Rural Health Innovations
NATIONAL RURAL HEALTH RESOURCE CENTER

CARE COORDINATION CANVAS AT A GLANCE

CARE COORDINATION CANVAS GUIDE

<table>
<tr><td colspan="2">1. Target 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 target population be identified?
Community health needs assessments
EHR data
Payer claims data
Population focused
Registries
Referrals</td><td>2a. Is one needed?
Commonly, the target population is generally defined. An assessment can help determine the level of coordination needed or what types of services are needed.</td><td>2b. What is the type or how will it be used?
The type used will be determined by your target population and desired outcomes.</td></tr>
<tr><td colspan="2">1c. How will you communicate with and engage the population?
Phone, in-person, a combination. Where will it take place? How often?</td><td colspan="2">2c. How will results be communicated?
Where will it be stored? Do the results need to be shared with the Care Team? Do they help identify members of the Care Team? Can the results be used for evaluation and measurement?</td></tr>
<tr><td colspan="2">1d. How will technology be used to perform these functions?
Technology can be of great assistance to 'mine' data; it can be communicated via secure messaging or portals.</td><td colspan="2">2d. How will technology be used to perform these functions?
The assessment tool can be electronic, web-based and saved in EHRs. It can be communicated via secure messaging or portals.</td></tr>
<tr><td colspan="4">Collaboration – Who are the partners or stakeholders needed to successfully do the care coordination efforts? How are these partners are going to work together?</td></tr>
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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.

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.

3a. What approach to developing the Care Plan is being taken, so that it is:

- Developed along with the person
- Based on assessed strengths & needs
- Accounts for medical, behavioral health, wellness and human service's needs (social determinants)
- Incorporates existing care and treatment plan information

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

4a. Who is the coordinator?
Dependent of the needs of the population & what the focused outcomes are, but can be: Community Health Worker, Social Worker, Nurse, Physician Assistant, Certified Medical Assistant, Physician, Community Paramedic.

4b. How will you build collaboration with the provider or partners of the Care Team?
Team meetings to effectively build out the work flow. Communicating so each member of the team knows their role, expectations, and hand-offs.

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?

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.

3d. How will technology be used to perform these functions?
EHRs, secure messaging, portals

4d. How will technology be used to perform these functions?
EHR, secure messaging, portals, phone, video conferencing.

5. Leadership next steps?

- Community coaches
- Develop advocates
- Community education and information meetings
- Focused conversations

6. What is your business model?

- Community mental health
- Primary care integration
- Health plan based
- Provider based

Social Determents of Health (SDOH) - The conditions and circumstances in which people are born, grow, live, work and age. These circumstances are shaped by a set of forces beyond the control of the individual: economics and the distribution of money, power, social policies, and politics at the global, national, state and local levels.
What are the SDOH that are affecting your Target Population?