Case Studies From the 2017 Care Coordination Comparative Study

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ROLE OF CARE COORDINATION IN TODAY'S HEALTH CARE ENVIRONMENT

Strengthening Care Management exists as one of the key factors within an organization to successfully cross the "shaky bridge" into the new emerging health care environment. It is important to develop care coordination capabilities while redesigning the care process. The focus for care coordination, generally, begins with high cost patients and chronic illness management.

Health care organizations are having to redesign their service delivery systems to focus on prevention, chronic illness management, quality improvement and cost savings. In addition, engaging and enlisting partnerships with patients and their families is vital when moving toward population health.

Through Rural Health Innovation's (RHI) work with the Federal Office of Rural Health Policy (FORHP), Rural Health Network Development (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 models.

In 2017, RHI identified rural health networks that were implementing successful value-based models and conducted brief interviews and surveys with network leaders. Information from each network was transposed into individual Care Coordination Canvases to illustrate the network implementation and coordination initiatives. These are located in this document.

Approaches

The 2017 study revealed four basic approaches, or models, of care coordination. These approaches include:

- **Care Coach:** may be based in the community or in a clinical setting and is focused on transitions of care
- **Clinical**: an approach that is generally housed in a hospital or clinic setting

- **Community Health Worker:** an approach that is generally based within the community or public agencies
- **School-Based**: efforts either include a school clinic or close relationship between a school system and clinic

The following chart identifies characteristics at a high level for each approach. For details please see the individual case studies included in this document.

<table>
<tr><th colspan="2">Approaches of Care Coordination</th></tr>
<tr><th colspan="2">Care Coach</th></tr>
<tr><td>Target Population:
• Anyone being discharged from the hospital</td><td rowspan="4">Insights:
• Reduce readmissions within 30 days
• Follow for only 30 days
• Improve quality of life for participants
• Work with person to do their own interventions
• Workforce: needs to be trained as a Care Transitions Coach®
• “Personal Health Record”
• Need to show cost avoidance or return on investment</td></tr>
<tr><td>Assessment Tools:
• Patient activation assessment
• Medication reconciliation</td></tr>
<tr><td>Care Plan:
• Use of CTI ® “Personal Health Record”</td></tr>
<tr><td>Care Team:
• No formal care team</td></tr>
<tr><th colspan="2">Clinical</th></tr>
<tr><td>Target Population:
• High health care utilizers</td><td rowspan="4">Insights:
• Quality metrics
• Reimbursable services
• Workforce- most commonly professional
• Works toward connecting with needed services to assure health outcomes
• Generally, work in the clinical setting
• Works with the person until stable and goals met</td></tr>
<tr><td>Assessment Tools:
• Clinical
• Health risk assessments</td></tr>
<tr><td>Care Plan:
• Formal medical interventions
• Social Determinants of Health (SDOH)</td></tr>
<tr><td>Care Team:
• Primarily clinical staff
• Reaches to connect with community services</td></tr>
</table>

<table>
<tr><th colspan="2">Approaches of Care Coordination</th></tr>
<tr><th colspan="2">Community Health Worker</th></tr>
<tr><td>Target Population:
• Chronic conditions
• High ED utilization</td><td rowspan="4">Insights:
• Goes into the community and the home
• Focuses on what person’s goals are
• Empowers and walks along-side
• Self-efficacy focus
• Helps person overcome barriers
• Workforce- a person from the community
• most commonly not professionally trained as a Community Health Worker (CHW)
• Works with them until all goals or pathways are met
• Needs to show cost avoidance or return on investment</td></tr>
<tr><td>Assessment Tools:
• Intake assessment
• Self-efficacy</td></tr>
<tr><td>Care Plan:
• Focus on what person wants to achieve
• Pathways</td></tr>
<tr><td>Care Team:
• Informal
• As needed to achieve goals</td></tr>
<tr><th colspan="2">School-Based</th></tr>
<tr><td>Target Population:
• School age children needing medical attention
• High absentee rate due to chronic condition</td><td rowspan="4">Insights:
• Two Approaches
  ○ Link to clinic
  ○ Observe provider via telemedicine, from school location
• Address chronic conditions as a team with school staff
• Parental Consent
  ○ Contact parents and help them make an appointment
  ○ Walk student to tele-medicine equipment for them to see the doctor
  ○ Follow-up for student/parent
• Financial
  ○ Return on investment for schools and clinics</td></tr>
<tr><td>Assessment Tools:
• Determined by mental or physical condition</td></tr>
<tr><td>Care Plan:
• Chronic care management
• Episodic</td></tr>
<tr><td>Care Team:
• School health clinic personnel
• Provider</td></tr>
</table>

Lessons Learned

Some key insights from the 2017 study are inclusive of all parts of the canvas. These insights ranged from communication, to process, to canvas details. Things that those implementing care coordination would like to pass on to others are:

- Communication: intentionally “toot your horn”
- Continue to “build the plane as you fly”
- Process: foundation to continue to build on
- Don’t forget about the care plan and care team
- Collaboration: don’t assume you can relax
- Champions: keep finding them
- Remember, there is a lot that goes on outside the four walls of the clinic or hospital- the 80%
- Push forward with Technology

<table>
<tr><th colspan="4">CARE COORDINATION CANVAS: Care Coach Approach A</th></tr>
<tr><td colspan="2">Organization:
Rural Health Network
SC</td><td colspan="2">Aim of Care Coordination:
Better quality of life for the patients and better utilization of medical care. Increase Primary Care utilization, improve medication compliance, increase routine exams and improve the health of the population served. Avoid preventable readmissions.</td></tr>
<tr><td colspan="2">Contacts:
Network Director</td><td colspan="2">Partners:
Three regional hospitals</td></tr>
<tr><td colspan="2">Target Population:
• Diabetics, COPD, CHF, pneumonia and AMI
• Higher utilizers and / or 30 day readmits
• Over 18 years of age</td><td colspan="2">Assessment tool(s):
• Patient Activation Assessment; created by Dr. Eric Coleman
• Medication reconciliation</td></tr>
<tr><td>History of Target Population:
Begin with just Diabetes. As more Care Transition Coaches were trained and hospitals have identified other areas the target population has expanded. Each location has a target population mix unique to them.</td><td>Target population is identified by:
• Medical Records
• Referrals from the inpatient floor
• Discharge planners/case managers</td><td>Administered by:
In-person by Care Transitions Coach®</td><td>Stored in:
• Excel Spreadsheet
• Coach personal notes</td></tr>
<tr><td colspan="2">Engaging the person:
Once the person is identified as eligible, a care transitions coach visits them in the hospital, explains the program and confirms they are willing to participate in it.</td><td colspan="2">Communication of assessment to care team members:
The Green Book: Personal Health Record</td></tr>
<tr><td colspan="2">Use of technology:
Email</td><td colspan="2">Use of technology:
PC – Excel</td></tr>
</table>

CARE COORDINATION CANVAS: Care Coach Approach A

Care Plan:
Is developed with the individual during the in–home visit

Interdisciplinary Care Team:
- Care Transitions Coach® (Team Lead)
- Case Managers from the discharging hospital
- Other medical and community members based on personal goals developed with person

Social Determinants of Health Determination:
- In-person interviews
- Motivational interviews

Components included:
- The “Green Book” – personal health record
- Goals/outcomes, clinical needs
- Instructions/interventions
- Care team names

Care Team Meetings:
The Care Transitions Intervention® (CTI) model does not have a formal care team. The coach is brought up to speed on the needs of the persons often by a case manager.

