Care Coordination Canvas Guide

Developing and Improving Care Coordination Efforts

May 2018

525 South Lake Avenue, Suite 320 | Duluth, Minnesota 55802
(218) 727-9390 | info@ruralcenter.org
Get to know us better: www.ruralcenter.org/rhi

This is a publication of Rural Health Innovations, LLC (RHI), a subsidiary of the National Rural Health Resource Center. The Technical Assistance for Network Grantees Project is supported by Contract Number HHSH250201400024C from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Federal Office of Rural Health Policy.

TABLE OF CONTENTS

Background 3
Purpose 4
Getting Started 5
Definitions of Health 5
Definitions of Care Coordination 6
Care Coordination Canvas Components 8
Target Population 8
Assessments 10
Care Plan 11
Care Team 12
Communication 13
Technology 14
Collaboration 15
Social Determinants of Health (SDOH) 15
Leadership Next Steps 16
Business Model 16
Uses 17
Care Coordination Design 17
Additional Resources 18
Appendix A: Care Coordination Canvas at a Glance 19
Appendix B: Care Coordination Canvas Worksheet 21
Appendix C: Potential Partners Worksheet 27

BACKGROUND

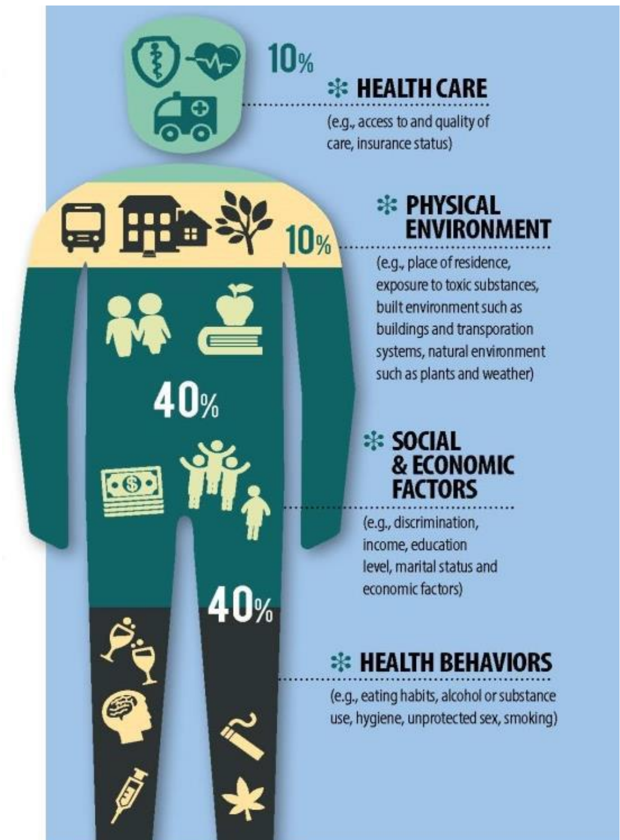
Rural Health Innovations (RHI), LLC, is a subsidiary of the National Rural Health Resource Center (The Center), a non-profit organization. Together, RHI and The Center are the nation's leading technical assistance and knowledge center in rural health. In partnership with The Center, RHI enhances the health of rural communities by providing products and services with a focus on excellence and innovation. RHI is providing technical assistance (TA) to the Rural Health Network Development (RHND) grantees through a contract with the Federal Office of Rural Health Policy (FORHP).

Through RHI's work with the RHND program, and in recognition of the accelerating pace of change in the American health care system in its transition from volume to value-based reimbursement, RHI identified a need to support rural health networks in awareness and understanding of emerging care coordination approach. This guide is designed to assist with the development, assessment and improvement of care coordination programs.

PURPOSE

As federal and state reimbursement for health services shifts from pay for procedures to pay for value, health care organizations are redesigning their service delivery systems to focus on prevention, chronic illness, population health management, quality improvement and cost savings. At the core of these new systems is care coordination.

