Care Coordination Canvas Guide

Developing and Improving Care Coordination Efforts

Released in May 2018
Updated in May 2022
Updated in April 2025

Rural Health Innovations
National Rural Health Resource Center

525 South Lake Avenue, Suite 320
Duluth, Minnesota 55802
(218) 727-9390 | info@ruralcenter.org | www.ruralcenter.org

This is a publication of Rural Health Innovations, LLC (RHI), a subsidiary of the National Rural Health resource Center. Originally Funded in 2018 Through Technical Assistance for Network Grantees Project funded by Contract Number HHSH250201400024C from the U.S. Department of Health and Human Services, Health Resources and Service Administration, Federal Office of Rural Health Policy.

Contents

Background

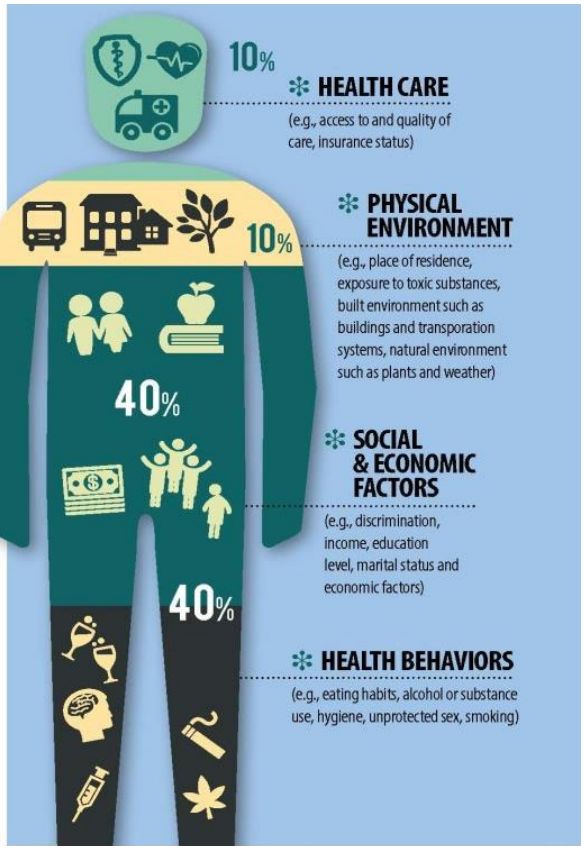
Rural Health Innovations (RHI), LLC, is a subsidiary of the National Rural Health Resource Center (The Center), a non-profit organization. Together, RHI and The Center are the nation's leading technical assistance and knowledge center in rural health. In partnership with The Center, RHI enhances the health of rural communities by providing products and services with a focus on excellence and innovation. This guide was created while RHI was 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 care organizations and networks in awareness and understanding of emerging care coordination approach. This guide was 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 lifestyle 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

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

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

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.

Social Drivers of Health

The conditions and circumstances in which people are born, grow, live, work, and age. In care coordination planning, we need to incorporate how to address the Social Drivers 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.

Definitions of Care Coordination

Many definitions of care coordination exist. Below are three definitions that were foundational in RHI's 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.

As we move toward value-based payments we must move toward Community Care Coordination which is*, "a collaboration among health care professionals, clinics, hospitals, specialists, pharmacies, mental health, community-services, and other resources working together to provide person-centered coordinated care."*[1] This working definition of community care coordination sets the framework for this guide.

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[1] Rural Care Coordination and Population Health Management Summit, 2019, p. 11

[1] Rural Care Coordination and Population Health Management Summit, 2019, p. 11

A few definitions referenced within this guide 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

Intended 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.

Intended Population

Intended population is about improving the care, health and reducing costs for a specific group of people. *Specific* is the key word. It is 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 intended population is seniors with chronic conditions who are high utilizers of ED and often hospitalized. This described 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 ED five or more times in the past three months.*

In this example, the goal of intended 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 intended 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 drivers of health, prevalence of chronic disease
    - On community priorities
- Clinical Data from Electronic Health Records (EHR) can identify:
    - High utilizers of the ED
        - 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 intended 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 etc.
- Clinical partners such as:
    - Hospitals
    - Clinics
    - Specialty care providers
    - Etc.
- Registries

Communication and technology are an integral part of working effectively with the intended 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 intended population, reflect and ask the question, "Is an assessment needed?" If the intended 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:

- PRAPARE 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.
- 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 culturally specific needs, and if necessary, the 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 workflow, 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 result of the workflow 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 workflow while including problem solving. Considerations for care team meeting include frequency and format, in person, virtual meeting 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	
Intended 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	
Intended Population: • How will it be used to identify the intended population? • How will it be used to communicate to persons in the intended 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?
Care Plan: • How will it be used to perform these functions? • Will EHRs, secure messaging or portals be used? • Where will it be stored?	**Care Team:** • 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. Reference the Potential Partners Worksheet, included in Appendix C, to help you through this process. This worksheet includes details such as: partner organization, organizational representative, role in partnership, contribution, messaging to engage partner, communication methods and person delivering message. Keep in mind that perhaps a different set of partners, depending upon the segments of the selected intended population, may be identified.

