

Sustainable Community Care Coordination Guide

Development Guide for a Sustainable Community Care Coordination Program

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Background and Purpose

The National Rural Health Resource Center provides technical assistance, information, tools and resources for the improvement of rural health care. It serves as a national rural health knowledge center and strives to build state and local capacity.

Through the years, The Center has provided direct support to organization leaders across the country, held knowledge-sharing summits and delivered capacity-building workshops, education, and resources. The Center's knowledge and understanding of rural health organizations and collaborations, coupled with a systems approach, a study of rural health networks, and concepts from the Baldrige Performance Excellence Framework, has led to the development of our Sustainability Tools.

The purpose of this Sustainable Community Care Coordination Guide is to provide a framework for rural organizations to actively plan for sustainability of their care coordination programs.

Program sustainability is defined as the ability to achieve desired outcomes and maintain the ability to do so over time.

Sustaining funding outside of grant dollars is a worthy goal and guides the development of this content. Often grant funds have been used to establish the program. For the program to be sustainable once grant dollars are no longer available, the ongoing costs must either be covered, or the value of the program deemed worthy of the cost.

This guide is meant to be used with the *Sustainable Community Care Coordination Workbook* as well as the [Strategic and Marketing Thinking Canvas](#) and [Worksheet](#) (Appendix A).

Care Coordination

Participants at the *Rural Care Coordination and Population Health Management Summit* focused on defining community care coordination performed at a 'local level'. After discussion, unanimously agreed the definition of Care Coordination should focus on 'person-centered care' to reflect the community at large, defining Community Care Coordination as, "*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.

Figure 1: Community Care Coordination²



As illustrated in Figure 1., the fundamental difference between Care Coordination and Community Care Coordination is that Care Coordination generally is grounded in and commonly takes place in the health care environment.

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

² [National Rural Health Resource Center; Network Technical Assistance \(TA\)](#)

Community Care Coordination involves community organizations in addition to health care organizations and may take place in a home or community setting as well as a clinical setting.

There are many benefits of Community Care Coordination. Community Care Coordination focuses on improving care for a population at a lower cost. Improving communication by providing care in medical communities. Involving many partners and citizens with innovative models. This is illustrated in detail in Figure 4.

Figure 4: Benefits of Community Care Coordination³



³ [National Rural Health Resource Center; Delta Region Community Health Systems Development \(DRCHSD\) Program](#)

This Guide's Audience

This guide is designed to help organizations solve the funding mystery and do a gaps analysis for performance improvement. An assumption of this guide is that there is a functioning care coordination program in place and a desire to collaborate. This guide is written for two audiences performing care coordination. To help community-based and social service sectors enlist the support of health care organizations **or** for health care to garner collaboration from “outside the walls”. Most elements of this guide are applicable to both audiences.

If something is specifically for community-based organizations, the designated icon will appear next to it.



If it is something specifically for health care organizations, the designated icon will appear next to it.



There are **community-based and social service organizations and collaborations** doing care coordination focusing around community resource navigation and Social Determinants of Health (SDOH). These community-based organizations often use Community Health Workers (CHW's) to do this work. This guide will provide you with answers to:

- Gain the needed support of health care organizations
- Finding support for the CHW's wages for the program to continue over time



There are **health care organizations** doing coordinated care for their patients. These efforts may be done through an Accountable Care Organization (ACO), Patient Centered Medical Home (PCMH), or part of the organizations operation to facilitate the movement toward Value Based Payments.

This guide will provide you with a way to move toward Community Care Coordination:

- By connecting to needed clinics, hospitals, specialists, pharmacies, long term care, and mental health organizations
- By connecting to community resource supports
- Gaining the needed Community-Based organizations to support their efforts
- Garnering financial support for the care coordination staff

As we move further into Value Based Payments (VBP) and a focus on Population Health, Community Care Coordination has an even more important role, even being described as the lynch pin to Health Care Transformation. Another transformation taking place is that health care generally is trending toward a more relationship-based philosophy, realizing the limits of a purely transactional model of service delivery. Care coordination, particularly the use of CHW's, is part of this shift. Effective and successful community care coordination doesn't take place without strong collaboration, connecting health care and community organizations. This guide was developed to help aid the efforts of organizations, in the thick of care coordination, to grow toward sustainability.



An additional benefit of community care coordination is that it can be an excellent method of marketing hospital services. Accountable Care Organizations, for example, that generally have access to comprehensive data on Medicare patients in their service area, informally report that rural hospitals in the ACOs retain less than one half of the revenue spent by their Medicare recipients for services available locally. The National Rural Health Resource Center has conducted more than a hundred community health surveys throughout the United States and has found in almost all cases that most citizens in the service area are unaware of health services available locally. They know that the hospital has an emergency room, for example, but generally a minority realize that there is also cardiac rehab available or different types of therapy services. Therefore, developing an ongoing dialog with community members and other service providers through community care coordination provides an excellent opportunity to improve the bottom financial line through increased patient volume.

Glossary of Terms

The following are terms you will find throughout the guide. Many are adapted from the Baldrige criteria⁴, as these served as the foundation while creating material for this Toolkit. Thoroughly understanding these Baldrige terms will create a better understanding of your organizations' sustainability work. For more information please visit:

<https://www.nist.gov/baldrige/publications/baldrige-excellence-framework>

Accountable Care Organization (ACO): ACOs are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high-quality care to their Medicare patients. The goal of coordinated care is to ensure that patients get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, the ACO will share in the savings it achieves for the Medicare program.⁵

Alignment: A state of consistency among plan, processes, information, resources decisions, workforce capability and capacity, actions, results, and analyses that support key organization-wide goals.

Assumptions: Describe a circumstance, decision, or environment that is anticipated, and expected, to influence strategic, marketing, operational, or financial components of an organization or project.

Goals: Future conditions/performance levels your organization intends/desires to attain.