Building Collaboration:
- Case manager at daily interdisciplinary meetings aka huddles
- Remain in contact with provider’s office and educate them on program
- Meet with and help the home health division understand the program

Care team communication with the person, coordinator and amongst themselves:
This model includes a booklet for the patient to keep track of their own personal health record and is encouraged to bring it to all appointments. Transitions Coach® engages the individual in-person and through the phone. An initial in-person meeting in the hospital (5 – 10 min) followed by a 90-min in-home meeting. Then at least 3 follow-up phone calls of approximately 15 minutes each.

Use of technology:
PC – Word

Use of technology:
- PC – Word, Excel
- Phone

Persons Experience:
Once the Care Transitions Coach® receives the referral, the person is visited in-person by the coach. Most often in their hospital room before discharge. The coach explains the program by use of a flyer and the “Green Book” (personal health record). They are told about setting personal goals and how the Green Book helps guide their way to better health along with the 30-day follow up period. At this point the person is given a choice to participate or not.

Once in agreement to participate, an appointment is made to do a home visit within 72 hours of discharge. This home visit can take up to 90 minutes. During this visit, personal goals they would like to achieve in the next 30 days are established and written in the

<table>
<tr><th colspan="2">CARE COORDINATION CANVAS: Care Coach Approach A</th></tr>
<tr><td colspan="2">Green Book. All their medications are looked at, recorded in the Green Book and checked for polypharmacy. Discharge papers are reviewed to make sure the person is compliant and has set up an appointment with their provider. Questions for provider are written in the Green Book. Warning signs of condition getting worse are reviewed and an action plan established if that happens.

The person will receive three calls over the next 30 days as to how they are progressing on their personal goals and to answer any other questions.</td></tr>
<tr><td>Financial Model:
Grant funding has helped initially get the Transition Coaches® trained and in their positions. Our goal is that at the end of the grant, the statistical data will be reviewed by the hospital and they will see the benefits of CTI, so that they will incorporate this into their hospital (In-Kind contributions by partners) and keep the program growing.</td><td>Coordination Model:
Care Transition Intervention®</td></tr>
<tr><td>Communication Strategies:
On the agenda for the monthly network board meeting as well as other health related meetings. The hospitals discuss it regularly in their staff meetings. Network PSAs and press releases.</td><td>Technology Strategies:
The use of an Excel spreadsheet that is shared.</td></tr>
<tr><td>Lessons Learned:
• If the Transitions Coach® does not wear other hats within the organization, they are much more effective at their job.
• Have the coach’s supervisor trained so that person can be a champion</td><td>Evaluation – Process/Impact:
• Number not re-admitted to the hospital in the first 30 days
• Number re-admitted to hospital
• Number that have declined the program
• Patient Activation Assessment Scores
• Customer satisfaction</td></tr>
</table>

<table>
<tr><th colspan="2">CARE COORDINATION CANVAS: Care Coach Approach B</th></tr>
<tr><td>Organization:
Rural Health Network
AL</td><td>Aim of Care Coordination:
To reduce readmissions in these patient populations. Educate patients about red flag or warning signs that their condition is worsening and ensure each patient has an action plan. Conduct medication reconciliation with patients on home visits. Ensure patients have a follow up appointment with their primary care physician. CHF patients are referred to a nurse practitioner in the Diagnostic and Medical Clinic cardiology group for outpatient CHF clinic visits. These appointments can be conducted via telemedicine to address issues with transportation or finances that may create a barrier for a patient getting access to care.</td></tr>
<tr><td>Contacts:
Care Coordinator, Community Outreach</td><td>Partners:
Hospital
Diagnostic and Medical Clinic
Apria Healthcare
Community outreach organizations that serve COPD and CHF clinics
Community outreach to provide education to all tobacco/nicotine users
Social Workers</td></tr>
<tr><td>Target Population:
COPD and CHF
NICOTINE/TOBACCO USERS</td><td>Assessment tool(s):
Patients are screened to learn the following:
current reason for admission
symptoms
compliance with medications
follow up appointments with primary care</td></tr>
</table>

CARE COORDINATION CANVAS: Care Coach Approach B

History of Target Population:
The original target population was COPD. The numbers rise in the fall through the winter. Overall the number of persons effected with COPD continues to grow. Tobacco and nicotine continue to contribute to the increase in readmissions and now we provide The FFS Class teaching the ALA guidelines to help QUIT tobacco/nicotine.
CHF is a growing need and has been included in the care coordination program due to the access to a CHF outpatient clinic using telemedicine

Target population is identified by:

- EHR
- Medical Records
- Referrals

Administered by:
Care Transition Coach®

- inpatient consults (30 minutes)
- home visits (1-2 hours)
- ongoing 30 Day monitoring

Stored in:

- EHR and paper
- MIDAS\EPIC

Engaging the person:
An appointment is set up with the person to develop a self-directed care plan. The person is followed up with for 30 days. If the person's family members are visiting when the benefits of the Care Transitions Intervention® is explained, they are asked to be included in home visit. Family members are encouraged to take part in the process, especially the ones that live with the patient. It is important the patients support systems understand the disease and including them in the education can improve outcomes for success.

Communication of assessment to care team members:

- Reports at regular rounding's
- Reports at readmission meetings.
- MIDAS – EPIC -electronic health record

Use of technology:
EHR

Use of technology:
EHR, MIDAS, EPIC

<table>
<tr><th colspan="4">CARE COORDINATION CANVAS: Care Coach Approach B</th></tr>
<tr><td colspan="2">Care Plan:
Developed with the patient, based on their individual needs and what they desire to accomplish. The patient fills in their “Personal Health Record Booklet” with assistance. Many patients struggle with literacy in this rural population.</td><td colspan="2">Interdisciplinary Care Team:
• Care Transition Coach® lead
• Social Worker
• Nurse Practitioner
• Respiratory care</td></tr>
<tr><td>Social Determinants of Health Determination:
Electronic Health Records,
In-person interviews,
Phone interviews</td><td>Components included:
• In the Personal Health Record: Demographics of individual Goals/outcomes,
• Clinical needs,
• Instructions / interventions,
• Medication Reconciliation
• Social needs
• Care team members</td><td>Care Team Meetings:
Patients are evaluated in rounding meetings with all members of the clinical care team present. The Care Transitions Coach® works directly with the person.</td><td>Building Collaboration:
• Participating in rounding’s
• Participate in the monthly re-admission meetings.
• Select and refer COPD patients for the NIV Apria evaluation</td></tr>
<tr><td colspan="4">Care team communication with the person, coordinator and amongst themselves:
Person: Their Personal Health Record. Phone calls. Home visit with the Care Transition Coach®, telemedicine
Coordinator and team: Direct Messaging, MIDAS, EPIC, EHR, telemedicine</td></tr>
<tr><td colspan="2">Use of technology:
MIDAS, EPIC, Phone, Direct Messaging, telemedicine</td><td colspan="2">Use of technology:
Direct messaging, MIDAS, EPIC, EHR, telemedicine</td></tr>
<tr><td colspan="4">Persons Experience:
While the person is in the hospital, the Care Transitions Coach® would visit and explain the program and have the person sign a consent form. This initial visit to the hospital room is about 30 minutes. This will be followed by the home visit which is normally about an hour but it can run up to two hours. This depends on that patient's education or literacy level and how involved that patient is and how many medicines they take. We create a personal health record at the home visit that is six pages. We put all that patient's pertinent medical information in there and that's something that they keep, they take to their follow up appointments, they take to any physician that they see, anything medical-wise they're supposed to take that with them.</td></tr>
</table>

