

Section 0.1 Overview

How to Use the CCC Toolkit

This document describes the types of tools in the Toolkit, how they are used, and illustrates how they may be used to support a community-based care coordination (CCC) program.

Time needed: 1 hour

Suggested other tools: CCC Program Workflow and Tools; Glossary of Terms for CCC

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How to Use

- When members of a health care community consider the need for a community-based care coordination (CCC) program, take some time to reflect upon:
 - The **scope** of such a program and the community's readiness for it. Tools in the OVERVIEW and ASSESS section of this toolkit can help you understand more about the types of CCC programs that might be established and assess how ready the community is to engage in such an undertaking.
 - The **purpose** of such a program (e.g., to improve quality and cost of care in general, to become an accountable care organization in particular, or to respond to payers' value-based purchasing initiatives as they arise). Tools in the PLAN section of this toolkit are especially helpful for focusing on what components need to be in place for different types of programs.
 - How the community might go about **planning, designing, and implementing** such a program. Tools in the PLAN, DESIGN, and IMPLEMENT sections of this Toolkit provide step-by-step directions for these critical elements of constructing a CCC program.
- Review the outline** of tools in the CCC Toolkit, checking off tools that represent steps the community has already taken, identifying which tools may be helpful as the program progresses further into maintenance mode (see MAINTAIN tools), and contemplating tools to optimize the CCC program (see OPTIMIZE tools).
- Refer back** to the Toolkit frequently as the CCC program development is underway and as any "bumps in the road" occur.
- For **additional guidance**, many of the tools provide links to supplemental resources. If any of those links are broken, set your browser to the title of the page to which the link applies. Contact Stratis Health (at info@stratishealth.org) if you are unable to find the reference, if you have any additional questions, or if you need other assistance.

Using the Toolkit

Much like a carpenter's toolbox, the CCC Toolkit provide a variety of tools for use at different stages in the development of a CCC program. Some tools will be used frequently for many types of tasks, much like using a hammer and a set of nails – the same hammer can help you build a doll house, a shed, or a mansion. Similarly, workflow tools will help you improve processes whether it's for helping communities recognize how a patient's health information needs to be shared during transitions of care or to ensure that patients are referred to appropriate providers within the context of the CCC program. Some of the tools may be developed once and referred to many times.

A blueprint for a building project provides an overall planning framework – from the point of selecting the proper building site to making sure you have all the doors you need. Likewise, a set of CCC tools will help you: define what care coordination strategies might work best for different types of patients; introduce new approaches to communicating with patients; acquire information technology to help with risk stratification, reporting, or monitoring goal achievement; and manage change, including evaluating results of CCC program efforts.

The CCC Toolkit is a set of tools you must learn *when* and *how* to apply. Each tool includes:

- **A brief statement of purpose**, which describes what the tool should help you accomplish.
- **Instructions for use**, which guides you in effective use of the tool.
- **Tool structure**, which describes how the tool is organized. Depending on the tool, you may customize it to help you perform a task, or use it as a model and modify it to meet your program-specific needs.

The **Toolkit Organization** section in this document describes how the tools in the Toolkit are organized by section, each of which contains tools on related topics.

The **Overview of Tools** section in this document lists all of the tools and the stages at which the tools may be helpful. Note that not all tools will apply to all programs.

A variety of types of tools are included in this Toolkit:

- **Short recorded webinars and links to videos** may be viewed to introduce specific concepts. For example, you may view the webinar on “Overview of CCC” during a steering committee meeting to help you focus your planning. You may make a link available to a video on care coordination from the patient's perspective through a closed-circuit television in your waiting room.
- **Survey forms** can help you assess your readiness to undertake a CCC program. **Checklists** help ensure all steps in a process are taken. **Inventories** help you describe current status and compare with requirements for specific needs. For example, you may take an inventory of the current resources that are needed for a care coordinator to begin work. A **directory** can help you easily reference provider resources and community resources.
- **Charts or matrices** of various kinds aid in evaluating and improving workflows, processes, communications, or data needs. For example, you may find that some tasks performed by the community-based care coordinator (CC) are duplicative of tasks performed by a hospital's case manager, while at the same time there are care coordination tasks that are “slipping through the cracks.”
- **Sample job descriptions, content for agreements, and other documents** are included for you to use as-is or modify as needed. For example, a model communication plan may help ensure that all communications are conducted as needed. **Scripts** are included as examples to help communicate new types of information.