Care coordination effectively integrates the patient experience across a continuum of services including primary care, hospital, behavioral health, social services, rehabilitation, long-term care and home care. According to multiple research studies, clinical health care is responsible for only about 10 percent of a person's health outcomes, as seen in the graph to the right. Environmental, social and life style factors have an even greater effect.



Statistics from: Booske, B. C., Athens, J. K., Kindig, D. A., Park, H., & Remington, P. L. (2010).
Image from: http://ww.naco.org/sites/default/files/documents/Social Determinants of Health.pdf

Care coordination provides a team-based, integrated approach to population health management; this approach systematically addresses many of the factors that affect health outcomes. In the new value models, care coordination is key to both successful patient care outcomes and financial success.

The purpose of this guide is to help teams and partners conducting care coordination develop an effective program. The tool is also valuable to evaluate current efforts and make improvements.

GETTING STARTED

In order to create a care coordination approach that will help meet the goals set out for improved population health, we must understand all the factors that create health.

Definitions of Health

Health

The World Health Organization defines health as:

> "…a state of complete physical, social and mental well-being, not merely the absence of disease or infirmity."

Source: Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946: signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

Physical Health

> "Health is a state of being associated with freedom from disease and illness that also includes a positive component (wellness) that is associated with a quality of life and positive well-being."

Source: (Corbin & Pangrazi, 2001).

Social Determinants of Health

> "The conditions and circumstances in which people are born, grow, live, work, and age. These circumstances are shaped by a set of forces beyond the control of the individual: economics and the distribution of money, power, social policies, and politics at the global, national, state, and local levels."

Source: (World Health Organization [WHO] and the Centers for Disease Control [CDC], adapted)

In care coordination planning, we need to incorporate how to address the Social Determinants of Health (SDOH) that directly impact a given community and the person whose care is being coordinated.

Mental Well Being

> "Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."

Source: (World Health Organization [WHO], 2014).

Definitions of Care Coordination

Many definitions of care coordination exist. Below are three definitions that RHI uses in our work.

1. Community-based and integrated primary care, behavioral health, oral health, local health and community resources to provide **person-centered**, coordinated **services**.

Source: Rural Health Innovations (RHI), National Rural Health Resource Center, Duluth, MN.

2. An opportunity to supplement the diagnosis and treatment priorities of medicine with **clinical and non-clinical** prevention and management in a system that also supports the **social aspects** of patients' lives that contribute to health.

Source: Rural Policy Research Institute (RUPRI) – Care Coordination in Rural Communities: Supporting the High Performance Rural Health System, June 2015, p. 2)

3. Provide information to clinicians to share and provide next care steps in diagnosis and treatment. It assures the patient is in an **appropriate care** setting as they transition across settings.

Source: Certification Commission of Health Information Technology (CHHIT) - A Health IT Framework for Accountable Care, June 6, 2013.

Though these three definitions come from very different foundations, they have similar points and/or meanings. The first definition is community based, the second definition is clinical-based and the third definition is from an information technology perspective. They exist at the patient or person level, include clinical and non-clinical services and discuss care across settings. To effectively create a care coordination model to impact and improve care, it must have a wholistic person-centered approach.

A few definitions that are used within this document that we'd like to highlight and discuss include:

Person-centered: refers to an individual person rather than a patient.

Services: In the first definition, outlined by RHI, rather than use the word "care", implying a more clinical definition, the word "services" is utilized. Care coordination is about coordinating the services, often beyond clinical walls, that lead to or help improve the care outcomes with the person.

Clinical and non-clinical: Care coordination is an opportunity to blend both the clinical and non-clinical together. Coordinating care is about making sure the diagnosis and treatment priorities of medicine are adhered to but supplemented with non-clinical prevention and management opportunities. Care coordination also supports the social aspects of patient' lives that contribute to health.

Appropriate care setting: utilizing a wholistic approach and identifying a person's physical and social needs will help identify what the appropriate level of care setting is necessary for them.

CARE COORDINATION CANVAS COMPONENTS

Target Population: Improving the health and care while reducing costs for a specific group of people.

Assessment: A tool or survey used by the care coordinator to assess a person's level of need for services and coordination.