CARE COORDINATION CANVAS: Care Coach Approach B	
Financial Model: Originally grant funded with the goal of proving to hospitals the saving they can experience of uncompensated care costs. That the Care Transitions Coach® will pay for themselves.	**Care Coordination Model:** Care Transition Coach® working with person to set goals (may or may not be health goals) that directly affect their health. Then follow up on progress.
Communication Strategies: Reporting at the readmission committee the work done with 'frequent flyers' brings awareness of the CTI® program. Regular discussions with the director of nursing or one of the other case managers also tell the story of the CTI® program.	**Technology Strategies:** Telemedicine for CHF patients, direct EPIC HYPERSPACE MIDAS
Lessons Learned: Have a better understanding of what computer programs and technology might be helpful--to make the everyday job easier	**Evaluation – Process/Impact:** • Number of program participants • Number of potential participants • Number completed the 30-day post-discharge program without readmission • Number of program participants readmitted in the 30-days • Number that decline program when offered to them • Number that agreed in-patient and decline post discharge • Number ineligible with in the target population

<table>
<tr><th colspan="4">CARE COORDINATION CANVAS: Clinical Approach A</th></tr>
<tr><td colspan="2">Organization: Community Care Alliance
Rural Clinical Network
CO</td><td colspan="2">Aim of Care Coordination:
To coordinate care for the top 10% of ACO’s highest cost, highest utilizing, highest risk patients, Medicare beneficiaries by:
• Increase Primary Care utilization,
• Improve clinical outcomes,
• Improve the health of the population served,
• Improve quality of care,
• Decrease total cost of care - receive CMS Shared Savings</td></tr>
<tr><td colspan="2">Contacts:
Director of Care Coordination and Quality</td><td colspan="2">Partners:
• Behavioral Health
• Clinics
• Emergency Services
• Home Health
• Hospital
• Long-term care</td></tr>
<tr><td colspan="2">Target Population:
Highest Risk (top 10%) - high cost/high utilizing Medicare Beneficiaries</td><td colspan="2">Assessment tool(s):
Medicare health risk assessment
eCW/CCMR (Care Coordination Medical Record) - ACO developed care plan templates</td></tr>
<tr><td>History of Target Population:
The ACO practices are finding the top 10% to be a manageable number to get the program off the ground and process in place. As the practices become confident in this number they then can begin expanding amongst the Medicare Beneficiaries or expand to other high utilizers. Increasing their numbers as they are comfortable.</td><td>Target population is identified by:
Payer reports
EHR</td><td>Administered by:
Depends on the practice workflow - generally they will be done in person</td><td>Stored in:
Web based
Centralized data base; CCMR</td></tr>
</table>

<table>
<tr><th colspan="4">CARE COORDINATION CANVAS: Clinical Approach A</th></tr>
<tr><td colspan="2">Engaging the person:
In person and telephonic
If person choses, care givers are involved in planning</td><td colspan="2">Communication of assessment to care team members:
HIE: eCW/CCMR</td></tr>
<tr><td colspan="2">Use of technology:
EHR and data mining of pay reports</td><td colspan="2">Use of technology:
eCW/CCMR and eCW Financial/Analytics Platform -
care plans, clinical quality measures and claims data</td></tr>
<tr><td colspan="2">Care Plan:
Care Plans are developed with the individual, based on their needs, clinical and beyond. The whole person is considered.</td><td colspan="2">Interdisciplinary Care Team:
This will vary on the practice (individual ACO member) -
All care teams include a provider and care coordinator.
Case Managers
Clinical care teams</td></tr>
<tr><td>Social Determinants of Health Determination:
This depends on the practice workflow - currently utilizing CCMR and primarily in-person encounters</td><td>Components included:
Demographics of individuals Goals/outcomes
Clinical needs
Instructions / interventions
Care Team names
Social needs
Clinical interventions and instructions are limited and dependent on the scope/licensure of the care coordinator. CCMR care plans are for the purposes of care coordination and therefore content is heavily weighted to non-clinical needs such as the social determinants of health.</td><td>Care Team Meetings:
Case Managers are often huddling with care coordinators.
Care Coordinators are regularly huddling with clinical care teams.
If the care coordinator is embedded in the practice, a huddle is easy, in the morning, to huddle on any persons who are coming in who may also be receiving care coordination. If the care coordinator isn't embedded in the practice, the process is to have a face-to-face with the provider once a week for those receiving care coordination.</td><td>Building Collaboration:
A lead from every hospital is part of the care coordination training
Both hospital and practice representation at any networking meetings
Embrace those that are already partnering and keep them talking
Let natural process and workflows happen
Care coordinators coming together at a regional level</td></tr>
</table>

CARE COORDINATION CANVAS: Clinical Approach A

Care team communication with the person, coordinator and amongst themselves:
Face-to-face appointment with the care coordinator to work on community needs, then follow up either by phone or by face-to-face. That first appointment is encouraged to be face-to-face, but after that, a virtual visit on a phone or through a patient portal, if they were utilizing that in their own EMR< is acceptable. Often the care plan is printed and handed to the person for their reference. The documentation would then be done in the centralized database (CCMR). The care plan becomes part of the person EMR. Plans to expand to phone communication to electronic to pharmacy and social services.

Use of technology:	**Use of technology:**
Care Plan Templates from eCW/CCMR and eCW Financial/Analytics Platform - care plans, clinical quality measures and claims data	eCW/CCMR and eCW Financial/Analytics Platform - care plans, clinical quality measures and claims data

Persons Experience:
If you were eligible, you would be notified to come in for your annual wellness visit. During that visit, the provider would introduce the care coordination program and encourage you, as a beneficiary, to take advantage of that. If the care coordinator is embedded in the practice, which in a lot of cases they are for our ACOs, the care coordinator might meet with you that day just to introduce themselves and to set up a follow-up appointment.
The follow-up appointment would consist of another health risk assessment that is very focused on the social determinants of health and some of the factors that might be impacting your clinical health but that are social in nature. This meeting with the care coordinator might take up to an hour, just identifying the things in the person's life like transportation, issues with understanding medications or access to medications, nutritional status, things like that. The care coordinator isn't addressing any kind of clinical interventions. They're really focusing on all those social needs and helping them get connected out in the community with potential services. Action plans that are developed during this first visit might very well have some sort of non-clinical goals: like walking or nutritional goals.
After the initial face-to-face appointment and the care coordinator was able to work on some of those community needs, they would follow up with the person either by phone or by face-to-face. We encourage that first appointment to be face-to-face, but after that, we recognize that a virtual visit on a phone or through a patient portal, if they were utilizing that in their own EMR< is acceptable, but the documentation would then be done in the centralized database.
There would be follow up until the provider, the care coordinator, and the person felt that they had met their goals and that they were able to sustain on their own.

