Community-based Care Coordination (CCC) Maturity Assessment

RidgePointe Healthcare District

Who/What	Program Elements	Level 1. Beginning	Level 2. Progressing	Level 3. Intermediate	Level 4. Advanced
• Organization(s) sponsoring CCC • Providers • Community services • Patients (pts) • Payers	**A. LEADERSHIP** - Transformative change - Community engagement - Goal setting - Team-based, patient-centered care - Evidence-based care - Innovative delivery models	☑ Sponsoring organization(s) on board ☑ Providers notified ☑ Community services relationship building initiated ☑ Business case for accountable care anticipated ☑ Local care coordinator on board	☑ CCC on board ☑ Providers on board ❑ Triple Aim goals identified ☑ Some community services on board ☑ Payers engaged in goals-setting ☑ Communications with pt representatives about CCC	❑ Many community services on board ❑ CCC extends to ToC & fees received ❑ Community steering committee in place ❑ Learning about or implementing new models of care ❑ Triple Aim goals measured & refined	❑ All members of community embrace new models of care ❑ Care coordination fully actuated ❑ Triple Aim goals being met
• Patients • Primary Care Provider (PCP) panels • Specialties • CCC cohorts • Population	**B. PATIENT POPULATION / PANEL MGMT** - Patients assigned to PCP - Results tracking - Appointment F/U calls - Referrals tracking - Risk stratification to balance panel size - Panel maintenance	❑ Patients assigned to PCPs ☑ Results tracking for all patients ❑ CCC cohorts identified for care management	☑ Appointment F/U calls for high-risk pts ☑ Referrals tracking for high risk pts ❑ CCC cohorts managed through ToC	❑ Risk stratification to balance panel size ❑ Panel composition maintained ❑ Consumer experience of care measured	❑ Consumer experience of care improved ❑ Providers share savings

• Emergency department
• Observation
• Hospitalization
• Clinical pharmacy
• Rehabilitation
• Nursing home
	C. CARE MANAGEMENT
	- Pre-admission
	  ○ Clinical summary
	  ○ Triage
	- Admission
	  ○ Care plan
	  ○ Medication reconciliation
	  ○ Case review
	  ○ Shared decisions
	- Discharge planning
	  ○ Care plan
	  ○ Instructions
	  ○ Clinical summary
		☑ Treatment plan exists for all pts
		☑ Local medication reconciliation by nursing staff
		❑ Discharge instructions given to pt/caregiver
		❑ Clinical summary provided to pt
		☑ Local care coordinator manages transfers to nursing home/rehab
		☑ Clinical summary shared with next provider &/or PCP
			☑ Clinical summaries obtained for all high-risk pts admitted
			❑ CCC conducts case review for high-risk pts during care
			❑ Clinical pharmacist engaged in local medication reconciliation
			❑ CCC reviews discharge care plans with high-risk pts
				❑ CCC engaged in pre-admission triage
				❑ CCC engaged in care planning during admission
				❑ Pts & providers engaged in shared decision making
				❑ CCC actively engaged in discharge care planning for high-risk pts
					❑ Level of care utilization improved
					❑ 30-day readmissions & ED frequency reduced
					❑ Medication safety outcomes improved

