Care Coordination IHI Compass Tool

As you consider your organization’s journey toward improving Care Coordintion, please select the description that best represents the attitudes, behaviors, or actions currently underway.

The responses represent examples of the types of activities an organization may be undertaking. We are asking you to focus specifically on activites around Care Coordination.

The purpose of completing the Compass is to provide a snapshot of your organization’s current activities and suggest some possible next steps to help your organization progress to where it wants to be.

Each response contributes to a “score” to assess current activities for each component, and to help your organization evaluate the balance of activities across the components.

The Compass takes approximately 20 minutes tocomplete

The Compass includes a series of statements to identify the current state of your organization’s Care Coordination activities to advance different components of the Pathways to Population Health Framework:

Physical and/or Mental Health Social and/or Spiritual Well-Being Community Health and Well-Being Communities of Solutions As you consider your organization’s journey toward improving Care Coordination, please select the description that best represents the attitudes, behaviors, or actions currently underway.

Stewardship

1) As you consider the perspective of your organization's leaders as it relates to Care Coordination as a part of a population health framework, please select the description that best represents the attitudes, behaviors, or actions currently underway.

- ◯ Our board and/or senior leadership do not consider addressing Care Coordination as population health, to be our organization's responsibility.
- ◯ Our board and/or senior leadership believe we have a role to play Care Coordination for the health of our community, but we do not have a cohesive strategy to do so.
- ◯ Our board and/or senior leadership believe that Care Coordination as population health is a priority for our organization. We have dedicated resources and initiatives to improve the health of individuals and discrete patient populations.
- ◯ Our board and/or senior leadership ensure we have dedicated resources to improve Care coordination and the lives of everyone in our community, regardless of whether they are our patients.
- ◯ Our organization is part of a multi-stakeholder coalition working to improve Care Coordination, health, well-being, and equity in our communities, with shared governance and dedicated resources to advance the work across stakeholders.

Equity

2) As you consider your organization's efforts to improve equity for Care Coordination, please select the description that best represents the attitudes, behaviors, or actions currently underway.

- ◯ We do not discuss health equity in relation to care coordination in our organization.
- ◯ We've had some discussions or educational sessions related to health equity for care coordination but have not taken any action to address equity issues.
- ◯ We routinely collect data on race, ethnicity, language, and socio-economic status and have active improvement efforts underway to address health equity gaps in care coordination.
- ◯ We stratify community data based on key socio-demographic factors and work with community partners to close equity gaps for care coordination.
- ◯ We work with community partners to implement, evaluate, and improve programs and policies to address the root causes of inequities and their impact on care coordination.

Payment

3) As you consider your organization's attitudes, behaviors, or actions currently underway around payment for care coordination, please select the description that best fits.

- ◯ We are entirely fee-for-service and do not take on financial risk for the health outcomes of any defined populations, including those needing care coordination.
- ◯ We are having preliminary discussions with payers to take on financial risk for defined care coordination populations. Less than 5% of patients are currently covered under such arrangements.
- ◯ We have several risk-based contracts for defined care coordination populations that cover 5% to 20% of our patients and/or employees.
- ◯ 21% to 50% of our patient and/or employee population is covered under a global payment/shared savings arrangement. We are actively exploring adding new patient populations that may need care coordination or additional payers over time. We embrace new financial models to improve the health of our patients who need care coordination and communities.
- ◯ More than 50% of our patient and/or employee population is covered under a global payment/shared savings arrangement. We are expanding to create mechanisms to share risk and savings across sectors in our communities.
- ◯ Not applicable to our organization

Partnership

4) As you consider your organization's efforts to partner with people with lived experience of care coordination, please select the description that best represents the attitudes, behaviors, or actions currently underway.

- ◯ We do not have formal mechanisms to engage patients, families, or others with lived experience of care coordination in co-designing the care experience.
- ◯ We have established a patient and family advisory council (PFAC) or equivalent group of patients and family members with care coordination, but do not yet partner with them in a meaningful and systematic way.
- ◯ We routinely engage our PFAC or others with lived experience of care coordination to help identify quality improvement priorities.
- ◯ All quality improvement projects are co-designed with patients and family member with lived experience of care coordination, who remain active members of the improvement teams.
- ◯ People with lived experience of care coordination co-lead improvement initiatives in our organization or in our community.

Mental and/or Physical Health

As you consider your organization's efforts to improve mental and/or physical health as they relate to care coordination, please select the description that best represents the attitudes, behaviors, or actions currently underway in the four components.

5) Select all statements that apply to your organization regarding Data for Mental and/or Physical Health.

Please select ANY/ALL that are true for your organization, or "none".

- ☐ We collect data to proactively manage the physical health of discrete populations receiving care coordination.
- ☐ We collect data to proactively manage the mental health of discrete populations receiving care coordination.
- ☐ Our strategic planning staff present basic GIS Zip code data of key patient cohorts receiving care coordination as part of our community benefit assessment.
- ☐ We use physical and mental health data in our risk stratification to proactively manage prevention, disease management, and complex care management needs for discrete populations receiving care coordination.
- ☐ We use our data in improvement initiatives related to mental and/or physical health of patients receiving care coordination.
- ☐ None of the statements apply to our organization.
- ☐ Not applicable to our organization

6) Team-Based Care:
Choose the response that best describes your organization at this time.