Health care Transformation: The US health system—consisting of public health, health care, insurance, and other sectors—is undergoing a critical transformation in both financing and service delivery. These changes include improving the efficiency and effectiveness of health organizations and services, as well as increasing connections and collaborations among public health, health care, and other sectors.⁶

⁴ National Institute of Standards and Technology, Baldrige Performance Excellence

⁵ <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index>

⁶ <https://www.cdc.gov/publichealthgateway/program/transformation/index.html>

Key: Major or most important; critical to achieving your intended outcome.

Market Segment: A subgroup of people or organizations sharing one or more characteristics that cause them to have similar product or service needs. What are categories or types of people or organizations that could benefit by being involved you your organizations care coordination service?

Mission: Your organization’s overall function.

Partners: Key organizations or individuals who are working in concert with your organization to achieve a common goal or improve performance.

Patient Centered Medical Home (PCMH): is a care delivery model whereby patient treatment is coordinated through their primary care physician to ensure they receive the necessary care when and where they need it, in a manner they can understand. The objective is to have a centralized setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient’s family. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.⁷

Population Health: the health outcomes of a group of individuals, including the distribution of such outcomes within the group. ^{8 9}

Pricing: Describes the amount customers pay for each unit of a specific product or service. Units vary depending on the product or service.

Pro Forma: Financial forecast based on assumptions or decisions that influence the financial outlook of a product or service.

⁷ <https://www.acponline.org/practice-resources/business-resources/payment/delivery-and-payment-models/patient-centered-medical-home/understanding-the-patient-centered-medical-home/what-is-the-patient-centered-medical-home>

⁸ Kindig, D.A. & Stoddart G. (2003). *What is population health?* American Journal of Public Health, 93, 366-369.

⁹ Kindig DA. (2007). *Understanding Population Health Terminology*. Milbank Quarterly, 85(1), 139-161.

Projected: A term that can be used interchangeably with forecast.

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

Stakeholders: All groups that are or might be affected by your organization’s actions and success.

Strategic objectives: The aims or responses that your organization articulates to address major changes or improvement, competitiveness or social issues, and service advantages.

Sustainability: The ability to achieve desired outcomes and maintain the ability to do so over time.

Target Market: A specific names of people or organizations for which an organization designs, implements and maintains a marketing mix intended to meet the need of that group. What are specific names of organizations or people that could be from your care coordination service?

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

Value-based Payments: Value Based Payment (VBP) is a concept by which purchasers of health care (government, employers, and consumers) and payers (public and private) hold the health care delivery system at large (physicians and other providers, hospitals, etc.) accountable for both quality and cost of care. ¹⁰

Vision: Your organization’s desired future state.

¹⁰ <https://www.aafp.org/about/policies/all/value-based-payment.html>

Getting Started

Understanding Sustainability

Sustainability of a rural health organization's program is defined as the organizations ability to achieve desired outcomes and maintain the ability to do so over time.¹¹ *"For care coordination to be sustainable it must connect all of the basic components of the local healthcare system, so that patient care flows smoothly across each community's continuum of services."* Says Terry Hill, Sr. Advisor to Rural Health Innovations. These initiatives require organizations such as yours to serve as leaders, facilitate continuous planning, convene and engage stakeholders, provide meaningful education, connect resources within communities, and act on data for making decisions. Additionally, it is crucial to have finances to support the work.

As stated earlier, successful care coordination is key in health care transformation. In order to provide the best health care and impact population health, we need successful, sustained care coordination programs.



Health care-based organizations have some revenue streams to support care coordination through reimbursement the Centers for Medicare and Medicaid Services (CMS) for example:

- Chronic Care Management (CCM) – 150 CCM patient visits will pay for one nurse
- Transitional Care Management
- Annual Wellness Visits (AWV) – Three AWV a day pays for one nurse
- Targeted Case Management
- Health Homes State Plan Amendments
- See [Appendix C](#) for a more exhaustive list of revenue opportunities.

In select states, reimbursement of care coordination services with Medicaid patients is available. Opportunities for compensation is

¹¹ Scheirer, M. A. (2005). *Is sustainability possible? A review and commentary on emperical studies of program sustainability*. American Journal of Evaluation, 26(3), 320-349.

present in select managed care organizations and private insurers. Another element of sustainability is the strength of collaboration in the care coordination program. In conclusion, sustainability of a health care model is affected by the number and strength of community partners it has made as well as how well it has built a financial base for ongoing operation of the community care coordination system.



Community-based and social service organizations (CBO) do not have the CMS funding streams that health care-based care coordination programs do. If the CBO happens to employ a CHW, in a handful of states, CHW services are paid through Medicaid. These payments are a very limited amount, resulting in a gap in meeting costs. There are opportunities for compensation in select managed care organizations and private insurers. Due to the limited financial compensation for CBO, sustainability comes from the demonstrated value that their care coordination efforts add to employee health or to the health care organizations goals.

This guide will walk your organization through such considerations as; cost avoidance and quality measures, while exploring the value of these to an organization. The Care Coordination Canvas is used as a base to the framework of this guide, as the foundation that the care coordination program is built on plays a significant role.

The Companion Workbook

The Sustainable Community Care Coordination Workbook is a place for your organization to document the work you do as you move through this guide.



When you see this symbol, it will indicate that there are things to record in your workbook.

The Process

Throughout this guide, three major phases to determine sustainability will be discussed. Before you begin, preparatory work needs to be completed including facilitating the development of the [*Strategic and Marketing Thinking Canvas*](#), followed by gathering the plans previously developed,

including your strategic plan and marketing plan along with your Bylaws and perhaps your IRS990. The information present in these documents will help you build your plan for sustainability. Note: if you have already created a financial plan for your care coordination service, retrieve that plan as well.

Phase 1 involves using previous plans and the data from the *Strategic and Marketing Thinking Canvas* to complete the Organizational Profile and Strategic Thinking section of your workbook.

Phase 2 encompasses using the information from the *Strategic and Marketing Thinking Canvas* to complete the Marketing Thinking section of your workbook.

In Phase 3 you'll build out the operational and financial components of your care coordination service. This can be done by a small group of staff, based off the prep-work done by the large group.

