Community-Based Care Coordination Maturity Assessment

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.

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

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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
   a. ***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?
   b. ***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.]
   c. ***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?
5. **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					
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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<tr><th colspan="6">Community-Based Care Coordination (CCC) Maturity Assessment</th></tr>
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<tr>
<td>• Community setting
○ Home
○ Assisted living
○ Domiciliary
○ Rest home
• Home health
• Hospice
• Retail pharmacy</td>
<td>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</td>
<td>❑ 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</td>
<td>❑ 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</td>
<td>❑ 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</td>
<td>❑ Population health outcomes improvement
❑ Pts engaged in self-management</td>
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<tr>
<td>• Nutrition
• Transportation
• Support groups
• Homemaker
• Respite
• Social services
• Local public health
• Housing
• Vocational
• Schools</td>
<td>E. COMMUNITY RESOURCES
- Identification
- Utilization
- Directory
- Formal agreements
- Online availability checking
- Online arrangement for services</td>
<td>❑ Initiation of community resources identification
❑ Information exchanged with community resources about CCC & accountable care</td>
<td>❑ Agreements with services most used by high-risk pts
❑ CCC makes referrals to community resources, facilitated by directory of services, availability</td>
<td>❑ Many agreements across range of community resources
❑ CCC arranges for community resources directly online</td>
<td>❑ Active use of community resources
❑ Improved consumer experience of care
❑ Community resources included in shared savings</td>
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• 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)	**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 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	**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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Produced under contract with The Office of the National Coordinator for Health Information Technology (ONC)

For support using the toolkit

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