Toolkit Organization

The CCC Toolkit is organized in a manner similar to other toolkits provided by Stratis Health, notably the Health IT Toolkits for physician offices, critical access hospitals, nursing homes, home health agencies, and local public health departments. The following briefly describes each section of this CCC Toolkit:

0. **OVERVIEW.** The Overview section provides tools that introduce basic concepts, terminology, and resources for CCC programs.
1. **ASSESS.** 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 a tool to help engage physicians in CCC – which can be a transformative experience for them.
2. **PLAN.** 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.
3. **DESIGN.** The Design section provides tools for helping structure the various components of the CCC program. These include staffing considerations, population risk stratification and patient cohort identification, and tools that will assist in ensuring that you have the community and technology resources identified and in place. Changes in how communications occur with patients is a big part of a CCC program. Therefore, this section of the toolkit emphasizes approaches to patient communications, which is developed in other tools provided in later sections of the toolkit. Data also are critical to the success of a CCC program, and in particular, the assessment of data needs for clinical quality measures. A workflow and process analysis tool is also provided in this section.
4. **IMPLEMENT.** 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. In fact, those who have used the Toolkit suggest using restraint in moving too quickly toward using the Optimize tools without laying the proper foundation. A workflow and process redesign tool is provided in this section.
5. **MAINTAIN.** 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.
6. **OPTIMIZE.** 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, however, the Optimize tools generally reflect new forms of healthcare practices that support wellness and prevention as well as illness and injury management. A workflow and process optimization tool is included in this section.

Overview of Tools

The following is a list of the current tools in the CCC Toolkit. For newly-forming CCC programs, it is recommended that the tools be used in the sequence below (OVERVIEW tools, ASSESS tools, and so on). Tools within each phase are listed alphabetically for convenience and do not imply sequence. The tools can be used as-is or modified to meet program-specific needs.

- 0. OVERVIEW Tools:** Tools to introduce toolkit users to CCC and the CCC Toolkit components
 - 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
- 1. ASSESS Tools:** Tools to help a community determine readiness to adopt a CCC program
 - Steering Committee for CCC
 - Community Data Collection Form
 - CCC Maturity Assessment (and assessment template, example, and sample reports)
 - Physician Engagement in CCC (and assessment template)
 - CCC Fact Sheet for Providers
- 2. PLAN Tools:** Tools to help lay out the various components needed to implement a CCC program
 - 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 (and template)
 - CCC Program Project Plan (and template)
 - CCC Program Change Management
 - Communication Plan (and template)
 - Issues Log (example and template)
 - Meeting Agenda and Minutes Template
- 3. DESIGN Tools:** Tools to help a community structure the programmatic aspects of a CCC program
 - 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 (and template)
 - Technology Tools and Optimization for CCC
 - Approaches to Patient Communications
 - Introduction to Clinical Guidelines

4. **IMPLEMENT Tools:** Tools that help a community implement essential components of a CCC program. These are distinguished from more advanced components that would be implemented later (see OPTIMIZE Tools).
 - Provider Resource Directory (and template)
 - Community Resource Directory (and template)
 - Business Associate and Other Agreements
 - Authorization Form Template
 - Referral Tracking and Follow-up
 - Patient Visit Agenda and Preparation Checklist Template
 - Documentation for CCC Reimbursement (and template)
 - Patient Empanelment
 - Patient Care Coordination Variance Reporting (and templates)
 - Pharmacist Outreach
 - CCC Patient Plan (and template)
 - Patient Action Plan (and template)
 - Care Coordinator Task Plan and Weekly Schedule
 - Patient Recruitment
 - Supportive Communications
 - Promoting Patient Self-Management
 - Patient Discharge Care Coordination Checklist
 - Health Risk Assessments (and templates)
 - Health and Wellness Preventive Services
 - Workflow and Process Redesign for CCC
5. **MAINTAIN Tools:** Tools to evaluate success with the CCC program and plan for celebration, course correction and optimization
 - Quality Scores Monitoring and Reporting
 - CCC Program Satisfaction Surveys (and templates)
 - CCC Program Evaluation
6. **OPTIMIZE Tools:** Tools to help a community implement more advanced components of a CCC program
 - 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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