CARE COORDINATION CANVAS: Clinical Approach A

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Financial Model:

- ACO Investment Model Funding (AIM)
- Annual Wellness Checks
- There are fees for Hospitals.
- There are no fees for the primary care practices
- Chronic Care Management (CCM)
- PCM Codes
- Transitions of care and the advanced planning codes.

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Care Coordination Model:

- ACO
- Clinical
- Care Coordinators range from Medical Assistants to RN's, LPN's, to PA and NP

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Communication Strategies:
Intentional meetings with commercial payers and those with other programs/grants working in communities. Try to make our presence well-known to other entities within the community, be involved. A monthly newsletter that goes out to all the provider champions, project managers, and care coordinators. Available to CEO's when they need information or present to a board at any time about the ACO.

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Technology Strategies:
eCW/CCMR and eCW Financial/Analytics Platform
Created templates for centralize database in CCMR for six of the top chronic conditions. A general template that can used when it falls out of the six and then customize through free text.

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Lessons Learned:

- "In a perfect world, you would love to have six, eight, even 12 months of program building before you launched something. I think building the plane while you're flying it has some advantage in that if something's not working and you must change it, you can at least do it on the fly."
- Probably slow down a bit, we had a very rapid deployment. We put a lot of things out there, including our analytics and care coordination documentation platform at the same time.

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Evaluation – Process/Impact:

- Using a lot of claims data
- Looking at the percent of well visits that have been completed
- Number of care plans do in CCMR
- Are all of care coordinators documenting the CCMR?
- One of our metrics, for success at the end of 2016 was where we were successful in having every care coordinator have three care plans in CCMR
- More subjective at this point, once have hard-and-fast data measures will change

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<table>
<tr><th colspan="4">CARE COORDINATION CANVAS: Clinical Approach B</th></tr>
<tr><td colspan="2">Organization:
Rural Accountable Care Organization
TX</td><td colspan="2">Aim of Care Coordination:
Primary goal is to reduce hospital readmissions, reduce ER use, and to make sure ACO quality metrics are met. A major focus is transition care management; capturing people as they are discharged from the hospital and follow them intensively for 30 days to prevent readmission. The chronic care management program is to reduce ER use, to make sure that people are getting proper preventive care, and to do some health coaching to help them manage their chronic diseases so they are healthier and stay out of the hospital.</td></tr>
<tr><td colspan="2">Contacts: Care Coordinator</td><td colspan="2">Partners:
Clinics
Hospitals</td></tr>
<tr><td colspan="2">Target Population:
Medicare Beneficiaries with Diabetics, COPD, CHF, High Emergency Department utilization</td><td colspan="2">Assessment tool(s):
PHQ-9, Health Risk Assessment
Mini-Cog – when indicated</td></tr>
<tr><td>History of Target Population:
Started with their major chronic diseases; diabetes, heart failure, high blood pressure, and COPD. Discovered renal disease is a big issue in service area, it's secondary to the diabetes. Within this group begin to narrow by looking at high cost, high utilizers, who have a high-risk score. Also, patients that have those chronic diseases that may not be managing well. It's a multi-pronged approach.</td><td>Target population is identified by:
• HER
• Medical records
• Referrals
• Claims data from Lightbeam</td><td>Administered by:
In-person by Care Coordinator</td><td>Stored in:
EHR, Database</td></tr>
</table>

<table>
<tr><th colspan="4">CARE COORDINATION CANVAS: Clinical Approach B</th></tr>
<tr><td colspan="2">Engaging the person:
Initial in-person meeting, then regular touches monthly. Send the message that the care coordinator is here for support and guidance and any expert information that they may need and for us to work together on making this work for them. Distant family is communicated to through email or phone.</td><td colspan="2">Communication of assessment to care team members:
Placed in EHR. Positive results are hand carried to provider same day</td></tr>
<tr><td colspan="2">Use of technology:
EHR, Medical records</td><td colspan="2">Use of technology:
EHR, Lightbeam</td></tr>
<tr><td colspan="2">Care Plan:
Care Plans are developed with the individual based on their needs, clinical and beyond. The whole person is considered.</td><td colspan="2">Interdisciplinary Care Team:
• Primary Care Provider
• NP, RN and other nursing staff
• Office staff
• Home Health
• Hospital Care Management Team
• Specialists</td></tr>
<tr><td>Social Determinants of Health Determination:
• Electronic Health Records
• In-person interviews
• Phone interviews</td><td>Components included:
• Demographics of individual
• Goals/outcomes
• Clinical needs
• Instructions / interventions
• Care Team names
• Social needs</td><td>Care Team Meetings:
The patient care team meetings are informal. Started off having scheduled weekly, 15 minute updates with physicians. As care coordinator and PCP got busier it was hard to keep up with those meetings. Now the PCP's are very open to a quick drop in meeting as needed. When a patient is coming in to the clinic, the provider receives a quick update. Everything that the care coordinator does is charted in the person's record.</td><td>Building Collaboration:
• The personal touch
• Sit down meeting with PCP's
• Met with PCP's nursing staff
• Personal contact has been key in team building.
• It takes time</td></tr>
</table>

CARE COORDINATION CANVAS: Clinical Approach B

Care team communication with the person, coordinator and amongst themselves:
Primary contact is by phone, but in-person whenever possible. One longer personal meeting for care plan development and then periodic face-to-face checks to increase level of trust. Between care team members; Charting in EMR, phone, in person, email. Occasionally a written update about a patient given to a physician. Referrals are a paper documents from physicians. A lot of verbal communication.

Use of technology: Our care plans are access through Lightbeam and EHR.	**Use of technology:** Direct, Fax, HIT

Persons Experience:
A physician referral is made, so the Care Coordinator will see that patient in the clinic and introduce themselves and explain their doctor thinks that they might benefit from our chronic care management program. If the person is interested they are given a little card that is a synopsis of the program as the care coordinator explains the program. They are told that this is a program for people who are managing chronic diseases. Sometimes those can be kind of complicated to deal with; a lot of medications and many doctors that you're managing. What this program does is work with people to help you reach your health goals.
An hour to an hour and a half appointment is set, most commonly held in the clinic. The focuses of this meeting is to understand what the doctor perceives, medication management, greatest personal health concerns and personal goals. A care plan based on those initial concerns to help reach their personal and health goals. This is a service that is covered by Medicare but it does have the same 20% copay that your clinic visit does so there is a monthly charge for the service that I provide and the copay is usually between 8 and 9 dollars but if you have a secondary insurance, it may cover this cost.
There is contact at least monthly over the phone or in-person and the care plan is always being up dated until all goals are reached.

Financial Model: • Medicare reimbursement for transition care management and chronic care management. • Medicare annual wellness visits • Fees are currently paid for through the AIM grant.	**Care Coordination Model:** • ACO • Clinical
Communication Strategies: At Regional meetings for Caravan, TRACO care coordinator monthly meetings, and local steering committee's success stories are shared and notable case management situations are discussed.	**Technology Strategies:** Using Lightbeam for claims data for our Medicare patients from all providers of care. Where appropriate, we use home health monitoring and/or remote patient monitoring (through one of our home health partners) to improve patient outcomes. Lightbeam is used to put data for reporting.

