Section 0.2 Overview

Table of Contents for CCC Toolkit

This document lists and briefly describes all the tools in the CCC Toolkit in alphabetic order.

Time needed: As needed

Suggested other tools: How to Use the CCC Toolkit; CCC Program Workflow and Tools

Tool Name	Description/Purpose	Phase
Approaches to Patient Communications	This tool identifies the types of communications a care coordinator will have with patients in a CCC program, and provides links to tools that help in conducting and documenting patient communications.	DESIGN
Assessment of Data Needs for Clinical Quality Measures (CQMs)	This tool introduces clinical quality measures (CQMs) for evaluating quality outcomes, and provides guidance for monitoring quality outcomes and assessing progress toward CCC program goals.	DESIGN
Authorization Form Template	TEMPLATE—for use with *Business Associate & Other Agreements*	IMPLEMENT
Business and Reimbursement Models for CCC	This tool provides an overview of reimbursement models, and includes tools and resources to support development of new business model(s) being contemplated.	PLAN
Business Associate and Other Agreements	This tool identifies the types of agreements that may be necessary for a CCC program to have in place to provide access to or exchange data among participants in the program and with vendors.	IMPLEMENT
Care Coordinator Sample Job Description	This tool provides a sample job description for a care coordinator (CC) serving in a community-based care coordination (CCC) program.	DESIGN
Care Coordinator Task Plan and Weekly Schedule	This tool identifies the types of tasks that a care coordinator might perform in a given week, and provides an example schedule and approach to planning weekly care coordination tasks.	IMPLEMENT
CCC Fact Sheet for Providers	This document provides "Ten Facts Providers Need to Know about Community-based Care Coordination" for use in engaging physicians in CCC program planning and implementation.	ASSESS
CCC Governance	This tool provides guidelines for planning an effective governance structure for a CCC program.	PLAN
CCC Maturity Assessment	This tool identifies a number of attributes associated with four levels of community-based care coordination (CCC) program maturity, against which a nascent or current CCC program can be assessed.	ASSESS
CCC Maturity Assessment Example Report	This tool provides an example of how the CCC Maturity Assessment instrument was used to assess community readiness for a CCC program, together with a sample report.	ASSESS

Tool Name	Description/Purpose	Phase
CCC Maturity Assessment Template	TEMPLATE—for use with *CCC Maturity Assessment*	ASSESS
CCC Patient Plan	This tool provides an overview of the community-based care coordination (CCC) patient plan for use by a care coordinator in planning for and tracking CCC program services for a patient.	IMPLEMENT
CCC Patient Plan Template	TEMPLATE—for use with *CCC Patient Plan*	IMPLEMENT
CCC Program Change Management	This tool provides an overview of CCC program change management — focusing on challenges and opportunities for program change, stages and agents of change, and conflict resolution.	PLAN
CCC Program Evaluation	This tool provides a CCC program evaluation process and tools to assess both processes and outcomes against program goals, and to identify opportunities for improvement.	MAINTAIN
CCC Program Project Plan	This tool outlines the general sequence of activities required to implement a community-based care coordination (CCC) program.	PLAN
CCC Program Project Plan Template	TEMPLATE—for use with *CCC Program Project Plan*	PLAN
CCC Program Satisfaction Survey Template	TEMPLATE—for use with *CCC Program Satisfaction Surveys*	MAINTAIN
CCC Program Satisfaction Surveys	This tool provides sample survey tools that can be used to assess patient, provider, and CCC program/system staff satisfaction with community-based care coordination services.	MAINTAIN
CCC Program Staffing Models	This tool helps program leadership determine the type and level of staffing required for care coordination functions to be performed within a community-based care coordination (CCC) program..	PLAN
CCC Program Workflow and Tools	This tool provides a brief overview of each phase in CCC program development, along with a process flow diagram and a list of tools that support the processes in each phase.	OVERVIEW
CCC Program Workflow Diagram	This tool provides a pictorial view of CCC program development, including processes and workflows by phase.	OVERVIEW
Coaching Patients in Self-Management	This tool provides techniques and example scripts to encourage patient engagement in self-management. For an overview of patient self-management concepts, see *Promoting Patient Self-Management.*	OPTIMIZE
Communication Plan	This tool describes the use of a communication plan to support the CCC program, and describes how to construct and manage a communication plan.	PLAN
Communication Plan Template	TEMPLATE—for use with *Communication Plan*	PLAN
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.	ASSESS
Community Resource Directory	This tool supports the identification and use of a variety of community resources to help patients with health care-related needs.	IMPLEMENT

