Workflow and Process Optimization for CCC

This tool provides the "third step" after workflow and process analysis and redesign. Once the community-based care coordination (CCC) program team has analyzed and redesigned current processes that impact the program and determined that the CCC program is ready to adopt more advanced components of CCC, workflow and process optimization can help implement such components.

Time needed: 3 hours

Suggested other tools: Workflow and Process Analysis for CCC; Workflow and Process Redesign for CCC; CCC Program Satisfaction Surveys; CCC Maturity Assessment

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How to Use

1. **Review** the *Workflow and Process Analysis for CCC* and *Workflow and Process Redesign for CCC* tools if not previously studied. Also review or update the *CCC Maturity Assessment* to determine readiness for adoption of more advanced components of CCC.

2. **Focus** initial optimization efforts on components of the CCC program which were newly added when the program was initiated. For example, *Patient Action Plan*, *Pharmacist Outreach*, and *Documentation for Reimbursement* and other tools are fundamental CCC components typically added when the CCC program is initiated. Determine if the workflows and processes as currently implemented are working properly. Review user satisfaction and outcomes to assess their current effectiveness or if there are opportunities for workflow and process improvement. Improve the workflow and processes in those components using the *Workflow and Process Redesign* tool.

3. **Review** the OPTIMIZE Tools in this Toolkit (or other resources) to identify components of the CCC program that have not yet been implemented and which the community may find useful. Use the *Workflow and Process Analysis for CCC* to map how any component being considered for implementation is expected to be used, and use the *Workflow and Process Redesign for CCC* to test, implement, and monitor results.

Optimize Workflows and Processes through Monitoring and Redesign

The CCC components identified in the table below are those which are often implemented early in a CCC program and which tend to be new to the community of users.

Consider some of the more common problems that arise during implementation, using clues for how to spot issues. Add clues not listed that may be helpful for continuous monitoring. If any of the problems with current CCC components are occurring in your environment, consider mapping the associated workflow and process, and use redesign techniques to find ways to improve them. Identify who and when (priority) such improvement activities will be undertaken.

Keep track of your progress in conducting the optimization and indicate by date completed those that are finished so the list seems less daunting.

Identify Opportunities for Optimizing Current Workflows and Processes		
CCC Component	**Clues to Spot Issues**	**Need to Optimize?** (Who / When / Done)
Roles and Communications	• Duplications and/or gaps occur regularly	❑
Population Risk Stratification and Patient Cohort Identification	• Insufficient number of patients are being recruited in the CCC program • No one is "selling" the CCC program	❑
Goal Setting	• CCC program is well underway but there is no commitment to specific goals • Goals initially set for CCC program have not been monitored, achieved, or updated	❑
CCC Program Resources	• CCC program lacks certain essential resources • Not all patients are receiving CCC as scheduled	❑
Technology for CCC	• Registry/patient tracking functionality does not exist or is not fully functional • Directory services are not available or fully functional • Reporting functionality not delivered as promised • Home monitoring technology lacking	❑
Data Collection for CQMs	• Data needs for CQMs have not been identified • Some data needed for CQMs are not being collected • Issues with data sharing in order to collect CQM data	❑

Identify Opportunities for Optimizing Current Workflows and Processes		
CCC Component	**Clues to Spot Issues**	**Need to Optimize?** (Who / When / Done)
	• Follow up on adequate data documentation for CQMs has not been done	
Clinical Guidelines Adoption	• Physicians have not yet adopted clinical guidelines for highest-risk disease conditions or those most prevalent in population • Clinical guidelines adopted have not been used as evidenced by lack of CQM data associated with their use, no change in outcomes measures, or poor use of CCC program	❑
Patient Communications	• No education provided on moving provider culture toward patient empowerment • Lack of support for use of patient empowerment tools, such as patient action plans, health diaries, patient agendas	❑
Workflow and Process Improvement	• No workflow and process maps have been documented • No training on redesigned workflows and processes • Satisfaction scores remain unchanged with respect to "hassle factors"	❑
Provider Resource Directory	• Not fully functional	❑
Provider Agreements	• Agreements not completed by all providers	❑
Community Resource Directory	• Not fully functional	❑
Community Agreements	• Agreement not completed by all providers	❑
Patient Empanelment	• Patients continue to be seen by any provider available • Patients continue to experience long wait times between request for appointment and being seen	❑
Patient Recruitment into CCC	• Number of patients in CCC program are not as anticipated • No one is "selling" the program	❑
CCC Plans for Patients	• CCC plans for patients are not documented • CCC plans for patients are incomplete • CCC plans for patients are not being routinely used	❑

Identify Opportunities for Optimizing Current Workflows and Processes		
CCC Component	**Clues to Spot Issues**	**Need to Optimize?** (Who / When / Done)
Health and Wellness Preventive Services Scheduling	• Number of patients expected to receive health and wellness preventive services are not as anticipated	❑
Health Risk Assessments	• Health risk assessments, especially for key conditions such as depression, are not conducted as needed • Patients are not referred to specialists who can address health risk areas • Specialists who can address health risk areas are not available in the community	❑
Patient Action Plan	• Patients are not asked to develop a patient action plan with their care coordinator • Patient action plans are not being used by patients • Care coordinators are not following up with patients or their family/caregivers on their use of their patient action plan	❑
Patient Tracking and Follow Up	• Technology tools are not fully functional • Not all patients are followed up on a timely basis	❑
Patient CC Variance Reporting	• CC variance reporting has not been implemented • CC variance report has no variances identified • No one is analyzing the CC variance reports	❑
Pharmacist Outreach	• Pharmacist outreach has not begun • Providers are not responsive to outreach by pharmacists • Pharmacists are not responsive to outreach by providers or CC	❑
Documentation for CCC Reimbursement	• Documentation for CCC has not been initiated • Documentation for CCC is lacking vital data • No one has received reimbursement for CCC	❑

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For support using the toolkit

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