Care Plan: A person-centered, individualized plan of care that is developed with the person/caregiver and providers to identify the person's strengths in meeting their identified needs and while creating an approach to meet their needs.

Care Team: A team of interdisciplinary providers identified with the person and/or caregiver that represents the clinical, behavioral and oral health, social services, long-term care and community resources needed to help meet the goals and outcomes of the person.

Other Considerations: Each of the above components has aspects of four more elements: communication, technology, collaboration and SDOH. An organization or network must consider leadership development and the business model for care coordination.

Target Population

Target population is about improving the care, health and reducing costs for a specific group of people. Specific is the key word. It's important to have a measurable and clearly defined goal, or outcome.

Example*: Decrease Emergency Department (ED) usage and hospitalization of high-risk seniors with complex chronic disease who overuse hospital care because of poorly managed chronic disease.*

In this example, the target population is seniors with chronic conditions who are high utilizers of ED and often hospitalized. This description population is too broad and does not define, seniors, the diagnoses or what 'overuse' is.

A more specific description is: *Seniors age 65 and older with diabetes and congestive heart failure who have utilized the emergency department five or more times in the past three months.*

In this example, the goal of target population is to decrease ED utilization for this population through better identification of triggers of ED visits and addressing those triggers through increased outpatient coordinated care.

A part of defining the target population is to determine what are the major SDOH for this population. Taking time to do a quick scan of the environment will help determine necessary partners to meet those needs and effectively "move the needle" on health. Discovered SDOH will inform the assessment tools, care plan and care team members.

There are some specific ways to help identify the SDOH and narrow a population. The method(s) chosen depends on what is available to review. These methods include:

- Community Health Needs Assessments may be used to gain insights:
  - On perceived barriers to care
  - From secondary data analysis that will provide information on social determinants of health, prevalence of chronic disease
  - On community priorities
- Clinical Data from Electronic Health Records (EHR) can identify:
  - High utilizers of the Emergency Department
    - Admit diagnosis
    - Age
  - Readmissions diagnosis
  - Other disease specific information
- Payer Claims Data can identify:
  - High utilizers of ED and hospitalizations
  - Disease specific information
  - Other data as appropriate

Once the target population and data source are identified depending on the form, the individuals in that population can be identified from or referred by

- Community partners such as:
  - Public Health
  - Schools
  - Social services
  - Faith Communities
  - Community Organizations and etc.

- Clinical Partners such as:
    - Hospitals
    - Clinics
    - Specialty Care Providers
    - Etc.
- Registries

Communication and technology are an integral part of working effectively with the target population. Please see the details of these two components later in this guide.

Assessments

An assessment is a tool, or survey, used by the care coordinator to assess a person's level of need for services and coordination. When identifying the target population, reflect and ask, "Is an assessment needed?" If the target population is generalized, such as Medicare or Medicaid, an assessment may help determine the level of or type (in person, telephonic) coordination needed.

Assessments can help determine the level of the person's:

- Social, environmental, mental health, physical and psychosocial functional needs
- Risk or severity level of a diagnosis and/or disease

Examples of types:

- Prepare Tool -The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) is a national effort to help health centers and other providers collect the data needed to better understand and act on their patients' SDOH.
    - http://nachc.org/research-and-data/prapare/
    - http://nachc.org/research-and-data/prapare/toolkit/
- EHR assessment form– incorporate a questionnaire/survey that addresses or asks questions related to SDOH. For example, language preference, education level, living location etc…
- ACO – Assessment tools developed by the ACO to identify SDOH and specifics around a medical condition relating to potential risk for or severity of a medical condition.

The previous listed assessments include social issues and cognition. Examples that are more clinical focused include:

- EHR assessment form – incorporate a questionnaire/survey that addresses or ask questions related to levels of severity around a disease or diagnosis classification
- PHQ - 9 – Depression
- Asthma
- Falls Risk Assessment
- LACE - Hospital readmission score
- Community Health Workers often use assessments around chronic conditions: Stanford Chronic Disease Self-Efficacy, General Self-Efficacy, PHQ-9, Health Care Utilization Screen

Communication and technology are an integral part of assessments. Please see the details of these two components later in this guide.