Social Drivers of Health (SDOH)

As stated previously, Social Drivers of Health are the conditions in the environments where people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality-of-life outcomes and risks.

SDOH exist as a foundational element to your care coordination efforts. Knowing that the SDOH for the intended 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/or 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 include:

- Develop advocates within the community
- Implement community education through information meetings
- Hold focused 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 necessary changes

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

Business Model

Key Business Strategies to Make Care Coordination and Value-based Payment Models Profitable

Rural hospitals participating in value-based payment (VBP) models can improve financial performance by coordinating care, reducing costs, improving patient outcomes and optimizing efficiency. Because hospitals will perform better financially by reducing inpatient census, managing chronic illnesses and keeping patients healthy, the following are key strategies to generate greater profits:

- **Invest in care coordination and integration of health services.** This provides a higher quality patient experience, eliminates waste, improves patient safety and increases outpatient volume. It also enhances the perception of the hospital, making it a medical destination of choice. It is increasingly becoming an imperative for outstanding hospital financial performance.
- **Minimize duplicative tests and unnecessary procedures.** This can be done locally but it is especially important when patients are referred to larger medical centers. Unnecessary and expensive surgeries and hospitalizations in these centers are costly and diminish the profits in a value-based model. Access to cost and quality information which is provided to the hospitals in VBP models will enable better management of patients when they are referred to larger centers. With medical procedures varying widely by cost and quality in medical centers, referring to lower cost, high quality providers will save money. As physicians typically make the referrals, this strategy requires the understanding and partnership with local primary care physicians.
- **Enhance preventative care.** Wellness visits for patients, health care coaching, and patient education are only a few of the many methods of supporting patients before they become sick. Wellness visits, for example, can identify mental health needs and provide counseling to patients, but they are also a source of referrals to primary care services available at the

hospital. This increases outpatient revenue and prevents costly referrals of sick patients for treatment outside of the local health system.

- Chronic disease management. Managing chronic illnesses before they become acute in a VBP model provides a means of increasing revenue and avoiding costly medical treatments "downstream" in large medical centers. An important feature of this type of patient management includes utilizing patient navigators or care coordinators to help patients and their families navigate the extremely complicated healthcare system. Improving the support for family care providers, brings a low-cost, important supplement to the care coordination team and is good for patient care.
- Leverage distance technology. Telehealth and other distance technology provide a means to access various types of medical expertise for local patients and avoids expensive referrals to downstream medical providers. Another important use of distant technology is to provide primary care and chronic illness management services directly into the home, thereby limiting more expensive inpatient services. Care coordination, therefore, expands to initial entry into the health system and continues throughout the hospital and post-acute care services and then directly into the home.
- Data management and analysis. Gaining access to comprehensive patient data will be essential for improving patient health and reducing cost in VBP models. For example, cost and quality data can enable "smart shopping" by rural providers for medical services not provided locally and becomes an important component of the care coordination process.
- Achieve a share of VBP financial savings by improving the cost effectiveness of hospital and clinic services. Savings achieved by Accountable Care Organizations (ACOs) are generally shared with Medicare and result in bonuses for hospitals in the ACOs. In global budget models a portion of the savings achieved by cost effective care coordination and management can improve hospital financial performance and might be used to address social drivers of health.
- Optimize quality metrics and incentive. In most VBP models, achievement of quality goals and high patient satisfaction scores is a requirement for being awarded a share of the VBP's

financial savings. High quality outcomes have also historically been associated with high financial performance and low out-migration for services available locally.

- **Align physician incentives with VBP goals.** This strategy requires increasing provider focus on patient outcomes rather than service volume. It will be important for physicians to work at the top of their licenses, and to delegate other tasks to members of a diverse care and support team. This focus on teamwork and efficiency becomes a key component of the care coordination process.
- **Work closely with other health providers and care givers in the community including family members.** Because health care organizations in VBP models are given responsibility for the health of their community residents, they will need a myriad of partners to address the social drivers of health. This becomes an important factor for achieving comprehensive community care coordination, which extends beyond the hospitals, clinics and post-acute care facilities into the homes and community organizations. Examples of potential community partners might include churches, businesses, senior centers, schools and even libraries. Working in partnership with public health, EMS and mental health providers, these community organizations can help offset the cost of the hospital's population health improvement initiatives.

