to note that these tools are distinguished from tools provided in the Optimize section. Although a CCC program might tap tools from the OPTIMIZE section for earlier implementation, the IMPLEMENT tools are those that are most basic to begin operationalizing the program. A workflow and process re-design tool is provided in this section.	
Tools	▪ Provider Resource Directory / template ▪ Community Resource Directory / template ▪ Business Associate and Other Agreements ▪ Authorization Form Template ▪ Referral Tracking and Follow-up / checklist ▪ Documentation for CCC Reimbursement / template ▪ Patient Empanelment ▪ Patient CCC Variance Reporting / templates ▪ Pharmacist Outreach ▪ CCC Patient Plan / template	▪ Patient Action Plan / template ▪ Care Coordinator Task Plan and Weekly Schedule ▪ Patient Recruitment ▪ Supportive Communications ▪ Promoting Patient Self-Management ▪ Patient Discharge Care Coordination Checklist ▪ Health Risk Assessments / templates ▪ Health and Wellness Preventive Services ▪ Workflow and Process Redesign for CCC



PHASE 5	MAINTAIN
Description	The MAINTAIN section provides tools to help evaluate effectiveness of the CCC program. There is a significant difference between a program that has just been implemented and one in which all the essential components have been fully adopted, which also implies a readiness for optimization. Monitoring goal achievement, celebrating success, correcting course where necessary, and preparing to optimize are key steps in maintaining a successful program.
Tools	▪ Quality Scores Monitoring and Reporting ▪ CCC Program Satisfaction Surveys / templates ▪ CCC Program Evaluation



PHASE 6	OPTIMIZE
Description	The OPTIMIZE section provides tools to help communities implement more advanced components of a CCC program. Some of these include tools that may already be in place if a community has adopted a patient-centered medical home (PCMH) model. For example, open access is a way to improve management of office visits that enable patients to be seen when needed. As another example, some patients may already be using a patient health diary, especially for chronic disease management. Collectively, the OPTIMIZE tools generally reflect new forms of health care practices that support wellness and prevention as well as illness and injury management. A workflow and process optimization tool is included in this section.
Tools	▪ Shared Decision Making ▪ Coaching Patients in Self-Management ▪ Patient Health Diary ▪ Patient-Provider Agenda ▪ Remote Patient Monitoring ▪ Personal Health Record ▪ Making Smart Referrals ▪ Open Access ▪ Workflow and Process Optimization for CCC



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For support using the toolkit

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