Care Plan

A Person-Centered Care Plan is an individualized plan of care that is developed with the person, their caregiver and provider(s) to identify the person's strengths in meeting their identified physical, mental health and social needs and create an approach to ensure they are met.

The holistic approach should include goals or outcomes stated from the person's perspective. Guidance, instructions and interventions in achieving the goals and outcomes are a component as well. It is essential to include clinical needs such as medications, treatment or care, advance directives, preventive care needs and disability status. Social Needs such as transportation, food assistance, adult or child protection, and guardianship should also be included in the care plan. It is helpful to include the person's demographic information such as: living arrangement (where do they live- nursing home, foster or group home?) language and/or cultural specific needs, and if necessary, need for an interpreter.

In addition, the standard information such as date of birth, contact information, insurance carrier, and contact information for the Care Team Members.

Communication and technology are a very important part of the care plan. Please see the details of these two components later in this guide.

Care Team

A Care Team is defined as a team of interdisciplinary providers identified with the person and/or caregiver that represents the clinical, behavioral and oral health, social services, long-term care and community resources needed to help meet the physical, mental wellness and social goals and outcomes of the person.

An interdisciplinary approach is crucial for meeting the needs of the person. Interdisciplinary means representatives from both the medical community, behavioral health and community organizations. For example:

- Representatives of clinical or physical needs are different for each person and may include:
  - Primary Care Providers
  - Specialty Care Providers
  - Behavioral Health
  - Long Term Care
  - Home Health
- Inclusive of community organizations such as, but not limited to:
  - Social Services
  - Public Health
  - Transportation
  - Faith Communities
  - Volunteer organizations
  - Housing organizations
  - Schools
  - Business entities

The care coordinator is generally the primary contact to assist the person and convener of the team. It is important that a person on the team be designated to fulfill the communicator and convener role. The coordination will help ensure that all team members are working at the top of their license. The care coordinator can come from many disciplines including:

- Community Health Worker
- Social Worker or Social Service
- Nurses
  - Registered Nurse,
  - Public Health Nurse,
  - Licensed Practical Nurse
- Physician Assistant

- Nurse Practitioner
- Certified Medical Assistant
- Community Paramedics

Identifying work flow, or the communication process, is significant part of care team considerations, clearly articulating each individual team member's role. Ensure to document these identified roles and tasks. If there are multiple 'care managers', this important step helps to decrease the likelihood of duplication. An individual could have multiple case managers or coordinators from several organizations such as: county case manager, payor or a Patient Centered Medical Home.

Ultimately, the end result of the work flow will help identify how the Person-Centered Care Plan is designed, stored, shared and updated moving forward. The hand-offs and communication must be identified and documented throughout the process of coordination. This will allow and provide status updates, medical and/or social changes from those interacting with the person whose care is being coordinated to the rest of the team.

Establish Care Team meetings to discuss the patient's needs updates, and to ensure the coordination supports the work flow while including problem solving. Considerations for Care Team meeting include: frequency & format, in person, webinar or telephonic. Being intentional is imperative.

Communication

An element of each component is communication. The intentionality of answering questions for each quadrant will establish communication that effectively supports the workflow or the care coordination efforts. The following chart reflects those communication elements to consider.

Communication Questions to Answer	
Target Population • How will you communicate with and engage the person? • By phone; in-person; a combination? Where will it take place? • How often will it happen?	**Assessment Tools** • How will the results be communicated? • Where will it be stored? • Do the results need to be shared with the Care Team? • Do they help identify members of the Care Team? • Can the results be used for evaluation and measurement?
Care Plan • How will the Care Plan be created and communicated with the person and include the Care Team? • How will updates be completed and shared?	**Care Team** • How will the Care Team communicate with the person, coordinator and amongst themselves?

Technology

Technology is core element of all components. The intentionality of answering questions for each quadrant will assure optimal use of technology that effectively supports the care coordination effort. The following chart reflects technology elements to consider.