At the end of each of these phases, your organization will have the opportunity to make a "go / no go" decision about progressing.

	Phase 1: Complete Organizational Profile and Strategic Thinking	Phase 2: Complete Marketing Thinking	Phase 3: Complete Operational and Financial Thinking
Who?	Organizational leadership	Organizational leadership, key partners, and members	Organizational leadership and staff with stakeholder input
Why?	To ensure that care coordination is aligned with the mission and vision of your organization.	To gain insight into how your care coordination program can be marketed to gain support from other organizations	To document the infrastructure and operations of the care coordination program along with the true cost of the program.
How?	Complete the Organizational Profile and Strategic Thinking section of the workbook.	Complete the Marketing section of the workbook after facilitating the market analysis discussion.	Complete the Operational and Financial thinking section of the workbook

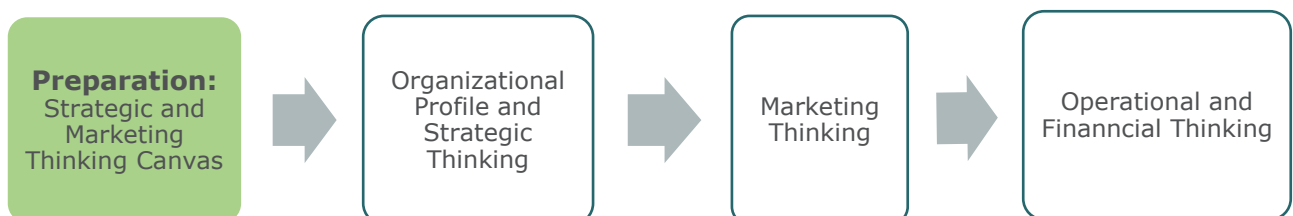
Preparation

To prepare your organization to make wise decisions, you must have a clear, accurate understanding of the market segments for your care coordination service. During this preparatory work, you'll work with your stakeholders to identify the jobs, or tasks, that your market segments are trying to accomplish, the things that get in the way of them doing this work (pains) and the things that would help them do their work (gains).

The next step in understanding market segments is to determine what care coordination can do for them to address the pains and gains. This is how you will identify target markets served by the care coordination services.

Appendix A contains a [Strategic and Marketing Thinking Canvas](#) tool, providing all the things to consider throughout this process, along with a facilitation guide to help you lead this process with your stakeholders.

Note: This part of the pre-work will take up to four hours. It involves convening a group of stakeholders, from the market segment. With this group, you'll conduct significant preparatory work to lay the foundation upon which your care coordination sustainability will be built.



Phase 1: Organizational Profile and Strategic Thinking

This phase will begin after completing the preparation work of the *Strategic and Marketing Thinking Canvas*. The organizational profile and strategic thinking are a starting point for self-assessment as it helps the organization leader carefully consider if a care coordination service truly fits within the organization. Look to existing plans, strategic and marketing, to find the information and the *Strategic and Marketing Thinking Canvas*. This information is recorded in the **Sustainable Community Care Coordination Workbook** (companion to this guide).

Organizational Profile



The following information sets the context for the organization's care coordination service and information should be added beginning on page 1 of your workbook.

ORGANIZATION DISCRPTION: Gives a high-level overview of the organization's history, culture, structure, and members. This can be found a strategic plan or bylaws.

ORGANIZATION MISSION: Articulates your organization's overall function. It describes how the organization will achieve its vision in relation to specific objectives and customer needs while answering the question, "What is the purpose of your organization?" This can be in a strategic plan, organization's IRS 990 or bylaws.

ORGANIZATION VISION: Expresses your organization's aspirations. It outlines where your organization aims to be in the next two-to-three years, acting as a beacon for your grant goals. This can be found in a strategic plan or bylaws.

CARE COORDINATION SERVICE DESCRIPTION: A description of care coordination delivery, high level view of the process, and outcomes. Some of this information will be found within the Phase 2: Marketing Thinking section below.

Strategic Thinking



This information validates how the care coordination service uniquely fits your organization and should be added to page 2 of your workbook.

TARGET MARKET: A description or list of the specific names of groups, people, or organizations that could benefit from a care coordination service. This information is gained in your work on the [Strategic and Marketing Thinking Canvas](#).



Target market for Community-Based and Social Service organizations will most likely be health care entities that can benefit from the type of care coordination services they are offering. It may also be large self-insured employers looking to better manage their employee's health.



Target markets for health care organizations may be multi-faceted including:

- Community organizations that support the care coordination effort.
- Other health care organizations such as clinics, hospitals, specialists, pharmacies, long term care, and mental health organizations.
- Internal staff that can advocate for payment of care coordination staff beyond reimbursable dollars.

ORGANIZATIONS' GOALS MET BY THIS CARE COORDINATION SERVICE: The future conditions or performance levels that your organization intends to attain. These goals often describe the desired outcome of care coordination.

ORGANIZATIONS' STRATEGIC OBJECTIVES MET BY THIS CARE COORDINATION SERVICE: Aims or responses an organization articulates to address major changes or improvement, competitiveness or social issues, and service advantages. Strategic objectives describe the pathways that care coordination will move toward the organization vision and goals.

Reflection:

- Does care coordination fulfill your organization’s mission and vision?
- Does care coordination help your organization meet some of its goals and strategic objectives?



This is a stopping point if the care coordination service is not in alignment with your organization’s vision, mission, goals, or strategies.

Phase 2: Marketing Thinking



If your organization has determined that care coordination is a fit with its mission, vision, goals, and strategies, it is time to move into Phase 2. It encompasses using the information from the *Strategic and Marketing Thinking Canvas* along with identifying the characteristics of a target population. In order to complete the Marketing Thinking phase, you will need to do some analysis work about the target markets established in the preparation work. The workbook will help you do this. Add the following information to your workbook beginning on page 3.

TARGET MARKET JOBS: These are identified as the problems being solved by the target market along with the jobs, discovered as a part of the *Strategic and Marketing Thinking Canvas* development, they are working on. During this process, the market segment jobs were identified. At this stage, select the jobs that pertain to your target market.