CARE COORDINATION CANVAS: Clinical Approach B	
Lessons Learned: • Round more with the physicians in all the clinics • Trying to have someone physically present in all referral avenues • Set up a tracking mechanism early • Take Clinical Health Coach Training (Iowa Chronic Care Consortium). It has been invaluable to understanding care coordination role.	**Evaluation – Process/Impact:** • Tracking interactions with persons • Re admits • Transfers to other care situations • Number of referrals • PQRS data • ACO metrics • Number of annual wellness visits • ED use by target population • Minutes bill for CCM

CARE COORDINATION CANVAS: Clinical Approach C

<table>
<tr><td colspan="2">Organization:
Clinical driven Rural Health Network
IA</td><td colspan="2">Aim of Care Coordination: Decrease Emergency Department Utilization, Increase Primary Care Utilization, Improve Clinical Outcomes, Improve Medication Compliance, Improve the health of the population served, Improve Quality of Care. To make sure patients are not falling through the cracks.</td></tr>
<tr><td colspan="2">Contacts:
Care Coordinator</td><td colspan="2">Partners:
Behavioral Health, Clinic, Emergency Services, Home Health, Hospital, Long-term care, Pharmacy, Public Health Department, Social Services</td></tr>
<tr><td colspan="2">Target Population:
Diabetics, COPD, CHF,
High Emergency Department utilization</td><td colspan="2">Assessment tool(s):
LACE tool, other pieces from our ACO</td></tr>
<tr><td>History of Target Population:
Begin with Diabetes and expanded to other common comorbidities of COPD and CHF.</td><td>Target population is identified by:
EHR, through ACO data warehouse Referrals; home health, clinic, inpatient floor</td><td>Administered by:
In person</td><td>Stored in:
Database</td></tr>
<tr><td colspan="2">Engaging the person: Once given referral from one of the above sources a in person meeting is set up. Sometimes in the home, other times in the clinic setting. The initial contact is always in person.</td><td colspan="2">Communication of assessment to care team members:
In person, over the phone or secure email.</td></tr>
<tr><td colspan="2">Use of technology:
Mining data and communicating referrals</td><td colspan="2">Use of technology:
Storing data</td></tr>
</table>

<table>
<tr><th colspan="4">CARE COORDINATION CANVAS: Clinical Approach C</th></tr>
<tr><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td colspan="2">Care Plan:
Developed with the individual, based on needs including clinical needs.
Takes in consideration the whole person. Developed by the care team.</td><td colspan="2">Interdisciplinary Care Team:
• Network Care Coordinator (Team Lead)
• Social Worker
• Wright County Public Health Nursing
• Pharmacists
• Long term care facility in some cases
• Directors or assistant director of nursing
• Inpatient discharge planner
• Physician
• Other Specialist’s as needed (OT, PT, RT)</td></tr>
<tr><td>Social Determinants of Health Determination:
Electronic Health Record, In-person interviews</td><td>Components included:
• Demographics of individual’s Goals/outcomes
• Clinical needs
• Instructions / interventions
• Care Team names
• Social needs</td><td>Care Team Meeting:
Interdisciplinary rounds (not bedside) at least twice a week. Care coordinator brings up concerns as needed. As time goes on full team is often not needed, and coordinator goes to individual team members.</td><td>Building Collaboration:
• a lot of transparency
• build relationships with providers and their nurses
• attend clinic operations meetings where providers and other clinical staff are in attendance
• provider nurses are a big factor - pay attention to building relationships</td></tr>
<tr><td colspan="4">Care team communication with the person, coordinator and amongst care team:
Person – Phone, educational handouts, stepping in to see them during a visit to the doctor office.
Coordinator and Care Team – Phone, in person and secure messaging.</td></tr>
<tr><td colspan="2">Use of technology:
Storage and direct messaging</td><td colspan="2">Use of technology:
Storage and direct messaging</td></tr>
</table>

CARE COORDINATION CANVAS: Clinical Approach C

Persons experience:
After receiving the referral and details of the situation from one of the referral sources, the Care Coordinator meets with the person. This is in person whenever possible as it establishes a face to face relationship. "The 'sleuthing' begins at this point to determine the crux of the problem." Assessments are given, records are reviewed, and when possible, they are visited in their home. "Home visits are the most beneficial because your eyes and ears and senses can look around and see right away what some concerns, some safety issues might be."
After the initial assessment, the person is seen in person most commonly at their provider visits for a short visit. Phone calls are placed to the person. The frequency and length is dependent on the need. The person is followed for the period of time that they uniquely need (1 month – months).
In person, telephonic, 15 min or less, monthly

Business Model:
- Used grant dollars to get the care coordination system set up
- Bundle Payments
- Chronic Care Management (CCM)
- Transitional Care Management (TCM)
- Medicare Annual Wellness Visits

Measures:
- Hospital re-admissions
- ER re-admissions
- AC1's

Communication Strategies:
The most common strategy is verbal; in person or phone**.** Wright County care transitions team- a 'grand rounds' of services. A secure message or phone call in between formal meeting times. Perhaps meet with interdisciplinary rounds and touch base with someone about "*Sadie* " and see if they've had any contact or anything they've been involved with her care since going home.

Technology Strategies:
Technology is used share information amongst multiple providers, Light Beam is the name of the data warehouse. Light Beam is used for data reporting. The hospital board takes responsibility for the data governance. Besides care coordinators; transportation services access this information. A partner, County Public Health uses telehealth monitoring.

Lessons Learned:
- Learn as you go; there is no manual written that says how to do care coordination for your situation, as each situation is unique.
- The biggest thing is to know who your key stakeholders are.
- Knowing who all the other who touch the life of a person.
- Keep the mindset of "there are a lot of things that go on beyond the four walls of the hospital or clinic."

<table>
<tr><th colspan="4">CARE COORDINATION CANVAS: Community Health Worker Approach A</th></tr>
<tr><td colspan="2">Organization:
Rural Health Network
OR</td><td colspan="2">Aim of Care Coordination:
• The Triple: better care, cheaper costs, and better health
• Increase Primary Care utilization
• Improve medication compliance
• Improve the health of the population served
• Reduce cost of care
• Decrease Emergency Department utilization
• Improve clinical outcomes
• Increase routine exams
• Improve quality of care</td></tr>
<tr><td colspan="2">Contacts:
Project Coordinator</td><td colspan="2">Partners:
• Behavioral Health
• Clinics
• Emergency Service
• Hospital
Social Service</td></tr>
<tr><td colspan="2">Target Population:
Diabetics, CHF, cardiac conditions</td><td colspan="2">Assessment tool(s):
An initial intake survey interview, and ongoing home visit survey interviews.
Monitor basic health status: BP, Cholesterol, BMI, tobacco use, A1c</td></tr>
<tr><td>History of Target Population:
At first a more rigorous qualification standard; diagnosed with diabetes or a cardiac diagnosis. We found in the early phases of the program it was too narrow and was broadened to include pre-diabetes and pre-hypertension.</td><td>Target population is identified by:
• EHR
• Medical records
• Referrals
• Partners working with their current population</td><td>Administered by:
In Person by CHW</td><td>Stored in:
Data Base
Web Based CLARA</td></tr>
</table>

