Section 2.5 Plan

Care Coordination Roles Planning Matrix

The tool helps the community-based care coordination (CCC) program leadership understand the various services, activities, and roles to be performed within a CCC program, and determine which team member, functional area, or role is to be responsible for each activity.

Time needed to review and use tool: 2-5 hours

Suggested other tools: CCC Program Workflow Diagram; Business and Reimbursement Models for CCC; CCC Program Staffing Models; CC Sample Job Description; Care Coordination Roles Planning Matrix Template

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How to Use

1. **Review** the overview on care coordination activities and team member roles.
2. **Understand** how the *Care Coordination Roles Planning Matrix* tool can help program leadership plan CCC program services or activities and assign team members/roles to provide primary and secondary support for each activity.
3. **Use** the *Care Coordination Roles Planning Matrix Template* to identify and plan program activities and roles.

Overview

As identified in this toolkit, there are numerous services, activities, and tasks involved in supporting patients within a community-based care coordination (CCC) program. Priorities and roles for care coordination may vary between programs and often depend on the entities participating in the program, if and how long they have been working together, and which care coordination processes are currently in place in one or more of the care settings. For example, if a participating primary care clinic is seeking or has achieved certification as a patient-centered medical home (PCMH) or health care home (HCH), it is likely that a number of care coordination roles and processes are in development or have already been implemented. Likewise, if a hospital routinely assigns a social worker or case manager to assist patients in transition to another care setting, many of the formal or informal processes involved in working with other organizational entities to coordinate care are understood.

Unlike acute or transaction-oriented care coordination, however, community-based care coordination is focused on broader and longer-term patient needs, and involves not only coordinating medical care with the patient's primary and specialty care providers and facilities, but also working with ancillary and community services that affect the patient's overall health and well-being.

CCC program leadership needs to understand the interrelationships and workflows among care coordination activities to minimize gaps or duplication of services and roles. It could be confusing or frustrating to a patient if multiple (well-meaning) professionals made referrals to a community resource, conducted a home environment assessment, or developed a patient care plan, for example.

Using the Care Coordination Roles Planning Matrix

During the CCC program planning and design phases, it is important to identify both one-time and on-going activities that are within scope of the program, and then decide which organization, team member, or role is best positioned to provide each service to meet the needs of the patient or patient cohort. This planning process may be iterative, and involvement of program participants and stakeholders is strongly encouraged.

The planning matrix is a useful tool to help identify the various services or activities, as well as the team members or roles needed to support the community-based care coordination (CCC) program. The tool also can be used to ensure optimum use of resources by identifying gaps and duplication of care coordination activities and roles, and to mitigate misunderstandings among team members by clarifying "Who is responsible for what" for a patient. (See an example on the next page.)

Use the *Care Coordination Roles Planning Matrix Template* to document both CCC program activities (x axis) and team members (y axis), and assign responsibility for each service or activity to a team member or role.

Care Coordination Roles Planning Matrix—*Example**

Care Coordination Role → **P** = primary responsibility **S** = secondary or support responsibility **Care Coordination Activity ↓**	CCC program manager	Care coordinator	Social worker	Health plan case manager	Front-desk staff/receptionist	Back-office staff/scheduler	Medical assistant or LPN	Provider—MD	Provider—PA	Provider—NP	Registered Nurse	Mental health professional	Health educator	ED manager	Clinic manager	Health coach
Identify eligible patients	P			S										S	S	
Develop patient recruitment strategy	P	S	S	S										S	S	
Recruit patients to program	P		S	S												
Schedule initial face-to-face CC visit				S		P								S	S	
Prepare CCC plan		P									S					
Prepare patient care plan (for Pt)								P	P	P	S	S				
Prepare patient action plan (with Pt)		P														S
Conduct medication reconciliation		P									S					
Develop referral process	P	S	S	S								S				
Schedule patient referrals					S	P										
Track/follow-up on patient referrals					S	P										
Conduct health risk assessment(s)		P	S								S	S				
Review Pt health diary		P						S	S	S	S	S				S
Provide condition-specific education		S									S		P			S
Complete Pt care coordination variance log	S	P														
Provide mental health crisis intervention			S									P				
Monitor vital signs and report out-of-range							S				P					

* Note: The planning matrix above is an ***example only***. Care coordination activities and roles may vary depending on the goals and objectives of the CCC program.

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For support using the toolkit

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