- ◯ We don't use team-based care for care coordination in our organization.
- ◯ We are exploring models of team-based care for care coordination in our organization.
- ◯ We are starting to implement a team-based care model for care coordination. The model is multidisciplinary and includes patients and families, as well as non-clinical providers.
- ◯ Team-based care for care coordination has been implemented throughout the organization. Our team-based care model enables each team member to work to their highest level of licensure.
- ◯ Not applicable to our organization

7) Behavioral Health Integration:
Choose the response that best describes your organization at this time.

- ◯ We provide behavioral health and medical care in separate facilities, with separate systems, for patients receiving care coordination. We are not trying to integrate behavioral health and medical care.
- ◯ We are examining approaches to address behavioral health needs within primary care for patients with care coordination. We are exploring which approach may work best based on our population, payment systems, and resources.
- ◯ Primary care providers routinely communicate with behavioral health providers to share information with one another in advance of care coordination patient encounters.
- ◯ Primary care and behavioral health providers partner in areas such as creating shared systems (scheduling or medical records), in person or virtual collaboration on care plans, sharing and learning about one another's roles, capabilities, etc. for care coordination.
- ◯ Not applicable to our organization

8) Care Coordination:
Choose the response that best describes your organization at this time.

- ◯ Our organization does not have dedicated staff for care coordination activities OR they are primarily focused on individual utilization review activities.
- ◯ We have ways to identify individuals in need of care coordination and direct them to a dedicated person/team. We are exploring how to identify at-risk populations for outreach by our care management team.
- ◯ Our multidisciplinary care coordination team includes patients and families. A core care coordination team function is actively identifying and engaging community partners to support patients and populations for social/spiritual needs.
- ◯ Our multidisciplinary care coordination team partners with community resources to enhance services for at-risk populations to improve the health and well-being of the community.
- ◯ Not applicable to our organization

Social Well-being

As you consider your organization's efforts to improve social well-being for patients receiving care coordination, please select the description that best represents the attitudes, behaviors, or actions currently underway in the two components.

Social drivers encompass socioeconomic factors such as food, housing, education, transportation, and income, as well as social connectedness.

9) Select all statements that apply to your organization regarding Data for Social Well-being.
Please select ANY/ALL that are true for your organization, or "none".

- ☐ We collect data to proactively manage the social well-being of defined populations receiving care coordination.
- ☐ We share data with all relevant clinical stakeholders, with whom we are collaborating to improve the social well-being of discrete populations receiving care coordination.
- ☐ We include social drivers of health in our risk stratification to proactively manage prevention, disease management, and complex care management needs for discrete populations receiving care coordination.
- ☐ We use our data in improvement initiatives related to social well-being for patients receiving care coordination.
- ☐ None of the statements apply to our organization

10) Social Determinants of Health (SDOH) Screening and Referrals:
Choose the response that best describes your organization at this time. Be sure to read all answer choices, as they build on each other.

- ◯ We do not screen for social needs and assets for patients receiving care coordination.
- ◯ We screen for social needs and assets for patients receiving care coordination, but do not have a reliable mechanism to connect individuals with the appropriate home- and community-based services.
- ◯ We have reliable mechanisms to direct patients receiving care coordination to the appropriate home- and community-based services for their social needs.
- ◯ We have reliable mechanisms in place for follow-up and to ensure patients receiving care coordination social needs were met.
- ◯ In addition to all activities listed in the preceding responses, we work collaboratively with community-based service partners to demonstrate impact (related to cost, quality, and experience) on patients receiving care coordination
- ◯ Not applicable to our organization

Community Health and Well-being

As you consider your organization's efforts to improve community health and well-being for patients receiving care coordination, please select the description that best represents the attitudes, behaviors, or actions currently underway in the three components.

11) Select all statements that apply to your organization regarding Data for Community Health and Well being. Please select ANY/ALL that are true for your organization, or "none".

- ☐ We collect data on patients receiving care coordination on a specific area of focus in our community work.
- ☐ We use tools like geotagging to understand the relationship of place to specific health and well-being outcomes among patients receiving care coordination.
- ☐ We have data sharing agreements in place and routinely share and review data on patients receiving care coordination with all relevant stakeholders (including the people most impacted).
- ☐ We analyze our care coordination data with a health equity lens with all relevant community stakeholders (including those most impacted).
- ☐ We use data to risk-stratify and prioritize opportunities with our community partners to improve specific health and well-being outcomes for patients needing care coordination.
- ☐ None of the statements apply to our organization.

12) Community Partnerships:
Choose the response that best describes your organization at this time.