Tool Name	Description/Purpose	Phase
Community Resource Directory Template	TEMPLATE—for use with *Community Resource Directory*	IMPLEMENT
Depression Risk Assessment Template	TEMPLATE—for use with *Health Risk Assessments*	IMPLEMENT
Digital Literacy Assessment Template	TEMPLATE—for use with *Health Risk Assessments*	IMPLEMENT
Documentation for CCC Reimbursement	This tool describes the documentation and potential workflow changes needed for reimbursement of transitional care management (TCM), chronic care management (CCM), and community-based care coordination (CCC) services.	IMPLEMENT
Documentation for CCC Reimbursement Template	TEMPLATE—for use with *Documentation for CCC Reimbursement*	IMPLEMENT
Environmental Risk Assessment Template	TEMPLATE—for use with *Health Risk Assessments*	IMPLEMENT
Establishing the Care Team: Roles and Communications	This tool describes the roles of health care professionals in a community-based care coordination (CCC) program, and provide resources to facilitate team communication and collaboration.	DESIGN
Fall Risk Assessment Template	TEMPLATE—for use with *Health Risk Assessments*	IMPLEMENT
Functional Risk Assessment Template	TEMPLATE—for use with *Health Risk Assessments*	IMPLEMENT
Glossary of Terms for CCC	This document provides definitions of commonly used terms in the context of a community-based care coordination (CCC) program.	OVERVIEW
Health and Wellness Preventive Services	This tool provides tips for improving use of preventive services among patients in a CCC program, and information on automated reminder systems.	IMPLEMENT
Health Literacy Assessment Template	TEMPLATE—for use with *Health Risk Assessments*	IMPLEMENT
Health Risk Assessments	This tool describes various health risk assessments to help understand potential barriers to meeting a patient's health care goals. A template for each assessment instrument is included in this Toolkit.	IMPLEMENT
How to Use The CCC Toolkit	This document describes the tools in the CCC Toolkit and how the Toolkit is organized.	OVERVIEW
Introduction to Clinical Guidelines	This tool describes the use of evidence-based guidelines and provides a plan for implementing them in a CCC program.	DESIGN
Issues Log Example and Template	TEMPLATE—for use with *Steering Committee for CCC* and *CCC Program Project Plan*	PLAN
Making Smart Referrals	This tool helps the care coordinator and providers make appropriate referrals for specialty health care or community resources for patients in a CCC program.	OPTIMIZE
Medication Reconciliation Template	TEMPLATE—for use with *Health Risk Assessments*	IMPLEMENT

Tool Name	**Description/Purpose**	**Phase**
Meeting Agenda and Minutes Template	TEMPLATE—for use with *Steering Committee for CCC* and *CCC Program Project Plan*	PLAN
Open Access	This tool provides information about implementing a scheduling system that reduces long wait times and appointment backlogs.	OPTIMIZE
Patient Action Plan	This tool provides an overview of the Patient Action Plan, a patient engagement tool to support management of patient-specific health conditions.	IMPLEMENT
Patient Action Plan Template	TEMPLATE—for use with *Patient Action Plan*	IMPLEMENT
Patient CC Variance Reporting	This tool describes variances in patient care coordination, and provides suggestions for documenting and reporting on variances.	IMPLEMENT
Patient CC Variance Reporting Log Template	TEMPLATE—for use with *Patient CC Variance Reporting*	IMPLEMENT
Patient CC Variance Reports Template	TEMPLATE—for use with *Patient CC Variance Reporting*	IMPLEMENT
Patient CCC Satisfaction Survey Template	TEMPLATE—for use with *CCC Program Satisfaction Surveys*	MAINTAIN
Patient Discharge Care Coordination Checklist	This tool provides a list of steps that the care coordinator should follow to ensure that a patient will be supported upon discharge from the hospital or ED.	IMPLEMENT
Patient Empanelment	This tool describes the process and considerations for assigning each provider a set of patients to be cared for by that provider (and provider's care team) to ensure continuity of care.	IMPLEMENT
Patient Health Diary	This tool describes how a patient health diary can help patients, care coordinator, and providers keep track of a patient's health status and recognize when there are health issues to be addressed.	OPTIMIZE
Patient Recruitment	This tool describes the general approach and strategies to recruit (invite) patients to participate in the community-based care coordination (CCC) program.	IMPLEMENT
Patient Visit Agenda and Preparation Checklist Template	TEMPLATE—for use with *Referral Tracking and Follow-Up* and *Patient-Provider Agenda*	IMPLEMENT
Patient-Provider Agenda	This tool describes the benefits of a visit agenda to both patients and providers, and suggests steps to implement a patient-provider agenda.	OPTIMIZE
Personal Health Record	This tool provides information about the personal health record (PHR) to support patient communication with providers and in self-management.	OPTIMIZE
Pharmacist Outreach	This tool helps establish a pharmacist outreach program to assist with medication management and coordination in the home setting.	IMPLEMENT
Physician Engagement Difficulty Assessment Template	TEMPLATE—for use with *Physician Engagement in CCC*	ASSESS