TARGET MARKET PAINS: These can be identified as the pains experienced by the target market while doing their work. What are their frustrations experienced while trying to achieve the goal, the job, or solve the problem? Describe the negative emotions, challenges, risks, and undesired costs that members experience before, during, or after getting the work or job done. Make sure to quantify (i.e. waiting 10 minutes).

TARGET MARKET GAINS: Gains exists as tasks that would make the jobs, or lives of your target market, easier. Gains can also be looked at as the benefits and outcomes experienced while achieving the goal, “job”, or

solving the problem. Gains describe the positive emotions, functional utility, social gains, and cost savings that members experience or wish to experience before, during, or after getting the work or job done.

TARGET POPULATION: The Target Population is the specific group of people your Target Market is aiming to improve the health and care of, while reducing costs. This population may be the same as for your current care coordination efforts. You may discover in order to gain support from “target market” organizations, you might need to shift your target population slightly. This can be discovered through analysis of the *Strategic and Marketing Thinking Canvas*; clues on selecting the appropriate target population may be identified within the three sections of your Market Segment Profile.

SOCIAL DETERMINANTS OF HEALTH (SDOH) OF THE TARGET POPULATION: A part of defining the target population is to determine what are the major SDOH for this population. Identify the factors that contribute to the target populations’ current state of health; these factors may be biological, socioeconomic, psychosocial, behavioral, or social in nature. Remember that these are often beyond the control of the individual. Looking in the most recent Community Health Needs Assessment (CHNA) will provide a first glance at the SDOH.

RELATIONSHIP: Take a moment and reflect on the type of relationship you would like to develop with the target market. (e.g. Long term, short term, informal, formal to a point of MOU or BAA)

COMMUNICATION: Consider what the best methods of communication may be for your target market. (e.g. in-person, phone, email, virtual, real-time remote, meeting attendance, written, verbal)

KEY MESSAGES: A key message describes the perceived value when receiving or using your product or service to the target market (what is the value to specific people or organizations from a care coordination service)



What is the value of community care coordination to a health care organization or larger self-insured employer?



What is the value of a community based or social service organization partnering with a health care organization?

A well-crafted key message spells out how the product or service addresses your target markets' pains and gains. The key message is often referred to as the value statement or value proposition. List the key messages for the target population.



NEEDED MESSAGING DATA: Create a list of data that is needed to back up your key messages and note where you will find this data. It is data that will allow you to get "your foot in the door". **This step is vital!** The more you can approach armed with specific numbers the more you can engage your target market. Here are a few examples of a care coordination services and the data needed to back it up:



Example I: The collaboration's goal is to contract with a local hospital for their Community Health Workers (CHWs) to work with the low acuity, or non-emergent ED patients; these patients generally have SDOH factors, such as low income and self-pay, that need to be addressed. The premise is CHWs can reduce readmissions. Data to fold into key messaging:

- Numbers supporting how CHWs can address non-medical issues for this population (local, regional, and national numbers)
- How many do not have a Primary Care Provider (PCP) or have not been visiting their assigned PCP regularly (patient engagement)?
 - NOTE: In many states there are state incentives for getting people into a PCP. Does your state do this? What is the incentive?
 - How might a payer or provider benefit from better engagement with these patients/members if they bear financial risk for care of this population?
- The number of low acuity ED visits to the hospital and associated costs with those visits.
- The number of these patients who do not have a PCP and the reduction in costs when connected to a PCP (local, regional and national numbers)

- How CHWs can help meet incentives or standards for preventive services. What are those numbers for managing chronic conditions well and doing preventative care?
- Low income statistics
 - % of hospital population
 - % of low acuity ED visits
 - % of level 5 ED visit
 - Attention to frequent users of ED can save the system substantial money
- Numbers supporting how CHWs can improve HEDIS or CAHPS scores for this population



Example II: Networks wanting to contract with a large employer, who is self-insured, to work with diabetics and to reduce the likelihood of diabetes in the large employer’s population. The premise is that the networks CHWs can provide education and care coordination for the at-risk population.

- The companies, who are sponsoring these classes, will want to see tangible benefits to them as sponsors, while being able to measure success.
 - Show the improved management in diabetics that have taken classes. Consider using SMART goal writing. Realistic numbers in terms of percentages:
 - % of people who agree to participate when offered
 - % of people that complete the class
 - “We expect that if this is offered as a benefit that X% will enroll in the class and X% will complete.”
 - % of completers that will obtain the full benefit of the program and have a reduced A1c, reduced absenteeism, reduced doctor visits
 - Statistics on how CHWs have a higher % of takers and completers

SMART GOAL WRITING:

- *Specific*
 - *Measurable*
 - *Attainable*
 - *Realistic*
 - *Timely*
-

- Same type (above) of statistics for those whose care has been managed by a CHW.
- Statistics on rates of diabetes and pre-diabetes in their employee population and the cost of average diabetics and pre-diabetics. This will help them understand their risk exposure to diabetes.
- Statistics to show employer what their exposure is when they slip from prediabetes to full Type 2. The second threshold is from controlled diabetes to un-controlled.
- Try to run calculations for their workforce (# of employees) based on state numbers (%) if you do not have the raw data from employer. The employer's filter will be on how many years the employee works for them.
- Data to show the benefit to employer to reduced health care costs.



Example III: For a health care organization to improve its quality measures and move into population health and value-based payments, there is a need to connect to community-based organizations. In other words, expand their care coordination efforts to Community Care Coordination. These community-based and social service agencies can address the needed community resources. These are often the missing pieces for the patient; thus, improving patient outcomes. Some things these community-based and social service organizations would want to know are:

- Number of patients your organization is coordinating care for that need the type of service the community-based organization offers.
- Needed community resources for the patient population and the number of referrals for these services.
- Potential profit sharing or financial support for the community-based organization.