Technology Questions to Answer	
Target Population • How will it be used to identify the target population? • How will it be used to communicate to persons in the target population? • How will staff gather and use information? • Will secure messaging or portals be used?	**Assessment Tools:** • Will the tools be electronic? • Will they be stored electronically, web based and saved in EHRs? • Will secure messaging or portals be used?

Technology Questions to Answer	
Care Plan	**Care Team**
• How will it be used to perform these functions? • Will EHRs, secure messaging or portals be used? • Where will it be stored?	• How will it be used to perform these functions? • Will EHR, secure messaging, portals, phone or video conferencing be used?

Collaboration

Collaboration makes care coordination successful. An intentional effort in recognizing the partners or stakeholders needed to successfully implement the care coordination efforts, must be made. Please reference the Potential Partners Worksheet, included in Appendix C, to help you through this process. This worksheet includes details such as: partner organization, representative, role in partnership, contribution, messaging to engage partner, communication methods and person delivering message. Perhaps, a different set of partners, depending upon the segments of the selected target population, will be identified.

Social Determinants of Health (SDOH)

As stated previously, Social Determinants of Health are the conditions and circumstances in which people are born, grow, live, work, and age. These circumstances are shaped by a set of forces beyond the control of the individual: economics and the distribution of money, power, social policies, and politics at the global, national, state and local levels. (World Health Organization and the Centers for Disease Control [adapted]).

SDOH exist as a foundational element to your care coordination efforts. Knowing that the SDOH for the target population will directly impact the scope of and information gathered in the assessment, it is important to determine the factors outside the clinical aspects impacting the population. The elements included in the care plan and members of the care team are impacted by the SDOH.

For example: Assessment may include items about food availability, buying habits, program enrollment and transportation. One of the major SDOH for a diabetic population in a region is a food desert and food insecurity. The care plan would include elements of food assistance and perhaps

transportation. The care team would possibly include a representative from the local foodbank or an assistance navigator.

Leadership Next Steps

Leaders of the care coordination effort must constantly consider what steps need to be completed to promote and further the efforts ultimately leading to achievement of the intended outcome(s). Some promotion tactics are:

- Develop advocates within the community.
- Implement community education through information meetings.
- Hold focus conversations to learn how to better promote the care coordination in the partner organizations, along with the community as a whole.
- Use the Care Coordination Canvas Tool to evaluate efforts and make any necessary changes.

Intentional efforts must be made by leaders to keep moving the care coordination efforts to the next level.

Business Model

Care coordination is a long-term endeavor and one that warrants long-term sustainability. When embarking on care coordination development, the business model must be considered. What are the funding mechanisms, the financial revenue that assists in covering the expenses of managing and providing care coordination for continued sustainability? Options for funding mechanisms include:

- Grants
- Payor Models:
  - Medicare
  - Medicaid
  - Commercial
  - ACOs
- Reimbursement:
  - Per Member per Month (PMPM)
  - Capitated Fees Population based payments

Some potential business models are:

- Community mental health
- Primary care integration

- Health plan or payor based
- Provider based

Uses

The Care Coordination Canvas Tool is designed to help create a new care coordination program and to refine mature programs.

- Develop Program: The tool includes things that an organization must consider when setting up a program such as viewing it as a readiness and gaps analysis.
- Evaluation: The tool can be used to identify a problem or used as a yearly evaluation tool.
- Expansion: The tool will help an organization identify needed adjustments and readiness to expand to a new population or payment model.

Care Coordination Design

It is important to pull those who are involved in implementing or refining the care coordination work. Collaboration with partners and/or stakeholders, are needed to successfully implement and provide the care coordination efforts.