<table>
<tr><th colspan="4">CARE COORDINATION CANVAS: Community Health Worker Approach A</th></tr>
<tr><td colspan="2">Engaging the person:
In-person visits to develop the pathways to work on. If family members are care for the community member or the community member is caring for others, then the family is engaged in this process by the CHW. Again, through in person meetings.</td><td colspan="2">Communication of assessment to care team members:
The data from the intake interview is stored in CLARA. The CHW contacts (in-person or phone) the individual care team members with pertinent information.</td></tr>
<tr><td colspan="2">Use of technology:
EHR, EMR,</td><td colspan="2">Use of technology:
Web based data base (CLARA)</td></tr>
<tr><td colspan="2">Care Plan:
Developed with the individual, based on needs, and takes in consideration the whole person and family. All work done by the CHW on behalf of or with the Community Member is approved by the Community Member.</td><td colspan="2">Interdisciplinary Care Team:
Community Health Worker - charged with navigating all systems that support health for the Community Member.
• Social Worker
• Provider
• Mental Health
• NP, PA, RN
• PT/O
• Parish Nurse
• Community Service Agency</td></tr>
<tr><td>Social Determinants of Health Determination:
In-person interviews and CHW observations during in home meetings.</td><td>Components included:
Goals/outcomes, Social needs,

The care plan is a different way of saying "pathways that have been opened for the Community Member."</td><td>Care Team Meetings:
Very seldom is there a formal meeting amongst the team. The CHW is the connection point; who talks with the provider, nurse, front desk staff, and community agencies. The connection between the CHW and the provider is key.</td><td>Building Collaboration:
• Breaking down silos
• In constant communication with different entities
• CHW's from different agencies are working together.
• Network facilitating bringing leadership from various care team members organizations together to do joint problem solving.</td></tr>
</table>

CARE COORDINATION CANVAS: Community Health Worker Approach A	
Care team communication with the person, coordinator and amongst themselves: The primary mode of communication with the community member is either in-person or over the phone. The CHW is the 'conduit' for communication between care team members and is often done "in the hallway" through informal conversations. The CHW and care team members intersect in many ways at other meetings and often take advantage of these times to touch base about community members. CHWs working in clinics access patient portals to support the information requirements for the program.	
Use of technology: Web based Data Base (CLARA) Direct Secure Email Phone	**Use of technology:** Web based Data Base (CLARA) Direct Secure Email Phone
Persons Experience: When the community member is in a clinical setting and it is decided to link them with a community health worker, often the community health worker meets with this individual while they're in the clinical setting and conducts an informal discussion with them to see if there are some barriers to health going on. If it looks like there are barriers, then the community health worker (CHW) schedules a home visit with this individual. The CHW would figure out if community member has what they need when they go home. Often the hospital facilitates this, but if there were gaps the CHW would attend to those. After this community member gets home, the CHW would conduct a four-question survey to identify any barriers to health. Not necessarily just the medical aspects of health but the social determinates of health. Does this person have food in their cupboards? Have they been in to see their doctor in the last couple years? Have they not because they don't have transportation or because they don't have health insurance or some of these other very meaningful things, very meaningful barriers to health but that aren't something that is improved through a prescription or through talking with a doctor. After those barriers are identified, the CHW is an expert in resources and navigating those resources, that's their specialty. The CHW is going to help that community member to work through some of those resources to get access to services that will help address the specific barriers to health. The ideal situation is that the community member ultimately gets to a place where they're empowered to take care of themselves, to access these services on their own or they get into a place where they don't necessarily need these services because they improve their income through finding a job or they improve their situation in some other means. That's the main idea of the program. There are seven pathways that are available and if there is a pathway that a CHW is working on with a community member then they're still in the program. If the person gets to a place where there aren't pathways that they're working on, whether it be because they just find out that there aren't resources for the barriers or because they've addressed all the barriers, then that person gets all their pathways closed out and they are discharged. If they end up with another barrier down the road and need to work with a CHW again, then that relationship starts up again.	

<table>
<tr><th colspan="2">CARE COORDINATION CANVAS: Community Health Worker Approach A</th></tr>
<tr><td>Financial Model:
Payment from Medicaid Provider/ Coordinated Care Organization (CCO)
Funding from Oregon Department of Health for Evidence Based Health Programs
Grants
In-kind support: Partners support the leadership team, and some
work done by the CHWs that is not reimbursable.</td><td>Care Coordination Model:
Community Health Workers (CHW)
HUB Pathway’s model</td></tr>
<tr><td>Communication Strategies:
Working with an outside expert in marketing / public relations to develop strategies to communicate what the care coordination program / CHW’s is doing for the communities and persons they serve. Strategies to get the word out about the results of CHW’s work.
Working with partners to help them get the word out about their work.</td><td>Technology Strategies:
Uses CLARA, which is administered by Vistalogic. It is a HIPAA compliant web-based database. For reporting, data is drawn from CLARA for the use of a third-party evaluator. Direct and Secure email are used to exchange clinical information.</td></tr>
<tr><td>Lessons Learned:
• Do a better job of working with partners and supporting them and making sure that a new partner is going to be able to get CHW out into the community and doing great work.
• Provide startup funding to partners. That got a lot of different organizations over the hump and able to have a CHW doing enough work to earn enough outcomes to pay for their position.
• It is an evolving program and encourage folks to just get going and improve things as you go.
• An organization learns for just getting started.
• “Failing forward” (from Pathways to Pacesetters)</td><td>Evaluation – Process/Impact:
• Patient Satisfaction surveys
• Patient self-assessment of improved health
• Improved health scores (A1C, BP, cholesterol, BMI, Tobacco usage)
• Re-admission data</td></tr>
</table>

<table>
<tr><th colspan="4">CARE COORDINATION CANVAS: Community Health Worker Approach B</th></tr>
<tr><td colspan="2">Organization:
Rural Health Network
KY</td><td colspan="2">Aim of Care Coordination:
Decrease Emergency Department utilization and increase Primary Care utilization, increase self-efficacy and improve access to care. The establishment of a medical home.</td></tr>
<tr><td colspan="2">Contacts:
Network Director</td><td colspan="2">Partners:
• Behavioral Health
• Clinics
• Hospital
• Oral health
• Public health department
• Optometry</td></tr>
<tr><td colspan="2">Target Population:
• Diabetics
• High Emergency Department utilization
• Behavioral health
• Oral health
• Hypertension
• Heart Disease
• Asthma</td><td colspan="2">Assessment tool(s):
Initial Questionnaire (demographics, family history, medical history, medications, social needs)
General Self-Efficacy
Stanford Chronic Disease Self-Efficacy
PHQ-9
Self-Reported Health Status
Health Care Utilization</td></tr>
<tr><td>History of Target Population:
We have been more narrow in the past. We originally worked only with our Hispanic population. That's how it originally started. It originally started with Hispanics, and only for acute care. Then it broadened into opening it up to the Appalachian American population, but even though we kept the Hispanic and the American population as our target population, we moved to being chronic disease focused versus acute care.</td><td>Target population is identified by:
Both self-referrals and physician referrals</td><td>Administered by:
In-person, on paper by CHW in an approximate two-hour visit

Diabetic Eye Exam - optometrist</td><td>Stored in:
• Web based Database
• Specialized forms
• Persons’ medical records</td></tr>
</table>

CARE COORDINATION CANVAS: Community Health Worker Approach B

Engaging the person:
The CHW conducts an initial interview in person. Weekly contact, or more if needed, is made in person or over the phone for up to a year. Eventually it will begin to be every other week, then monthly. Often a care plan is established for another family member.