Example IV: Another aspect of Community Care Coordination is for a health care organization to connect to other types of health care in order to improve its quality measures and move into population health and value-based payments. Again, expanding their care coordination efforts to Community Care Coordination. These other health care organizations include but are not limited to: clinics, hospitals,

specialists, pharmacies, long-term care, and mental health. For many patients these are often the missing piece that leads to improving outcomes. Some things these other health care organizations would want to know are:

- Number of patients coordinating care for that need the type of service they offer.
- Needed specific specialty areas and services for the patient population and the number of referrals for these services.
- Potential profit sharing or financial support for.
- Types of workflows setup.

Reflection:

- Can we collect the key data needed to support our messages?
- Does the target market want us to do its care coordination?



This is a time to stop if you are unable to collect key data necessary to support your key messages.

Phase 3: Operational and Financial Thinking

If your organization has determined that it can gather the needed data to support your key messages and the target market will want to engage your organization as they do care coordination, it's time to move into Phase 3. This phase is where your organization determines and/or documents its ability to do care coordination, what it will take to fully operationalize it and finance it. There are three separate tools embedded in this section:

1. [Care Coordination Canvas](#) - use to operationalize the care coordination effort
2. [Product and Service Canvas](#) - use to operationalize the care coordination effort

3. [Financial Outlook Forecast Tool](#) - use to understand the finances associated with care coordination

Operational Thinking



The following information is the framework for your organization's care coordination service and information should be added to your workbook beginning on page 4.

TARGET POPULATION: The Target Population exists as the specific group of people your Target Market is aiming to improve the health and care for, while reducing costs. This population may be the same as for your current care coordination efforts. You may discover the appropriate target population by completing analysis in the [Strategic and Marketing Thinking Canvas](#); clues on selecting the appropriate target population may be identified within the three sections of your target market profile as well. See your work from the previous section.

SOCIAL DETERMINANTS OF HEALTH OF THE TARGET POPULATION: A part of defining the target population is to determine the major SDOH factors for this population. Identify the factors that contribute to the target population's current state of health, while considering factors such as biological, socioeconomic, psychosocial, behavioral, or social in nature. Remember that these are often beyond the control of the individual. SDOH exist as a foundational element to care coordination efforts. Recognizing that the SDOH for the target population will directly impact the scope of and information gathered in the assessment, it is important to determine the factors outside the clinical aspects impacting the population. The elements included in the care plan and members of the care team are directly impacted by the SDOH. For more details please refer to the [Care Coordination Canvas Guide](#) pages 14-15. Also see your work from the previous section.

SPECIFIC TARGET POPULATION: Specific is the key word. Is the target population narrow enough? It's important to have a measurable and clearly defined goal or outcome. Example: *Seniors age 65 and older with diabetes*

and congestive heart failure who have utilized the emergency department (ED) five or more times in the past three months.

In this example, the goal in identifying the target population is to decrease ED utilization for this population through better identification of triggers of ED visits and addressing those triggers through increased outpatient coordinated care. For more details please refer to the [Care Coordination Canvas Guide](#) pages 7-9.

IDENTIFYING TARGET POPULATION: There are several ways to identify members of the target population. These methods may include:

- Clinical Data from Electronic Health Records (EHR)
- Payer Claims Data
- Identified from or referred by community partners
- Identified from or referred by health care partners
- Registries

For more details please refer to the [Care Coordination Canvas Guide](#) pages 7-9.

[Communication and technology](#) are an integral part of working effectively with the target population. We will provide details of these two components later in this guide.

Assessment

An assessment is a tool, or survey, used to assess a person's level of need for services and coordination. For more details please refer to the [Care Coordination Canvas Guide](#) pages 9-10.

NEED FOR AN ASSESSMENT: When identifying the target population, reflect and ask, "Is an assessment needed to identify the target population?" If the target population is generalized, such as Medicare or Medicaid, an assessment may help determine the level of or type (in person, by phone) of coordination needed. If the target population is disease or chronic condition specific, an assessment may be needed to determine the severity of the condition.

ASSESSMENT PURPOSE: Assessments can help determine the level of the person's need in the following areas:

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

TOOL BEING USED: Examples of types of assessments can be found on pages 9 – 10 in the [Care Coordination Canvas Guide](#).

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

Care Plan

A Care Plan is an individualized plan to identify the person's strengths in meeting their identified physical, mental health and social needs, and create an approach to ensure that any gaps are filled. For more details please refer to the [Care Coordination Canvas Guide](#) pages 10.

CARE PLAN FOCUS: A Person-Centered Care Plan is developed with the person, their caregiver, and provider(s). An open discussion that identifies the person's strengths and creates an approach to meet any gaps.

CARE PLAN APPROACH: The holistic approach should include goals or outcomes stated from the person's perspective. This is often achieved through motivational interviewing.

INCLUDED IN CARE PLAN: Guidance, instructions, and interventions in achieving the goals and outcomes are all components. 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 (i.e. where do they live- nursing home, foster or group home) language and/or culturally specific needs, and if necessary, need for an interpreter.

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

For more details please refer to the [Care Coordination Canvas Guide](#) on page 10.

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

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. For more details please refer to the [Care Coordination Canvas Guide](#) pages 11-12.

INTERDISCIPLINARY CARE TEAM: 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 specific examples see pages 11 – 12 of the [Care Coordination Canvas Guide](#).

COORDINATOR: 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
- Physician Assistant
- Nurse Practitioner
- Certified Medical Assistant
- Community Paramedics

CARE TEAM COLLABORATION: Identifying workflow, or the communication process, is a significant part of care team considerations and 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 any 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 that coordination supports the workflow while including problem solving. Considerations for Care Team meetings include frequency and format, in person, webinar, or telephonic. Being intentional is imperative.

For more details please refer to the [Care Coordination Canvas Guide](#) on pages 11 & 12.

[Communication and technology](#) are an integral part of working effectively and efficiently with the target population.



Additional Operational Components



COMMUNICATION: Communication is an element of Target Population, Assessments, Care Plan, and Care Team. Intentionally answer questions for each care coordination canvas component to establish communication that effectively supports the workflow. The following chart reflects those communication elements to consider.