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• Community setting
  ○ Home
  ○ Assisted living
  ○ Domiciliary
  ○ Rest home
• Home health
• Hospice
• Retail pharmacy
	D. TRANSITIONS OF CARE (ToC)
	- CCC calls, visits high-risk patients
	- Medication monitoring
	- Care plan monitoring
	- Health literacy & education
	  ○ Medications
	  ○ Life style changes
	  ○ Screenings
	  ○ Immunizations
	- Pt engagement; pt self-management
	- Health outcomes monitoring
		☑ Local care coordinator reviews clinical summary & instructions prior to discharge
		❑ Local care coordinator provides education as appropriate
		❑ Local care coordinator conducts courtesy calls for high-risk pts, reviews medication compliance
			❑ CCC engages patient in post-discharge care planning; assesses health literacy
			❑ CCCs calls high-risk pts to monitor medication, care plan compliance
			❑ CCC discusses life style changes
			❑ CCC encourages home monitoring; educates pt on potential solutions
			❑ Retail pharmacist engaged in medication safety reviews
			❑ CCC F/U on screening & immunizations
				❑ CCC calls & visits high-risk patients
				❑ F/U calls for care plan monitoring; encourages self-management through motivational interviewing & use of community services
				❑ Retail pharmacist engaged in medication management (fill status notification)
				❑ CCCs address special populations:
				  ○ Pre-natal
				  ○ Special needs children
				  ○ Depression/BH
					❑ Population health outcomes improvement
					❑ Pts engaged in self-management

• Nutrition • Transportation • Support groups • Homemaker • Respite • Social services • Local public health • Housing • Vocational • Schools	**E. COMMUNITY RESOURCES** - Identification - Utilization - Directory - Formal agreements - Online availability checking - Online arrangement for services	☑ Initiation of community resources identification ☑ Information exchanged with community resources about CCC & accountable care	❑ Agreements with services most used by high-risk pts ❑ CCC makes referrals to community resources, facilitated by directory of services, availability	❑ Many agreements across range of community resources ❑ CCC arranges for community resources directly online	❑ Active use of community resources ❑ Improved consumer experience of care ❑ Community resources included in shared savings

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• Electronic health record (EHR) • Data mgmt. • Workflow & Process mgmt. • Health information exchange (HIE) • Data warehouse ○ Registry functionality ○ Risk strat. ○ Data analytics ○ Financial modeling ○ Evidence-based practices • Telehealth • Home monitoring device integration • Personal health record (PHR)	**F. DATA & PROCESSES** - Access to data - Use of data in clinical decision making - Exchange of data - Clinical quality measurement (CQM) reporting & improvement - Data used for knowledge management	❑ EHR MU initiated; CQMs reported via data abstraction ❑ Structured data required for MU in place ☑ Workflow & process management is recognized as a key factor for successful use of technology ❑ Limited (push via Direct email) HIE ❑ Registry functionality used for some clinical care tracking ☑ Pts encouraged to use home monitoring devices	❑ MU functionality used by minimum required number of providers; eSubmission of CQMs ❑ Clinical summaries in structured data format (C-CDA) ❑ Adoption of standard vocabularies ❑ Limited clinical & financial data integration ❑ Workflow & process mapping initiated ❑ Participation in HIE (for pull/query support) by providers ❑ Registry used for preventive care ❑ Pts encouraged to maintain health diary & share through portal, Direct email, PHR ❑ Reimbursable telehealth services adopted	❑ EHR is meaningfully used by all providers ❑ Increased clinical & financial data integration to measure cost of care on core measures ❑ All providers & community services online 24x7 ❑ Workflows & processes continuously monitored for improvement ❑ Community services initiate participation in HIE ❑ Registry functionality used for all pt F/U ❑ Home monitoring device data integrated with EHR ❑ Telehealth integrated into accountable care model	❑ Integrated risk stratification ❑ Big data analytics provide feedback loop for evidence-based clinical decision support ❑ Triple Aim outcomes compared to baseline &/or benchmarks for continuous improvement
• Community core measures of quality & cost ○ Reporting ○ Improvement	**G. QUALITY MANAGEMENT**	❑ <70% quality measures met in each domain ❑ Core measures quality reporting limited to local providers, in aggregate ❑ Community core measures quality reporting to local providers in aggregate	❑ 70% - 79% quality measures met in each domain ❑ Core measures quality reporting at provider & pt level of specificity ❑ Core measures quality improvement data publicized in aggregate ❑ Community core measures cost reporting initiated	❑ 80% - 89% quality measures met in each domain ❑ Care coordination cost effectiveness ❑ Pharmacy cost effectiveness ❑ Community core measures quality improvement data publicized at provider level	❑ 90%+ quality measures met in each domain ❑ Per capita cost reduced ❑ Community core measures quality & cost improvement data publicized at provider level
• Payer participation in performance-based payment (PBP)	**H. FINANCIAL MANAGEMENT**	❑ <5% performance-based payment (PBP)	❑ 5% – 15% PBP	❑ 15% – 30% PBP	❑ >30% PBP

