RUPRI Rural Policy Research Institute
Center for Rural Health Policy Analysis

Rural Health Value
UNDERSTANDING AND FACILITATING RURAL HEALTH TRANSFORMATION.

Stratis Health

# Care Coordination: A Self-Assessment for Rural Health Providers and Organizations

Care coordination encompasses a cultural shift from a focus on periodic, acute care visits to a more comprehensive view of managing care for those with chronic disease and complex conditions. Care coordination often includes use of staff as care coordinators to specifically work with and support individual patients. 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 for rural organizations looking to develop, expand, or enhance care coordination efforts.

| Care Coordination | Care Coordinator |
|---|---|
| A function | A person |
| Based on a population and their needs | Individualized action and support for a patient |
| 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 |

## Instructions

- The primary goal of this tool is to spark discussion, encourage debate, and help identify potential opportunities.
- Completion is recommended in one of two ways:
  - As a group exercise among an organizational or community-based leadership team
  - As an individual activity for leaders, with responses aggregated prior to a follow-up group discussion
- If completing the assessment as a community team that encompasses multiple organizations, assess the "organization and staff" questions from the perspective of each of the participating organizations.
- Use this assessment at as an initial and ongoing tool to plan and prioritize actions. Reassess progress every 12-24 months.

| ***Leadership and Planning*** | **None/ Not at all** | **Minimally** | **Moderately** | **Advanced** |
|---|---|---|---|---|
| 1. What is the level of awareness regarding the critical role of care coordination/care management in value-based health care reimbursement? (Please include a separate score for each of the three categories below.)<br>a. Among key health care staff and physician leaders (e.g., hospital CEO, clinic administrator, physician leaders)?<br>b. Among health facility boards of directors?<br>c. Among community-based organizations, such as human and social service agencies?<br>Notes: | | | | |
| 2. Is there a shared understanding of the business case and/or rationale for a focus on care coordination efforts?<br>Notes: | | | | |

| *Leadership and Planning (continued)* | None/ Not at all | Minimally | Moderately | Advanced |
|---|---|---|---|---|
| 3. How well has your organization articulated a vision for care coordination and how it increases value (increased quality and patient experience with reduced costs)?<br>Notes: | | | | |
| 4. To what extent has your organization incorporated care coordination approaches as part of ongoing regular strategic planning processes?<br>Notes: | | | | |
| 5. 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.<br>Notes: | | | | |

| *Partners and Community* | None/ Not at all | Minimally | Moderately | Advanced |
|---|---|---|---|---|
| 6. How effectively has your organization reached out to other health care settings to coordinate care for patients with complex illnesses?<br>Notes: | | | | |
| 7. To what extent has your organization worked with community and/or social services agencies to coordinate support for non-medical resources and needs?<br>Notes: | | | | |

| *Partnership and Community (continued)* | None/ Not at all | Minimally | Moderately | Advanced |
|---|---|---|---|---|
| 8. To what extent has your organization integrated behavioral health services to help ensure coordination of medical and behavioral health treatment/support?<br>Notes: | | | | |
| 9. How well has your organization engaged or interacted with Navigators or other personnel for outreach and enrollment in a health care insurance marketplace?<br>Notes: | | | | |

| *Workforce and Culture* | None/ Not at all | Minimally | Moderately | Advanced |
|---|---|---|---|---|
| 10. Has your primary care clinic(s) adopted a patient-centered home or other team-based care model?<br>Notes: | | | | |
| 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.?<br>Notes: | | | | |
| 12. How aware is your organization’s staff of social determinants of health and non-medical influences on chronic disease management and wellness?<br>Notes: | | | | |
| 13. Has your organization explored the use of innovative provider support roles such as community health workers, community paramedics, health coaches, or others?<br>Notes: | | | | |

| ***Operations and Processes*** | **None/ Not at all** | **Minimally** | **Moderately** | **Advanced** |
|---|---|---|---|---|
| 14. Has your organization developed specifications for the identification of target patient populations for care coordination efforts?<br>Notes: | | | | |
| 15. How effectively do you use your EMR to identify patients that meet target patient specifications?<br>Notes: | | | | |
| 16. How effectively have you defined roles and developed processes for a care coordinator to interact effectively with patients and providers?<br>Notes: | | | | |
| 17. How effectively does your organization utilize Health Information Technology (EHR, health information exchange, tele-medicine) to support care management goals?<br>Notes: | | | | |
| 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?<br>Notes: | | | | |
| **Data Collection, Management & Analysis/Outcomes, and Impact** | **None/ Not at all** | **Minimally** | **Moderately** | **Advanced** |
| 19. Has your organization identified target measures and goals that reflect the needs of your population(s) of focus for care coordination?<br>Notes: | | | | |

| Data Collection, Management & Analysis/Outcomes and Impact (continued) | None/ Not at all | Minimally | Moderately | Advanced |
|---|---|---|---|---|
| 20. Are you regularly utilizing data to monitor progress towards care coordination goals?<br>Notes: | | | | |
| 21. How broadly are care coordination goals and data promoted to the public as a mechanism to engage partners and the community?<br>Notes: | | | | |

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