Tool Name	Description/Purpose	Phase
Physician Engagement in CCC	This tool describes the importance of engaging physicians in a community-based care coordination (CCC) program and provides a framework for physician engagement in CCC program planning.	ASSESS
Planning Matrix for Care Coordination-Related Activities and Staff Roles	This tool helps CCC program leadership understand the various activities and roles to be performed within a community-based care coordination (CCC) program, and determine which function or member of the CCC program will be responsible for each activity.	
Planning Matrix Template for Care Coordination-Related Activities and Staff Roles	TEMPLATE—for use with *Planning Matrix for Care Coordination-Related Activities and Staff Roles*	PLAN
Population Risk Stratification and Patient Cohort Identification	This tool provides an overview of population risk stratification and a process to identify specific patients to be served by the CCC program.	DESIGN
Promoting Patient Self-Management	This tool provides a conceptual overview of patient self-management and describes steps to initiate patient self-management. For techniques and example scripts for engaging patients in self-management, see *Coaching Patients in Self-Management.*	IMPLEMENT
Provider CCC Satisfaction Survey Template	TEMPLATE—for use with *CCC Program Satisfaction Surveys*	MAINTAIN
Provider Resource Directory	This tool supports the identification of different types of providers to help patients with specific health care needs, and helps establish working relationships and agreements with those providers.	IMPLEMENT
Provider Resource Directory Template	TEMPLATE—for use with *Provider Resource Directory*	IMPLEMENT
Quality Scores Monitoring and Reporting	This tool describes potential quality measurement and performance requirements for a CCC program, the process of quality measure reporting, and ongoing monitoring of quality scores.	MAINTAIN
Referral Tracking and Follow-up	This tool describes tracking and follow-up on patient referrals within a CCC program, and suggests tools to manage patient referrals.	IMPLEMENT
Remote Patient Monitoring	This tool describes the nature of remote patient monitoring devices and offers recommendations on how to implement remote patient monitoring within a CCC program.	OPTIMIZE
Resource Checklist for CCC	This tool identifies the resources a community needs to set up a CCC program and helps identify those that are in place or are needed to be built or procured.	DESIGN
Setting and Monitoring Goals for CCC	This tool describes the importance of setting goals for a CCC program and for monitoring results toward achievement of the goals.	PLAN
Shared Decision Making	This tool describes how to encourage patients to participate in an informed dialogue with their providers to help them make health care decisions that best align with their values, preferences, and lifestyle.	OPTIMIZE

Tool Name	Description/Purpose	Phase
Social and Financial Risk Assessment Template	TEMPLATE—for use with *Health Risk Assessments*	IMPLEMENT
Steering Committee for CCC	This tool provides strategies for establishing and managing a steering committee for a CCC program, and provides sample meeting agenda and minutes.	ASSESS
Substance Use Risk Assessment Template	TEMPLATE—for use with *Health Risk Assessments*	IMPLEMENT
Supportive Communications	This tool describes a technique to invoke a desire for change in patients to make modifications to their lifestyles that will improve their health and wellness.	IMPLEMENT
Technology Tools and Optimization for CCC	This tool describes a variety of health information and technology tools and how they may be optimally used to support a CCC program.	DESIGN
Workflow and Process Analysis for CCC	This tool introduces workflow and process improvement, describes the value of workflow and process analysis to initiate changes necessary for a CCC program, and provides instruction on workflow and process mapping.	DESIGN
Workflow and Process Optimization for CCC	This tool provides the "third step" after workflow and process analysis and redesign. Once the team has determined that the CCC program is ready to adopt more advanced components of CCC, workflow and process optimization can help implement such components.	OPTIMIZE
Workflow and Process Redesign for CCC	This tool provides the "second step" after initial workflow and process analysis has been completed, and includes instructions for identifying processes needing improvement, determining the root cause of the problem, and redesigning and testing the improved process.	IMPLEMENT
Workflow Process Chart Template	TEMPLATE—for use with *Workflow and Process Analysis for CCC*	DESIGN

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For support using the toolkit

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