- ◯ We do not proactively seek partnerships with community organizations for care coordination.
- ◯ Our partnerships for care coordination are mostly based on existing relationships that serve the needs of individuals and the organization.
- ◯ We are proactively seeking partnerships for care coordination with multi-sector organizations to address social determinants of health.
- ◯ We are part of several community-wide, multi-sector coalitions that collectively identify and collaborate around key care coordination health improvement efforts.
- ◯ Not applicable to our organization

13) Select all statements that apply to your organization regarding Community Benefit.
Please select any/all that are true for your organization, or "none".

Note: Full Time Equivalent (FTE) is a unit of measurement that represents the number of hours an employee works.

- ☐ We have dedicated FTEs for community benefit programming who report to senior leadership.
- ☐ We have dedicated FTEs for community benefit programming who are accountable for our organization's community benefit performance.
- ☐ Our community benefit team includes key community organizations and stakeholders.
- ☐ Our community benefit investments address gaps identified in our community health needs assessment.
- ☐ We have a theory of what will improve the health and well-being of our community and a plan for making those improvements, developed with community stakeholders and people who are most affected, and we apply our community benefit resources accordingly.
- ☐ Our community benefits staff have timely access to data and resources to support community benefit programming.
- ☐ We report our community benefit performance and our population health performance to our governing board.
- ☐ We partner with other health care organizations in our community to co-invest community benefit dollars to achieve greater community and regional impact.
- ☐ We evaluate whether community benefit investments lead to improvement in the health and well-being of our community and change our approach accordingly.
- ☐ None of the statements apply to our organization.

Communities of Solutions

As you consider your organization's efforts to become a community of solutions for care coordination, please select the description that best describes the attitudes, behaviors, or actions currently underway in the three components.

14) Select all statements that apply to your organization regarding Data for Communities of Solutions. Please select ANY/ALL that are true for your organization, or "none".

- ☐ Community stakeholders across sectors drive the collection and integration of care coordination data to monitor overall trends in health, well-being, and equity in our community.
- ☐ We use tools like geotagging to understand the relationship of place to overall health and well-being outcomes for patients receiving care coordination.
- ☐ Together, we collect both people-reported well-being measures and proxy measures related to major initiatives we are working on for care coordination.
- ☐ We have data sharing agreements and integration platforms in place to promote interoperability for care coordination. This helps us proactively identify trends in integrated data across sectors.
- ☐ We routinely analyze our data with a health equity lens together with those who are most affected, and use it to co-design short- and long-term improvement initiatives for patients receiving care coordination.
- ☐ We use our data for community-level planning around resources to address the social drivers of health and well-being of patients receiving care coordiantion.
- ☐ None of the statements apply to our organization.

15) Select all statements that apply to your organization regarding Nontraditional Roles/Levers. Please select any/all that are true for your organization, or "none".

- ☐ Employer (e.g., develop career pipelines in communities with poor equity outcomes; join efforts to "ban the box"; offer a living wage for all employees; invest in peer workforce from underserved communities such as community health workers; incentivize employees to live in communities that are racially segregated to help with integration).
- ☐ Purchaser (e.g., procure selectively from vendors, or in communities, that have poor equity outcomes to build community wealth).
- ☐ Investor (e.g., give low income loans to women and minority-led businesses or nonprofits working to improve health, well-being, and equity in the community).
- ☐ Food purchaser and server (e.g., offer healthy food options for patients while hospitalized; connect to local sources of healthy food in food deserts to improve market for healthy food).
- ☐ Environmental steward (e.g., be responsible for your overall environmental footprint and work to reduce emissions and health care waste).
- ☐ Funder (e.g., use community benefit dollars to support the community).
- ☐ Builder (e.g., choose to locate new facilities in communities with poorer health outcomes to support job promotion).
- ☐ None of the statements apply to our organization.

16) Select all statements that apply to your organization regarding Policy .
Please select any/all that are true for your organization, or "none".

- ☐ We have institutional policies to improve working conditions for staff and contractors (e.g., livable wages).
- ☐ We have institutional policies to increase contracting with local vendors to enhance local economic development.
- ☐ We have institutional policies and investments to reduce our negative environmental impacts (e.g., waste disposal, energy utilization) at the local, regional, and/or national level.
- ☐ We partner with external stakeholders to build a common platform for public policy advocacy at the local level to address social drivers of health (e.g., improved schools, housing, food access, transportation, youth development).
- ☐ We advocate for public policies at the national level to increase attention and funding to address population health issues and the social determinants that drive them.
- ☐ None of the statements apply to our organization.

Thank you

17) Please share any additional thoughts and comments here:

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We are interested in receiving feedback about your experience completing this tool.

		Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree
18)	I could easily answer these questions about my organization.	○	○	○	○	○
19)	I would prefer to answer these questions with other members of my organization.	○	○	○	○	○
20)	The Compass tool wording kept me focused on Care Coordination while answering the questions.	○	○	○	○	○
21)	I would like more clarification from VCHIP about how the Compass tool will be used for the Summit.	○	○	○	○	○
22)	I would like to learn more about the Compass tool.	○	○	○	○	○