Communication of assessment to care team members:
In person contact with CHW, fax, EHR, secure email

Use of technology:
Phone, fax

Use of technology:
EHR, data base

Care Plan:

- With the individual, based on what client feels is most important to them
- Based on what the person wants to accomplish-- what is most important to them
- A release of information from client is needed to contact all different members of their health care team

Interdisciplinary Care Team:

- Community Health Worker (CHW) – team lead
- Depending on needs of person:
- Certified Diabetes Educator
- Healthy Homes Specialist
- Certified Asthma Educator
- Providers for FQHC
- Social Worker
- Behavioral Health Therapist
- Optometrist
- Oral Health professionals

Social Determinants of Health Determination:
In-person interviews

Components included:

- Demographics of individuals
- Goals/outcomes
- Clinical needs
- Instructions / interventions
- Social needs

Care Team Meetings:
CHW visits person with the needed above team members

Regular meetings in-house between the CHW and the diabetes educator, or the CW and the healthy homes specialist, to prepare and plan for next visit. If possible that happens verbally in-house. Otherwise over phone.

Building Collaboration:

- Wrote grant for FQHC – built in collaboration.
- Placed a CHW in the clinics
- Combining efforts on grants
- Membership on the network board
- Finding a champion to outreach to other organizations

CARE COORDINATION CANVAS: Community Health Worker Approach B

Care team communication with the person, coordinator and amongst themselves:
Person: In person, in home visits**.** Phone contact is extensive. Not uncommon to use text messages. The care plan is reviewed every 90 days in person with the person, often setting new goals at that time. Interpretation services when needed.
Coordinator and care team: Fax and secure email, phone, in-person.

Use of technology: Phone, fax	**Use of technology:** Clinic medical records, phone, fax, secure email.

Persons Experience:
The first step would be to gather information on demographics, family history, medical history, and medication adherence. We look at healthcare utilization, insurance or Medicaid status, and who is the primary care doctor and how often are they see [or have seen a physician] and what prevents them from seeing a physician. We look at other needs related to food, transportation, and those types of things.
Then, the second step would be to develop a care plan based on that information and looking at what's most important to the person. Maybe they do want to go to the doctor but they unable to obtain a medical card. They may be unsure who they should see. It may be giving a list of providers or getting them in with the FQHC. Sometimes it's the CHW making the phone call to get an appointment; other times, due to fear, the CHW can accompany them to that appointment.
We break down that care plan very simply. There is no more than three goals and three very simple and specific action steps aligning with reaching each goal. If somebody presents an issue of getting to the physician, it's not just going to be us simply saying, "make an appointment for the client." It's going to be breaking down the steps and finding transportation. Maybe it's an issue with childcare. We need to ensure that the child comes off the bus at 3 o’clock and follow up by ensuring the appointment is prior to that time. We get very specific at this point.

Financial Model: Through return on investment, while decreasing uncompensated care costs, the clinics and hospitals will see how they can fund a CHW position based on saving money elsewhere. There is a cost to the clinic and hospital for unwarranted care, return visits that are not reimbursable. These costs are more than what it costs to have this CHW on staff. Grants and in-kind contributions by partners to get programs started.	**Care Coordination Model:** Community Health Worker (CHW)

CARE COORDINATION CANVAS: Community Health Worker Approach B	
Communication Strategies: Presentations to different provider groups on the way it works to have a CHW in the emergency or how it looks to have a home visitation CHWs out of the health department. Sponsoring a seminar for Health Care organization officials to attend to learn more about CHW's and how to apply for a scholarship.	**Technology Strategies:** Basic use of common technologies of phone and fax. Some data is stored with in FQHC and is assessable at different levels by various care team members.
Lessons Learned: • One thing that I have found to be interesting in the program is based on our evaluation data, while we do not state that we have an income limit that you must meet to be enrolled, we will take anybody and help anyone. All people that have ever been enrolled have all been 150% of the federal poverty level or below. We're not singling out, but that's exactly who we have enrolled. • Have an evaluation program in place first and develop your forms based on that evaluation plan to make sure you're gathering the data. That has been key. Our evaluation team has been involved from the very beginning in establishing all the forms that we use with the client. • Gather data on what your community needs	**Evaluation – Process/Impact:** • Healthcare utilization questions • The self-efficacy scales that are being used to monitor their general self-efficacy as well as their chronic disease self-efficacy. We have now reached statistical significance in clients showing an increase in self-efficacy to manage their chronic disease. • Statistically significant in increasing people's ability to obtain a primary care physician.

CARE COORDINATION CANVAS: School-Based Approach A

Organization:
Prevention Coalition
GA

Aim of Care Coordination: Identify children that do not have access to healthcare: regular dental care, regular well-care, and regular mental health care, and regular monitoring of their medications for chronic conditions. When students present with an acute condition, such as an ear infection, they are seen in a very timely manner. To increase attendance at school.

Contacts:
Project Coordinator

Partners:

- Behavioral Health
- Clinic
- Emergency services
- Hospital
- Oral Health – Help A Child Smile
- Pharmacy
- Pre-K-12 School
- Public Health Department
- Children's Health Care of Atlanta

Target Population:
Every Child in the four school systems but focus on:

- Children with Behavioral Health needs
- Oral Health needs
- Children with Chronic Conditions
- Children whose parents who work during the day

Assessment tool(s):
Referrals, screenings, parent conferences

History of Target Population:
Children with transportation issues, parents working out of town or living with grandparents. Then broaden it to include teacher's children and people in town.

Target population is identified by:
Self-reporting
Referrals

Administered by:
In-person
Paper

Stored in:
Paper
Locked for confidentiality

CARE COORDINATION CANVAS: School-Based Approach A

Engaging the person: Once the student presents themselves with an acute issue or the health office becomes aware of a chronic condition the school-based health center coordinator begins to coordinate what will happen with student. Parent is also contacted.	**Communication of assessment to care team members:** How are the assessments, screenings and results communicated to various care team members? • The school-based health center coordinator contacts the parent to obtain parental permission or to confirm that the student is enrolled in the SBHC • The SBHC Coordinator set up an appointment for the child to be seen either in person or via telemedicine with provider • If a child is to be seen via telemedicine, the SBHC Coordinator or School Nurse takes all vital signs. Physician continue assessment. • The SBHC Coordinator communicates the outcome of the visit to the parent. • If a child needs oral care, the SBHC Coordinator works with our partner "Help A Child Smile" The mobile dental unit follows up with additional appointments if needed.
Use of technology: Phone	**Use of technology:** Telemedicine Carts with Georgia Partnership for Tele-Health
Care Plan: Once the student presents themselves with an acute issue or the health office becomes aware of a chronic condition the school-based health center coordinator begins to coordinate what will be happening with a student. Put all the pieces of going to see a physician via telemedicine or the mobile dental unit, contacting that parent, making sure an immunization or a flu shot is received. If they have a chronic health condition, checking, and re-checking that they are ok. Coordinating so everybody is on the same page.	**Interdisciplinary Care Team:** May include: • School Nurse • School-Based Health Center Coordinators • Social Worker • Mental health partner • Physician • Dental Provider • RN • Parent • Schools Staff (principle, teacher, counselor)