ADDITIONAL RESOURCES

National Rural Health Resource Center. Community Care Coordination and Chronic Care Management – Transitioning to Value-based Payments. Retrieved from https://www.ruralcenter.org/srht/rural-hospital-toolkit/community-care-coordination-and-chronic-disease-management

Stratis Health. (2017). Community-based Care Coordination – A Comprehensive Development Toolkit. Retrieved from https://www.stratishealth.org/expertise/healthit/carecoord/

Rural Health Innovations (RHI) Hub. Care Coordination Tool Kit. Retrieved from: https://www.ruralcenter.org/resource-library/care-management-and-coordination

Rural Health Innovations. Care Coordination Collection. Retrieved from: https://www.ruralhealthinfo.org/community-health/care-coordination

APPENDIX A: CARE COORDINATION CANVAS AT A GLANCE

<table>
<tr><th colspan="4">Care Coordination Canvas Guide</th></tr>
<tr><td colspan="2">1. Target Population: Improving the care, health and reducing costs for a specific group of people.</td><td colspan="2">Assessment Tool(s): A tool or survey used by the Care Coordinator to assess a person's level of need:
• Social, environmental, mental health, physical and psychosocial functional needs
• Risk or severity level of a diagnosis and/or disease</td></tr>
<tr><td>1a. Is it specific enough?
• Clearly define the goal/outcome of the identified problem
• Be specific
• It must be measurable</td><td>1b. How will the target population be identified?
• Community health needs assessments
• EHR data
• Payer claims data
• Population focused
• Registries
• Referrals</td><td>2a. Is one needed?
Commonly, the target population is generally defined. An assessment can help determine the level of coordination needed or what types of services are needed.</td><td>2b. What is the type or how will it be used?
The type used will be determined by your target population and desired outcomes.</td></tr>
<tr><td colspan="2">1c. How will you communicate with and engage the population?
Phone, in-person, a combination. Where will it take place? How often?</td><td colspan="2">2c. How will results be communicated?
Where will it be stored? Do the results need to be shared with the Care Team? Do they help identify members of the Care Team? Can the results be used for evaluation and measurement?</td></tr>
<tr><td colspan="2">1d. How will technology be used to perform these functions?
Technology can be of great assistance to 'mine' data; it can be communicated via secure messaging or portals.</td><td colspan="2">2d. How will technology be used to perform these functions?
The assessment tool can be electronic, web-based and saved in EHRs. It can be communicated via secure messaging or portals.</td></tr>
<tr><td colspan="4">Collaboration – Who are the partners or stakeholders needed to successfully do the care coordination efforts? How are these partners are going to work together?</td></tr>
</table>

<table>
<tr><th colspan="4">Care Coordination Canvas Guide</th></tr>
<tr><td colspan="2">3. Care Plan: An individualized Care Plan is developed with the person/caregiver and providers to identify the person’s strengths in meeting their identified needs; then create an approach to meeting needs.</td><td colspan="2">4. Care Team: Providers identified with the person and/or caregiver that represents the clinical, behavioral & oral health, social services, long-term care and community resources needed to help meet the person’s goals and outcomes.</td></tr>
<tr><td>3a. What approach to developing the Care Plan is being taken, so that it is:
• Developed along with the person
• Based on assessed strengths & needs
• Accounts for medical, behavioral health, wellness and human service’s needs (social determinants)
• Incorporates existing care and treatment plan information</td><td>3b. What is included (components of)?
• Goal or outcome
• Clinical and social needs
• Instructions and interventions
• Interdisciplinary care team members, including contact information
• Person demographics</td><td>4a. Who is the coordinator?
Dependent of the needs of the population & what the focused outcomes are, but can be: Community Health Worker, Social Worker, Nurse, Physician Assistant, Certified Medical Assistant, Physician, Community Paramedic.</td><td>4b. How will you build collaboration with the provider or partners of the Care Team?
Team meetings to effectively build out the work flow. Communicating so each member of the team knows their role, expectations, and hand-offs.</td></tr>
<tr><td colspan="2">3c. How will the Care Plan be communicated to engage the chosen population and include the Care Team?
How will the Care Plan be updated as well as be shared?</td><td colspan="2">4c. How will the Care Team communicate with the chosen population, coordinator and amongst themselves?
This is the workflow. Clearly articulate who does what, when and WRITE it down.</td></tr>
<tr><td colspan="2">3d. How will technology be used to perform these functions?
EHRs, secure messaging, portals</td><td colspan="2">4d. How will technology be used to perform these functions?
EHR, secure messaging, portals, phone, video conferencing.</td></tr>
<tr><td colspan="2">5. Leadership next steps?
• Community coaches
• Develop advocates
• Community education and information meetings
• Focused conversations</td><td colspan="2">6. What is your business model?
• Community mental health
• Primary care integration
• Health plan based
• Provider based</td></tr>
<tr><td colspan="4">Social Determents of Health (SDOH) - The conditions and circumstances in which people are born, grow, live, work and age. (economics and the distribution of money, power, social policies, and politics at the global, national, state and local levels). What are the SDOH that are affecting your Target Population?</td></tr>
</table>

