A Care Coordination Assessment for Providers and Organizations

Care coordination encompasses a cultural shift from a focus on periodic, acute care visits to a more comprehensive view of coordinating care for those with chronic and/or complex conditions. Care coordination often includes use of staff as care coordinators to specifically work with and support individual patients and families.

This assessment is intended to address both the function of care coordination and use of the care coordinator role. The assessment is designed to provide a preliminary review of critical factors as we look to enhance care coordination efforts for Vermont's children with special health needs.

The primary goal of this tool is to spark discussion, encourage debate, and help identify potential opportunities.

Please complete this tool thinking about your organization.

Thank you for taking the time to complete this assessment by March 15, 2022.

This assessment has been adapted from "Care Coordination: A Self-Assessment for Rural Health Providers and Organizations" developed by Rural Health Value.

Care Coordination	Care Coordinator
A function	A person
Based on a population and their needs	Individualized action and support for a patient and their family
A deliberate, systematic organization of patient care	Could involve case management, coaching, advocacy
Infrastructure, policies, communication, and resources	May be clinical or non-clinical
A function that helps ensure that the patient's needs and preferences for health services and information sharing across people, functions, and sites are met over time	A person in charge of coordinating client care in a clinical or health care setting, typically responsible for managing care plans, arranging, and tracking appointments; educating clients/patients; and coordinating other aspects of clients' well-being

Leadership and Planning

Your Organization: [0_arm_1][affiliation_type]

1) How well has your organization articulated a vision for care coordination?

- ◯ None/Not at all
- ◯ Minimally
- ◯ Moderately
- ◯ Advanced
- ◯ Not applicable to my organization

What is the level of awareness regarding the critical role of care coordination/care management in value-based health care reimbursement:

		None/Not at all	Minimally	Moderately	Advanced	Not applicable to my organization
2)	Among direct service staff (physicians, nurses, social workers, etc)?	◯	◯	◯	◯	◯
3)	Among organization leadership (CEO, physician leaders, board of directors, etc)?	◯	◯	◯	◯	◯
4)	Among community-based organizations, such as human and social service agencies?	◯	◯	◯	◯	◯
5)	Among patients and families?	◯	◯	◯	◯	◯

6) To what extent has your organization incorporated care coordination approaches as part of ongoing regular strategic planning processes?

- ◯ None/Not at all
- ◯ Minimally
- ◯ Moderately
- ◯ Advanced
- ◯ Not applicable to my organization

7) How engaged are your physicians and/or mid-level providers (e.g., physician assistants or nurse practitioners) in developing and implementing a care coordination model to help manage patients with chronic and complex illnesses.

- ◯ None/Not at all
- ◯ Minimally
- ◯ Moderately
- ◯ Advanced
- ◯ Not applicable to my organization

Partners and Community

Your Organization: [0_arm_1][affiliation_type]

8) How effectively has your organization reached out to other health care settings to coordinate care for children and youth with complex illnesses?

- ◯ None/Not at all
- ◯ Minimally
- ◯ Moderately
- ◯ Advanced
- ◯ Not applicable to my organization

9) To what extent has your organization worked with community and/or social services agencies to coordinate support for non-medical resources and needs?

- ◯ None/Not at all
- ◯ Minimally
- ◯ Moderately
- ◯ Advanced
- ◯ Not applicable to my organization

10) To what extent has your organization integrated behavioral health services to help ensure coordination of medical and behavioral health treatment/support?

- ◯ None/Not at all
- ◯ Minimally
- ◯ Moderately
- ◯ Advanced
- ◯ Not applicable to my organization

Workforce and Culture

Your Organization: [0_arm_1][affiliation_type]

11) How broadly does your organization use special techniques for chronic illness care such as planned visits, group visits, home monitoring, patient self-management programs, etc.?

- ◯ None/Not at all
- ◯ Minimally
- ◯ Moderately
- ◯ Advanced
- ◯ Not applicable to my organization

12) How aware is your organization's staff of social determinants of health and non-medical influences on chronic disease management and wellness?

- ◯ None/Not at all
- ◯ Minimally
- ◯ Moderately
- ◯ Advanced
- ◯ Not applicable to my organization

13) Has your organization explored the use of innovative provider support roles such as community health workers, community paramedics, health coaches, or others?

- ◯ None/Not at all
- ◯ Minimally
- ◯ Moderately
- ◯ Advanced
- ◯ Not applicable to my organization

Operations and Policies

Your Organization: [0_arm_1][affiliation_type]

14) Has your organization developed a process to identify care coordination needs of specific populations?

- ◯ None/Not at all
- ◯ Minimally
- ◯ Moderately
- ◯ Advanced
- ◯ Not applicable to my organization

15) How effectively do you use your EMR to identify patients that meet target patient specifications?

- ◯ None/Not at all
- ◯ Minimally
- ◯ Moderately
- ◯ Advanced
- ◯ Not applicable to my organization

16) How effectively have you defined roles and developed processes for a care coordinator to interact effectively with patients and providers?

- ◯ None/Not at all
- ◯ Minimally
- ◯ Moderately
- ◯ Advanced
- ◯ Not applicable to my organization

17) How effectively does your organization utilize Health Information Technology (EHR, health information exchange, tele-medicine) to support care management goals?

- ◯ None/Not at all
- ◯ Minimally
- ◯ Moderately
- ◯ Advanced
- ◯ Not applicable to my organization

18) How extensively have you engaged a variety of health care and social service providers to coordinate transitions of care and address underlying needs/concerns?

- ◯ None/Not at all
- ◯ Minimally
- ◯ Moderately
- ◯ Advanced
- ◯ Not applicable to my organization

Data Collection, Management & Analysis/Outcomes, and Impact

Your Organization: [0_arm_1][affiliation_type]

19) Has your organization identified target measures and goals that reflect the needs of your population(s) of focus for care coordination?

- ◯ None/Not at all
- ◯ Minimally
- ◯ Moderately
- ◯ Advanced
- ◯ Not applicable to my organization

20) Are you regularly utilizing data to monitor progress towards care coordination goals?

- ◯ None/Not at all
- ◯ Minimally
- ◯ Moderately
- ◯ Advanced
- ◯ Not applicable to my organization

21) How broadly are care coordination goals and data promoted to the public as a mechanism to engage partners and the community?

- ◯ None/Not at all
- ◯ Minimally
- ◯ Moderately
- ◯ Advanced
- ◯ Not applicable to my organization

Comments

22) Please share any additional comments or thoughts that came to you as you filled out this assessment.

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