CARE COORDINATION CANVAS: School-Based Approach A			
Social Determinants of Health Determination: In-person interviews	**Components included:** Demographics of individual's Goals/outcomes Clinical needs Instructions / interventions	**Care Team Meetings:** Example; if a student experienced seizure, we would bring in the parent, the principal, or assistant principal, the counselor, the school nurse, and the teacher to sit down and talk about the condition that the child has. Talk about what aggravates or cause the seizures.	**Building Collaboration:** • Making use of the Georgia Family Connection funding to build infrastructure along with partnerships. • Project Director going to meet face-to-face. • Bring outside health entities into the school to do education. • Inviting partners to collaborative meetings. • Coming around gaps
Care team communication with the person, coordinator and amongst themselves: School-based health center coordinator's main responsibility is to coordinate what is happening with a student. Most work is done in-person with the child. Fax is often used to transfer data. Email and phone is often used to communicate with each member of the care team.			
Use of technology: Fax, email		**Use of technology:** Fax, email	
Persons Experience: At the beginning of each school year a parental permission enrollment package to receive school-based health center services is sent home. The child comes to the nurse's office with an injury, or a complaint, or something that they need to be seen for, the parent is called. For example, a child comes in with a rash on their arm and the staff can't identify what it is, the parent is contacted to verify permission to seek treatment. Then the school nurse or school-based health center coordinator would set an appointment through telemedicine for a child. Usually within an hour or two, the child would be seen by a physician through telemedicine to determine what that rash is, and what kind of treatment they need, and if they need follow-up treatment. If the child needs a prescription, it is called into a local pharmacy and the parent picks that prescription up on their way home. The prescription could be delivered to that parent if needed. The school nurse will follow-up with the child to determine if the treatment is the correct treatment. If it is severe, then the child would be sent home following the appointment. Otherwise, the child goes back to class after the appointment so they're not missing class.			

CARE COORDINATION CANVAS: School-Based Approach A	
Financial Model: Grant was used to set up process and procedures and get equipment in place. In kind services by school district for connectivity, space, staff and supplies. Insurance reimbursement for procedures.	**Care Coordination Model:** School based health care
Communication Strategies: We have collaborative meetings once a quarter where we report out and tell the good news. At the end of the year, we show the work that we've done and give the numbers. An evaluator prepares reports and reports out to the stakeholders of where we were and where we've come, and if we're meeting those goals and objectives. Always keeping our finger on the pulse of what the stakeholders are doing and let them know what we're doing to always know and to be informed.	**Technology Strategies:** Telemedicine Using patient portal to get history and demographics on each patient
Lessons Learned: • We didn't realize we would have to educate quite as much as we did. We were just so busy we failed to do as much on the forefront as we should have. Parents needed to extend their trust in us, as an education system, to see a physician or treat their child when they're not in the room. • We wouldn't have assumed that just because we have trust in one area (academic and safety) that we would have that automatically in another (health care).	**Evaluation – Process/Impact:** • Telemedicine visits • Student grades • Student attendance • Student behavior and discipline

CARE COORDINATION CANVAS: School-Based Approach B

Organization:
Rural Health Network
AZ

Aim of Care Coordination: Increased communication between schools and clinic, reduce student absenteeism, reduce clinic visit no-shows, decrease emergency department utilization, Increase Primary Care utilization, improve clinical outcomes, improve medication compliance, Increase well child visits,
Improve the health of adolescents, improve quality of care, Improve referrals between school staff and primary care.

Contacts:
Care Coordinator

Partners:
Area Health Education Center (AHEC), Behavioral Health, Clinic, Pre-K-12 school, Social Service

Target Population:
(Pediatric and Adolescent) High absenteeism in middle school, un-insured, frequent health office visits, dental issues.

Assessment tool(s):
Provider discretion based on what the person is presenting with.

History of Target Population:
Begin with being open to all school children. Large number of referral indicated it was too broad. Narrowed to middle school age and those with excessive absentee rates and no shows to medical appointments. Begin to focus on un-insured and those needing oral health visits.

Target population is identified by:
Referrals

Administered by:
In-person

Stored in:
EHR

Engaging the person:
Families learn about the program through events at the schools and the school health department. They are engaged once a referral is made to the school health care program.

Communication of assessment to care team members:
Fax, through the EHR at Mariposa Clinic

Use of technology:
Mine data from school district

Use of technology:
EHR

<table>
<tr><th colspan="4">CARE COORDINATION CANVAS: School-Based Approach B</th></tr>
<tr><td colspan="2">Care Plan:
Developed with the individual, based on needs including clinical needs.
Takes in consideration the whole person. Developed by the care team.</td><td colspan="2">Interdisciplinary Care Team:
Community Health Worker
Providers
School Health Staff
NP or PA,
Community Service Agency
RN
Dental Department
Asthma Educator</td></tr>
<tr><td>Social Determinants of Health Determination:
In-person interviews, phone interviews, motivational interviews</td><td>Components included:
Demographics of individuals,
Goals/outcomes, Clinical needs, Instructions / interventions,
Care Team names, Social needs</td><td>Care Team Meetings:
Meetings with the school nurses and health aides. Often bring in members from various clinic departments. Discuss the issues they are seeing, what they need and how to better improve the program.</td><td>Building Collaboration:
Using department resources and already developed relationships
Being in meetings with partners
Keeping everyone in the loop to keep them informed.</td></tr>
<tr><td colspan="4">Care team communication with the person, coordinator and amongst care team:
Person – the primary communication is by the school nurse and once they get to the clinic it is a normal visit.
Care Team – face to face meetings. Fax. Additional communication through email.</td></tr>
<tr><td colspan="2">Use of technology:
EHR, Fax, secure email</td><td colspan="2">Use of technology:
EHR, Fax, secure email</td></tr>
<tr><td colspan="4">Persons Experience:
Student: Presents at the health office in the school and am seen by either the school nurse or health aide. Records are checked to see frequency of health office visit. Once deemed a persistent issue, the health office official makes a referral to the program. Parent signature is requested for referral. Upon signature, the referral is faxed to the clinic. When the clinic receives the referral the student’s record and the appointment are flagged. This tells clinic staff that they can find a signed release of information in the health record, allowing them to communicate with the school health office about the student and/or appointment. School nurse and/or parent call for an appointment. Upon completion of visit with provider – school health office receives any requested follow-up materials.</td></tr>
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CARE COORDINATION CANVAS: School-Based Approach B	
Parent: Parent receives a message from the school health office that they would like to make a referral to primary care for their child. They are requested to come to school and sign a release form. School nurse can coach parent on calling the clinic for a same-day appointment. Make sure child gets to appointment. School nurse is able to coach parent on navigating the health system, including same-day appointments and sliding fee scale.	
Financial Model: Offering to providers to improve their patient outcomes	**Care Coordination Model:** School based health care
Communication Strategies:	**Technology Strategies:** No formal data storage or exchange system at this point. All Mariposa patients are eligible for the patient portal system. Mariposa clinic has an EHR. Fax, secure email is used to exchange information.
Lessons Learned: • Begin by getting key contact for each school district. • Try to finalize forms before beginning to work with school district personal.	**Evaluation – Process/Impact:** Number of referrals to Mariposa Clinic from school districts Number of actual appointments Number of students that Mariposa follows up with the school health staff Number of no-shows Decreased absenteeism