In summary, the business case for hospitals developing community care coordination initiatives and participating in value-based business models includes the strategies cited above. To date, rural VBP models have out-performed urban VBP models and have been able to higher achieve financial rewards and quality scores in much less time than their urban counterparts. While rural VBP models models face significant challenges based on smaller size and limited resources, they generally can change faster, are better connected to their communities, and are generally built on a foundation of primary care services.

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 into the design. Collaboration with partners and/or stakeholders, are needed to successfully implement and provide the care coordination efforts.

Additional Resources

Stratis Health. (2017). Community-based Care Coordination – A Comprehensive Development Toolkit. Retrieved from: https://stratishealth.org/toolkit/care-coordination-toolkit/

Rural Health Innovations (RHI) Hub. Care Coordination Tool Kit. Retrieved from: https://www.ruralhealthinfo.org/community-health/care-coordination

Rural Health Innovations. Care Coordination Collection. Retrieved from: https://www.ruralcenter.org/resource-library/care-management-and-coordination

RHI White Paper

Care Coordination: An Essential Tool for Value

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 lifestyle factors have an even greater effect. 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 new value models, care coordination is key to both successful patient care outcomes and financial success.

The National Rural Health Resource Center (The Center) and Rural Health Innovations (RHI) conducted a survey of rural health organizations and networks engaged in implementing care coordination initiatives. The purpose of this study was to identify common characteristics, benefits, unique attributes, obstacles and lessons learned. These findings led to a refinement of the "Care Coordination Canvas Tool". The highlights of the study follow.

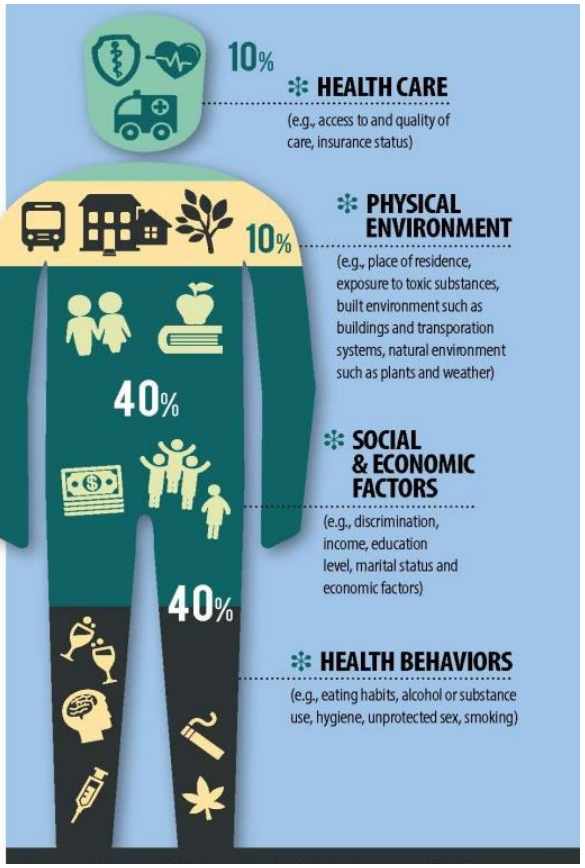

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Image from: http://ww.naco.org/sites/default/files/documents/Social Determinants of Health.pdf

Highlights of the RHI Care Coordination Study

Taking a Flexible Approach

- Each approach has four basic components: intended population, assessment tool(s), care plan and care team.
- Each community, however, However, is unique and utilizes these components in a one-of-a-kind care coordination approach.
- Different approaches have different focuses from achieving clinical outcomes, accessing appropriate out-patient care, establishing clinical directives, medication reconciliation and behavioral health.

Linking Clinical Health Care with Community Stakeholders

- The programs are engagement driven; they connect the person with needed community and clinical services, while including the person and their family.
- It effectively addresses a person's health behaviors, physical environment, social and economic factors. This is done by connecting clinical health care with community and behavioral health resources.
- High value is placed on effective partnerships of clinical, community and public entities developing a "circle of partners" around the person and family.

> *"How can a person effectively manage their diabetes if they are food insecure, can't afford the testing equipment or get to their provider?"*
>
> *Chief Nursing Officer*

Integrating and Coordinating Care Across the Continuum

- Ensures better care and smarter spending by directing the person to the right care at the right time. Examples of this are transitional care and chronic condition management.

- Care plans are determined through assessments of clinical needs, Social Drivers of Health (SDOH) and medication reconciliation. They are carried out by inter-disciplinary, inter-professional teams.