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Summary Report

Element	Level 1. Beginning	Level 2. Progressing	Level 3. Intermediate	Level 4. Advanced
A. Leadership				
B. PT Population / Panel Management				
C. Care Management				
D. Transitions of Care				
E. Community Resources				
F. Data and Processes				
G. Quality Management		— NOT ASSESSED —		
H. Financial Management		— NOT ASSESSED —		

Program Element A: LEADERSHIP

Maturity Level: **PROGRESSING**

General assessment: RidgePointe Healthcare District (RidgePointe) is making good progress in the Leadership element of a Community-based Care Coordination program. The sponsoring organization (RidgePointe Hospital), most providers (other than specialty providers), a community-based care coordinator and a number of community resources are on board with the program. One payer organization (Blue Cross Blue Shield) has been engaged in setting goals for the program, patient follow-up and standards of care. Communications about CCC has taken place with at least one patient representative. **[Level 1: 5/5; Level 2: 5/6]**

Program Element B: PATIENT POPULATION / PANEL MANAGEMENT

Maturity Level: **BEGINNING**

General assessment: RidgePointe is in the beginning stages of Patient Population / Panel Management. In general, patients' provider preferences are noted but they are not assigned to primary care providers (PCPs). Patients haven't yet been identified for care coordination. A process for tracking test or lab results is in place. In addition, referral tracking through follow-up calls is currently done for all patients. **[Level 1: 1/3; Level 2: 2/3]**

Program Element C: CARE MANAGEMENT

Maturity Level: **BEGINNING**

General assessment: RidgePointe is in the beginning stages of Care Management. Some care management activities are currently being done, such as treatment plans for all patients, medication reconciliation, and verbal clinical summary sharing with other providers. Discharge instructions are provided verbally to patients. Transfers to nursing home or rehab are done by the LSW working with the patient and family. Clinical summaries are obtained for high-risk patients admitted. **[Level 1: 4/6; Level 2: 1/4]**

Program Element D: TRANSITIONS OF CARE (ToC)

Maturity Level: **BEGINNING**

General assessment: RidgePointe is in the very beginning stages of Transitions of Care (ToC). Clinical summaries and instructions are reviewed with patients prior to discharge by the RN on duty, not by the care coordinator. Patient education is given by NP and provider. **[Level 1: 1/3]**

Program Element E: COMMUNITY RESOURCES

Maturity Level: **BEGINNING**

General assessment: RidgePointe is in the beginning stages using Community Resources to support its Community-based Care Coordination program and will continue to build on relationships already established. Information about CCC and accountable care has been communicated with some community resources, and a number of representatives from community services attended the RidgePointe Healthcare District CCC Program launch meeting. **[Level 1: 2/2]**

Program Element F: DATA AND PROCESSES

Maturity Level: **BEGINNING**

General assessment: RidgePointe is in the beginning stages using Data and Processes to support its Community-based Care Coordination program. Staff recognizes that workflow and process management as a key factor for successful use of technology, and works with patients to use home monitoring tools and devices such as glucose meters, blood pressure monitors, and diet history/diaries. **[Level 1: 2/6]**

Program Element G: QUALITY MANAGEMENT — NOT ASSESSED —

Maturity Level: **N/A**

General assessment: **N/A**

Program Element H: FINANCIAL MANAGEMENT — NOT ASSESSED —

Maturity Level: **N/A**

General assessment: **N/A**

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For support using the toolkit
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