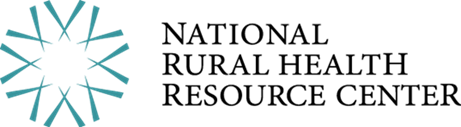
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| **Care Coordination Canvas** | | | |
| **1. Target Population:**  Improving the care, health and reducing costs for a specific group of people. | | **2.Assessment Tool(s)** A tool or survey used by the care coordinator to assess a person’s level of need:   * Social, environmental, mental health, physical and psychosocial functional needs * Risk or severity level of a diagnosis and/or disease | |
| **1a. Is it specific enough?**   * Clearly define the goal or outcome of the identified problem * Be Specific * It Must Be Measureable | **1b. How will the target population be identified?**   * Community Health Needs Assessments * EHR Data * Payer Claims Data * Population Focused * Registries * Referrals | **2a. Is one needed?**  Commonly the target population is generally defined and an assessment can help determine the level of coordination needed or what types of services are needed. | **2b. What is the type or how will it be used?**  The type used will be determined by your target population and desired outcomes. |
| **1c. 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? | | **2c. 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? | |
| **1d. How will technology be used to perform these functions?** Technology can be of great assistance to ‘mine’ data. Communication: Secure messaging, portals | | **2d. How will technology be used to perform these functions?** The assessment tool can be electronic, web based and saved in EHRs. Can be communicated via secure messaging, portals. | |
| **3. Care Plan:** An individualized plan of care that is developed with the person/caregiver and providers to identify the person’s needs. | | **4. Care Team:** Providers identified with the person and/or caregiver that represents the clinical, behavioral 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 with the person * Based on assessed 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 off)?**   * 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 outcome are, but can be: Community Health Worker, Social Worker, Nurses, Physician Assistants, Certified Medical Assistant, Physician, Community Paramedics | **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 person, and include the care team?** How will updates be shared and the care plan updated | | **4c. How will the care team communicate with the person, 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 | |

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| **Care Coordination Canvas** | | | |
| **1. What is your Target Population?** | | **2. What Assessment tool(s) is your organization using?** | |
| **1a. Is it specific enough? Further refine if needed?** | **1b. How will the target population be identified?** | **2a. Is one needed?** | **2b. What is the type or how will it be used?** |
| **1c. How will you communicate with and engage the person?** | | **2c. How will you communicate the results to who needs it? Store it?** | |
| **1d. How will technology be used to perform these functions?** | | **2d. How will technology be used to perform these functions?** | |
| **3. What is the focus of your Care Plan?** | | **4. Who is part of your Interdisciplinary Care Team?** | |
| **3a. What approach are you taking?** | **3b. What is included (components off)?** | **4a. Who is the coordinator?** | **4b. How will you build collaboration with the provider or partners of the care team?** |
| **3c. How will the care plan be communicated to engage the person, and include the care team?** | | **4c. How will the care team communicate with the person, coordinator and amongst themselves?** | |
| **3d. How will technology be used to perform these functions?** | | **4d. How will technology be used to perform these functions?** | |
| **5. Leadership next steps?** | | **6. What is your Business Model?** | |



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