Focusing on Outcomes

- Because care coordination provides person centered, coordinated and integrated services people are meeting their health goals and avoiding hospital re-admission.
- Care coordination decreases Emergency Department (ED) utilization, increases primary care utilization, improves care and creates a healthier population while generating cost savings.

Conclusion

Care coordination is an essential tool for developing new value-based payment systems. This study confirmed the four common factors and identified additional elements that are part of successful rural care coordination approaches.

Successful approaches include:

Four basic components: intended population, assessment tool(s), care plan and care team. Incorporating communication, collaboration and technology as integral functions of each component. Linking clinical health care with community stakeholders developing a 'circle of partners' around the person and family. Integrating clinical, behavioral health and social needs carried out by an inter-professional care team.

RHI has created a Care Coordination Canvas and guide to assist with developing and refining a care coordination approach. As always, please contact us with any questions or comments by email at NetworkTA@ruralcenter.org or by phone at (800) 997– 6685, ext. 222.)

Appendix A: Care Coordination Canvas At-a-Glance

<table>
<tr><th colspan="4">Care Coordination Canvas Template</th></tr>
<tr><td colspan="2">1. Intended Population: Improving the care, health and reducing costs for a specific group of people.</td><td colspan="2">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 intended population be identified?
Community health needs assessments
EHR data
Payer claims data
Population focused
Registries
Referrals</td><td>2a. Is one needed?
Commonly, the intended 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 intended 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>
</table>

<table>
<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>
<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 drivers)
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, Nurse Practitioner, 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 workflow. 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="4">Social Drivers of Health (SDOH): The conditions and circumstances in which people are born, grow, live, work and age. What are the SDOH that are affecting your Intended Population?</td></tr>
</table>

5. Leadership next steps?	6. What is your business model?
• Community coaches • Develop advocates • Community education and information meetings • Focused conversations	• Community mental health • Primary care integration • Health plan based • Provider based • Invest in care coordination and integration of health services • Minimize duplicative tests and unnecessary procedures • Enhance preventative care • Chronic disease management • Leverage distance technology • Data management and analysis • Achieve a share of VBP financial savings • Optimize quality metrics and incentive • Align physician incentives with VBP goals • Work with other health providers and care givers in community

Appendix B: Care Coordination Canvas Worksheet

Care Coordination Canvas Worksheet

Developing and Improving Care Coordination Efforts

Developed May 2018

Updated in April 2022 and April 2025

Rural Health Innovations
National Rural Health Resource Center

525 South Lake Avenue, Suite 320
Duluth, Minnesota 55802
(218) 727-9390 | info@ruralcenter.org | www.ruralcenter.org

This is a publication of Rural Health Innovations, LLC (RHI), a subsidiary of the National Rural Health resource Center. Originally Funded in 2018 Through Technical Assistance for Network Grantees Project funded by Contract Number HHSH250201400024C from the U.S. Department of Health and Human Services, Health Resources and Service Administration, Federal Office of Rural Health Policy.

Intended Population

1a. What is your intended population?	1b. SDOH Population
1c. Is it specific enough? Further refine if needed.	1d. How will the intended population be identified?
1e. How will you communicate with and engage the individual(s)?	
1f. How will technology be used to perform these functions?	

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

3. What is the focus of your Care Plan?	
3a. What approach are you taking?	3b. What is included (components of)?
3c. How will the Care Plan be communicated to engage the person and include the Care Team?	
3d. How will technology be used to perform these functions?	

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 Intended 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*

Potential Partner Organization	Organization Representative	Potential Role in Partnership	Potential Contribution to Partnership	Message to Engage Partner	Method of Communicating Message	Person Delivering Message

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 if 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 that 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.

Appendix D: Determination of SDOH

Social Drivers of Health (SDOH) Brainstorming Worksheet

Personal Experience

List all the things you can think of that get in the way of your patients achieving their goals and managing their health.

Hospital Community Health Needs Assessment (CHNA)

List the SDOH identified in your hospital's CHNA.

Secondary Data

List the insights gained from looking at secondary data.

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Social Drivers of Health (SDOH) Worksheet

As a team use this worksheet to record your Social Drivers of Health for your intended population. Use your individual brainstorming sheets and discuss each other's discoveries as a group. This worksheet allows you to record ten SDOH. Aim for at least the top five SDOH facing your intended population. Record those in the first column.

Your next task (in May and June) will be to research and record the community organizations, agencies, institutions that address the SDOH for the intended population. Use the last two columns to record these. This will be a key piece in determining community partners.

List the identified SDOH	List all organizations (community/regional) that address the given SDOH	

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List the identified SDOH	List all organizations (community/regional) that address the given SDOH	