Communication Questions to Answer	
Target Population <ul style="list-style-type: none">• How will you communicate with and engage the person?<ul style="list-style-type: none">• By phone, in-person, a combination• Where will it take place?• How often will it happen?	Assessment Tools <ul style="list-style-type: none">• 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 <ul style="list-style-type: none">• Who will create the Care Plan?• How will the Care Plan be communicated with the person and include the Care Team?• How will updates be completed and shared?	Care Team <ul style="list-style-type: none">• How will the Care Team communicate with the person, coordinator, and amongst themselves?



TECHNOLOGY: Technology is a core element of Target Population, Assessments, Care Plan, and Care Team. Intentionally answer these questions for each canvas component to establish optimal use of technology to effectively support care coordination efforts. The following chart reflects technology elements to consider.

Technology Questions to Answer	
<p>Target Population</p> <ul style="list-style-type: none"> • How will it be used to identify the target population? • How will it be used to communicate to persons in the target population? • How will staff gather and use information? • Will secure messaging or portals be used? 	<p>Assessment Tools:</p> <ul style="list-style-type: none"> • Will the tools be electronic? • Will they be stored electronically, web based, and saved in EHRs? • Will secure messaging or portals be used?
<p>Care Plan</p> <ul style="list-style-type: none"> • How will it be used to perform these functions? • Will EHRs, secure messaging or portals be used? • Where will it be stored? 	<p>Care Team</p> <ul style="list-style-type: none"> • How will it be used to perform these functions? • Will EHR, secure messaging, portals, phone or video conferencing be used?

KEY INITIATIVES: Key initiatives refer to significant actions or workgroups needed to develop, implement, support, and deliver your care coordination service. These are initiatives that take six to 18 months to implement and are important to bringing the care coordination service to life. Often these initiatives are focused on building infrastructure or capacity of the project.

KEY RESOURCES: It is important to examine your project’s infrastructure and assess what is needed to make the product or service delivery possible. This includes identifying the most important tools, technology, expertise, staffing, materials, and financial resources needed to develop, implement, support, and deliver the care coordination service.

Example: If you provide care coordination services, supporting infrastructure may include establishing dedicated care coordinators at each site that are responsible for implementation of the care coordination services. If you provide telemedicine services, your infrastructure may include dedicated telemedicine rooms, scheduling methodologies, and technology.

COLLABORATIONS: Collaborations are necessary to develop, implement, support, and deliver your product or service. Key partners are often members with a formal commitment, because without them the product or service may not be viable. Therefore, it is very important to accurately and creatively identify who they are. Stakeholders, not necessarily members, are affected by your product or service, are often very important to collaborations. Stakeholders may be both inside and outside of your coalition, so challenge yourself to think 'outside of the box'.

Please reference the [Potential Partners Worksheet](#), included in Appendix B, to help you through this process. This worksheet includes details such as: partner organization, representative, role in partnership, contribution, messaging to engage partner, communication methods and person delivering message. Perhaps, a different set of partners, depending upon the segments of the selected target population, will be identified.

Financial Thinking

The purpose of the financial thinking section of this guide is for your organization to determine the Care Coordination Programs financial outlook. A positive financial outlook is one of many moving parts that contribute to Community Care Coordination sustainability.



This section allows you to think through costs and revenues of your Care Coordination program, including a summary of the individual financial outlook forecasts for Care Coordination. Often this section is in the form of a chart; see the Care Coordination Sustainability Workbook for a template example. A link is provided for a spreadsheet that may be used or adapted for doing your financial forecasting.

A complete financial outlook generally has four components:

- Start-up costs
- Estimated operational costs
- Projected revenues
- Forecasted net income

START-UP COST: Start-up costs include costs that are incurred during development of care coordination. This may include designing, creating, or piloting a new product or service. These costs are sometimes considered research and development (R&D) and may also be referred to as development costs. If care coordination is already developed and is past the design and piloting stages, then in your start-up costs of the financial outlook will be zero.

Note: Use the [Financial Outlook Forecast Tool](#) to calculate start-up costs.

ESTIMATED OPERATIONAL COST: Operational costs are those incurred while producing and delivering care coordination. These costs are identified by considering how the project is operationalizing its marketing decisions and what infrastructure is already in place within the organization. An example includes desired experience, delivery methods, key initiatives, key resources, and key partners. Operational costs include both direct and indirect costs. It is important to understand the cost of care coordination so that net income can be calculated.

Direct Costs: Exist as costs that are needed to produce or deliver care coordination, such as, equipment fees, service subscriptions, and inventory replacement. Examples of direct costs include, payroll, fuel, travel, etc. They are often recurring costs, which exist as costs that are repeated with each delivery or production of the care coordination.

Indirect Costs: Exist as expenses related to general administration of care coordination, for example, accounting services, board expenses, insurance premiums, office space rent, utilities, supplies, and technology.

The total amount of indirect cost is allocated to care coordination. There are many ways to allocate indirect costs for different target populations of care coordination. Examples of allocation calculations include percentage of total direct costs and percentage of revenues.

Assumptions that influence estimated operational costs are often related to expected direct cost variables and demand for care coordination. For example, increased payroll costs, number of services provided, etc.

Note: Use the [Financial Outlook Worksheet](#) as a tool to calculate operational costs.

PROJECTED REVENUE:



Revenue is the amount of income generated through “sales” or fees related to care coordination. (i.e. income received for a completed Pathway, clinic paying per person the CHW works with, a large employer paying for health coaching for employees) There are two components to calculating revenue: the price and the unit of the sale. Price is established based on the cost of the care coordination service established in the previous section. Examples of unit payment types include per-use basis, and per time-period basis, per completed pathway.



Revenue is the amount of income generated through reimbursement, the effect on quality measures, out-migration reduction, and patient outcome incentives related to care coordination. There are two components to calculating revenue: income (the price) and the unit. Examples of income include reimbursements, incentives received for improved quality measures and patient outcomes, and income from retained out-migration. Examples of unit payment types include per-patient basis, per-retained service, per-quality or outcome incentive.