APPENDIX B: CARE COORDINATION CANVAS WORKSHEET

Care Coordination Canvas Worksheet

May, 2018

525 South Lake Avenue, Suite 320 | Duluth, Minnesota 55802
(218) 727-9390 | info@ruralcenter.org
Get to know us better: www.ruralcenter.org/rhi

This is a publication of Rural Health Innovations, LLC (RHI), a subsidiary of the National Rural Health Resource Center. The Technical Assistance for Network Grantees Project is supported by Contract Number HHSH250201400024C from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Federal Office of Rural Health Policy.

TARGET POPULATION

<table>
<tr><td>1a. What is your target population?</td><td>1b. SDOH Population</td></tr>
<tr><td>1c. Is it specific enough? Further refine if needed.</td><td>1d. How will the target population be identified?</td></tr>
<tr><td colspan="2">1e. How will you communicate with and engage the individual(s)?</td></tr>
<tr><td colspan="2">1f. How will technology be used to perform these functions?</td></tr>
</table>

ASSESSMENT TOOLS

2. What Assessment Tool(s) is your organization using?	
2a. Is one needed?	**2b. What is the type or how will it be used?**
2c. How will you communicate the results to who needs it? Store it?	
2d. How will technology be used to perform these functions?	

CARE PLAN

<table>
<tr><td colspan="2">3. What is the focus of your Care Plan?</td></tr>
<tr><td>3a. What approach are you taking?</td><td>3b. What is included (components of)?</td></tr>
<tr><td colspan="2">3c. How will the Care Plan be communicated to engage the person and include the Care Team?</td></tr>
<tr><td colspan="2">3d. How will technology be used to perform these functions?</td></tr>
</table>

CARE TEAM

4. Who is part of your Interdisciplinary Care Team?	
4a. Who is the coordinator?	**4b. How will you build collaboration with the provider or partners of the Care Team?**
4c. How will the Care Team communicate with the person, coordinator and amongst themselves?	
4d. How will technology be used to perform these functions?	

OTHER CONSIDERATIONS

5. Collaboration needed of community partners? (Information from the Potential Partners Worksheet)
6. Leadership next steps?
7. What is your Business Model?

APPENDIX C: POTENTIAL PARTNERS WORKSHEET

Segment of Target Population: ____

Potential Partner Organization	Organization Representative	Potential Role in Partnership	Potential Contribution to Partnership	Message to Engage Partner	Method of Communicating Message	Person Delivering Message
School	*Principal Dan*	• *Care Team Member* • *Advisory* • *Taskforce*	• *Referrals* • *Care plan development*	• *Improve low attendance* • *Decrease behavior issues* • *Improve low test scores* • *Reduce teacher stress/burnout*	• *PTSA Mtg* • *Email* • *Phone* • *School Board Mtg*	*Janice*

A Checklist for Organizing Partnership Engagement

- Ask partners to describe what they can bring to the partnership; this is also a way to assess their level of commitment.
- Create a compelling message based on your assessment of the community's need for addressing behavioral health.
- Identify how each partner will benefit from the partnership and how the partnership will benefit from the other's participation. Discuss the consequences and next steps in the event that a particular partner does not want to engage in the partnership.
- Identify how the message should be delivered. You can engage partners through large events, meetings and 1:1 conversations.
- Review the role each organization will play in your partnership.
- Use relevant data to support your partnership and goal while soliciting your partner's engagement. Sharing data that highlights your organizations priorities can effectively mobilize support for this initiative.