Section 1.3.1 Assess

Community-Based Care Coordination Maturity Assessment Template

This tool identifies four levels of community-based care coordination (CCC) program maturity. The maturity level of a nascent or current CCC program can be assessed by comparing the program with the maturity attributes listed. The tool can be used for various purposes: to assess community readiness for a CCC program; to set program goals; to assist in developing a roadmap for program implementation; to evaluate program status; to benchmark against other programs; or for other purposes as defined by program leadership.

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| **Time needed:** 2-5 hours  **Suggested other tools:** Glossary of Terms for CCC; Community Data Collection Form; CCC Program Project Plan; CCC Program Evaluation; CCC Maturity Assessment Template; CCC Program Maturity Assessment Example Report |

# How to Use

1. **Review** the *CCC Maturity Assessment* instrument (this tool) to become familiar with the elements and attributes associated with four levels of CCC program maturity: Beginning; Progressing; Intermediate; and Advanced.
2. **Review** *Glossary of Terms for CCC* for definitions of commonly-used terms.
3. **Review** the *CCC Program Maturity Assessment Example Report* to see what a completed assessment and report might look like.
4. **Determine** how the assessment tool and report will be used
   1. ***Purpose:*** To assess community readiness for a CCC program? To set program goals? To assist in developing a roadmap for program implementation? To evaluate program status? To benchmark against other programs? Some other purpose?
   2. ***Approach:*** Who will complete the assessment? How and when will it be done (e.g., individually, then as a group to compare and reconcile results; together as a team; or through another approach)? How and with whom will results be validated?

[Note: It is strongly advised that examples be cited or rationale given for each checkmark (✓) that denotes that an element is in place.]

* 1. ***Reporting:*** Who will compile the assessment results? Who will complete and distribute the assessment report? What will the report look like? Where will the assessment results/report be stored for future reference?

1. **Use** the *CCC Maturity Assessment Template* to complete the assessment. Develop an assessment report and share the results with CCC program leadership, steering committee and others as appropriate.

| **Community-Based Care Coordination (CCC) Maturity Assessment** | | | | | |
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| **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 | 1. **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 | 1. **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 | 1. **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 |
| • Community  setting   * Home * Assisted living * Domiciliary * Rest home   • Home health  • Hospice  • Retail pharmacy | 1. **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 | 1. **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 |
| • Electronic health  record (EHR)  • Data mgmt.  • Workflow &  Process mgmt.  • Health  information  exchange (HIE)  • Data warehouse   * Registry functionality * Risk stratification * Data analytics * Financial modeling * Evidence-based practice findings   • Telehealth  • Home  monitoring device  integration  • Personal health  record (PHR) | 1. **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 device | * 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 | 1. **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) | 1. **FINANCIAL MANAGEMENT** | * <5% performance-based payment (PBP) | * 5% – 15% PBP | * 15% – 30% PBP | * >30% PBP |

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