Assumptions that influence estimated revenue are often related to income variables and demand for care coordination. Examples include, changes in source of income for care coordination, type of services paid for, number of services provided, etc.

Note: Use the [Financial Outlook Worksheet](#) as a tool to calculate projected revenue.

FORECASTED NET INCOME: Net income is equal to total revenue minus total operating costs. The net income of care coordination illustrates the financial outlook of care coordination and in most cases excludes start-up costs.

A forecast is a best guess of what the future may look like, and always includes assumptions about the future. Building scenarios using different assumptions is also referred to as developing a pro forma. It is common for a business plan to forecast net income three to five years into the future.



It is important for your organization to do the different pro forma. This will benefit community-based organizations by allowing you to understand the needed size of contract to establish. The variables may be number of CHWs and number of patients or number of contracts.



Pro forma will benefit health care-based organizations by allowing you to establish the cost of someone to champion the care coordination program and the value of community-based organizations to your efforts. The variables may be changes in reimbursement, the effect on quality measures, the effect on out-migration, and patient outcomes. Refer to [Appendix C](#) for a list of possible revenue streams.

Note: Use the [Financial Outlook Worksheet](#) as a tool to calculate forecasted net income.

Reflection:

- Do we have a sound care coordination process and workflow?
- Can we proceed with the care coordination service with the determined profit margin?



As a community based and social service organization you may need to stop if you do not have a sound care coordination process and workflows or the additional support to make your efforts sustainable. Taking time to refine your care coordination efforts and looking for additional financial support.



As a health care organization, you may need to slow down if you answered no to either of the above reflection questions. Taking time to refine your care coordination efforts and workflows. Also increase profit by decreasing outmigration and increasing quality incentives.

Next Steps

Proceeding Through the Stop Signs

As you progressed through this guide, you determined it was a go if you are to this point. You have determined that:

- The care coordination service is in alignment with your organizations vision, mission, goals or strategies.
- You can collect key data necessary to support your key messages. Also, your target markets do not want to hire internal care coordinators.

- You have a sound care coordination plan operationalized with process and workflows. Your organization can proceed with the determined net income or find the additional financial support.

Now it is time to begin preparing to talk with your target market. When you worked through the [Strategic and Marketing Thinking Canvas](#) tool, you determined and named your target market. You used the pains, gains, pain relievers, and gain creators from that tool to establish key messages. All of this should be documented in your workbook. In the workbook you will see the data that will be needed to back up these key messages. You also are sure of the financial support need to continue your effort along with the needed collaboration.

Launching Your Sustainable Effort

Operational Implementation

Refer to the Operational Thinking section of your workbook for Key Initiatives (5.e). You also determined Key Resources (5.f) along with Key Partners (5.g). Now is the time to put these into motion. You may choose to use the Implementation Action Planning pages at the end of your workbook. These pages are designed to help breakdown the higher-level initiatives from 5.e into action steps.



Figuring out Funding; Pitch your service and make the sale

After doing the Financial Thinking, as a community-based organization, you know how much income is needed to keep the care coordination program going. Potential target markets were determined using the [Strategic and Marketing Thinking Canvas](#). Key Messages (4.h) and Data (4.i) needed to substantiate those messages were established during your Marketing Thinking. (Refer to the *workbook*.) Keep in mind cost reduction/avoidance and quality measures and the worth to a target organization.

Now is the time to begin building relationships with the organizations in your target market, while simultaneously gathering the data to illustrate your key

messages. This relationship building time is a time to showcase your organization's care coordination program, its workflows and outcomes. It is important to keep in mind that building a solid relationship could take days or months. Once a solid relationship is built, it is the time to draft Business Agreements (BA's) based on your financial need. Then "ask for the sale".

Getting Leadership Support and Building Community Relationships



A health care organization may need to do three things concurrently:

- garner support of administration for continuing staff time
- partner with clinics, hospitals, specialists, pharmacies, long term care, and mental health organizations
- and community collaboration development

Building collaborations to support the workflows of the care coordination effort is the other aspect. Potential target markets were determined using the *Strategic and Marketing Thinking Canvas*. Key Messages (4.h) and Data (4.i) needed to substantiate those messages were established Marketing Thinking (refer to the *workbook*.) Now is the time to begin building relationships with those organizations in your target market. Simultaneously, gathering the data to illustrate your key messages. This relationship building time is a time to showcase your organizations care coordination program, its workflows and outcomes. Building a solid relationship could take days or months. Once a solid relationship is built, it is the time to draft and MOU and ask for the organization's commitment.

Building relationships and collaborations with other health care entities is important to meet the needs of your patients and meeting the quality and health outcome measures. Just as with building collaborations to support workflows, use the *Strategic and Marketing Thinking Canvas* to identify the target organizations and begin building relationships. Collect the data you might need and develop those key messages. Once a solid relationship is built, it is the time to draft and MOU and ask for the organization's commitment.

