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

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

|----------|------------------|-------------------|---------------------|----------------------|------------------|
| • 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 care 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 |

*Section 1.3 Assess–CCC Maturity Assessment - 2*
# Community-Based Care Coordination (CCC) Maturity Assessment

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<tbody>
<tr>
<td>• Community setting o Home o Assisted living o Domiciliary o Rest home o Home health o Hospice o Retail pharmacy</td>
<td><strong>D. TRANSITIONS OF CARE (ToC)</strong> - CCC calls, visits high-risk patients - Medication monitoring - Care plan monitoring - Health literacy &amp; education o Medications o Life style changes o Screenings o Immunizations - Pt engagement; pt self-management - Health outcomes monitoring</td>
<td>□ Local care coordinator reviews clinical summary &amp; instructions prior to discharge □ Local care coordinator provides education as appropriate</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</td>
<td>□ CCC calls &amp; visits high-risk patients □ F/U calls for care plan monitoring; encourages self-management through motivational interviewing &amp; use of community services □ Retail pharmacist engaged in medication management (fill status notification) □ CCCs address special populations: o Pre-natal o Special needs children o Depression/BH</td>
<td>□ Population health outcomes improvement □ Pts engaged in self-management</td>
</tr>
<tr>
<td>• Nutrition • Transportation • Support groups • Homemaker • Respite • Social services • Local public health • Housing • Vocational • Schools</td>
<td><strong>E. COMMUNITY RESOURCES</strong> - 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 &amp; 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>
</tr>
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</table>
## Community-Based Care Coordination (CCC) Maturity Assessment

|----------|------------------|--------------------|----------------------|----------------------|------------------|
| • Electronic health record (EHR)  
• Data mgmt.  
• Workflow & Process mgmt.  
• Health information exchange (HIE)  
• Data warehouse  
  o Registry functionality  
  o Risk stratification  
  o Data analytics  
  o Financial modeling  
  o 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  
  o Reporting  
  o 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 |  
  □ 90%+ quality measures met in each domain  
  □ Per capita cost reduced  
  □ Community core measures quality & cost 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 |  
  □ 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 |