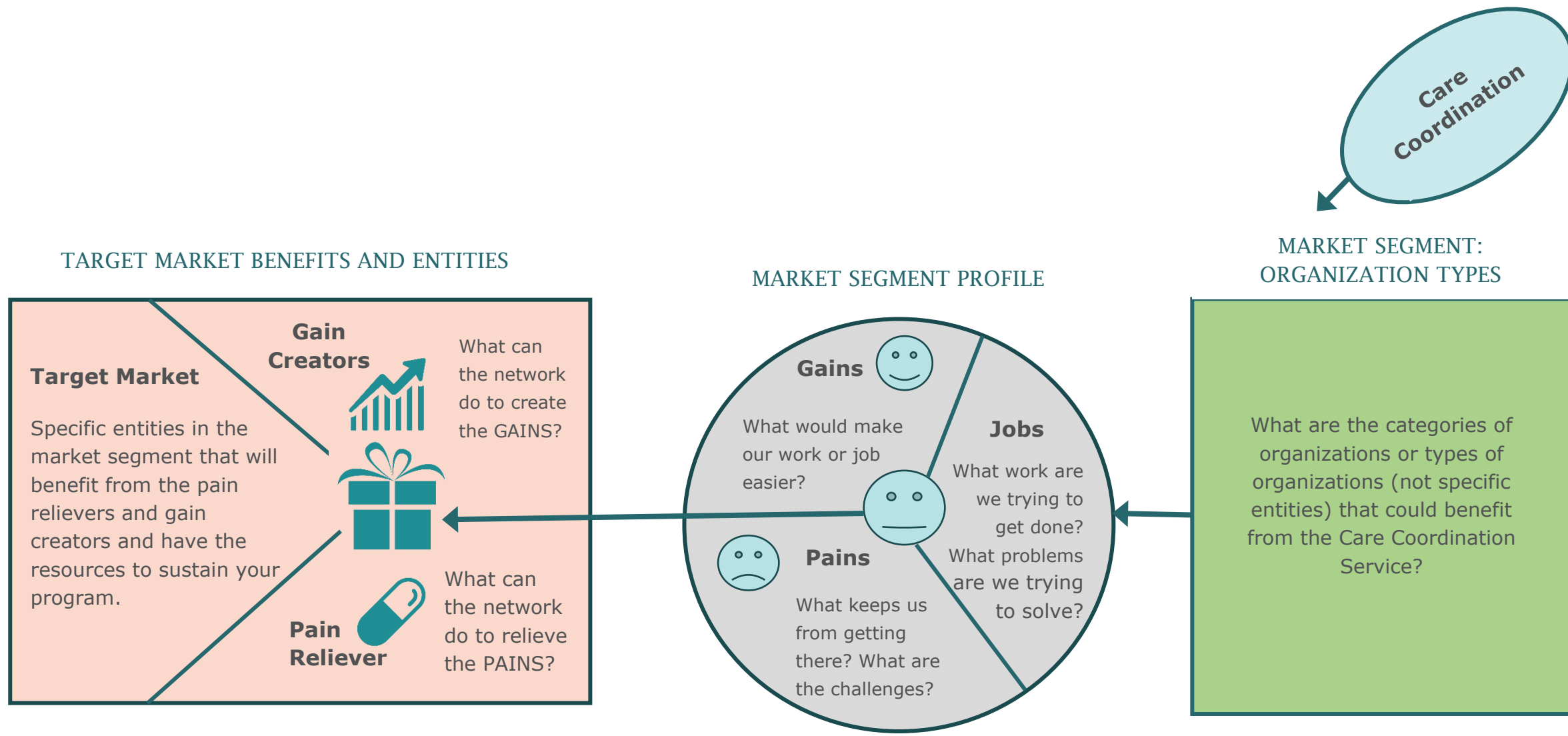
After doing the Financial Thinking you know how much in staff time it takes to do care coordination and know what your expected reimbursement revenue will be. This amount may not cover all staff time put into care coordination. This is the amount the organization will need to cover. If the *Strategic and Marketing Thinking Canvas* was not done through this lens, you may want to use it to determine staff that can make an impact on the organization financially supporting care coordination efforts. Use key messages and data similarly. Now is the time to begin building relationships with those staff members. Simultaneously, gathering data to illustrate your key messages. This relationship building time is a time to showcase your organizations care coordination program, its workflows and outcomes. Building a solid relationship could take days or months. Once a solid relationship is built, it is the time to ask for the support.

As your health care organization moves into the new payment models, having a strong care coordination program is imperative. What makes it strong is having the sound infrastructure, coupled with staff support and community collaborations. This is how your organization begins “moving the needle” on population health.

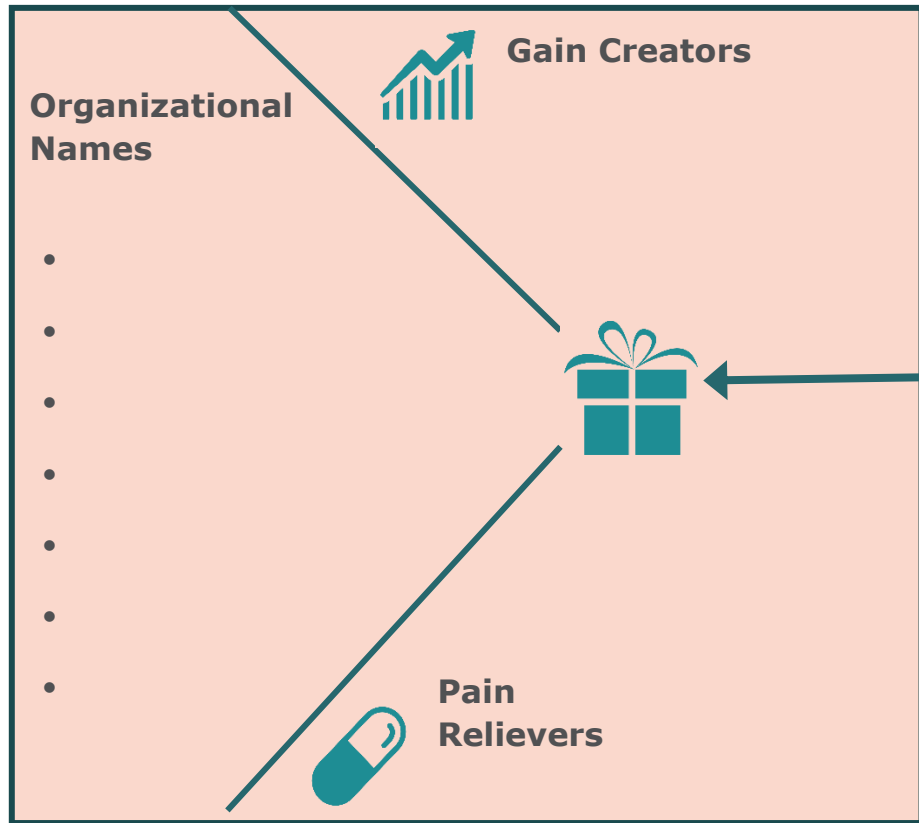
*I'm not telling you it's going to be easy;
I'm telling you it's going to be worth it.*

Art Williams

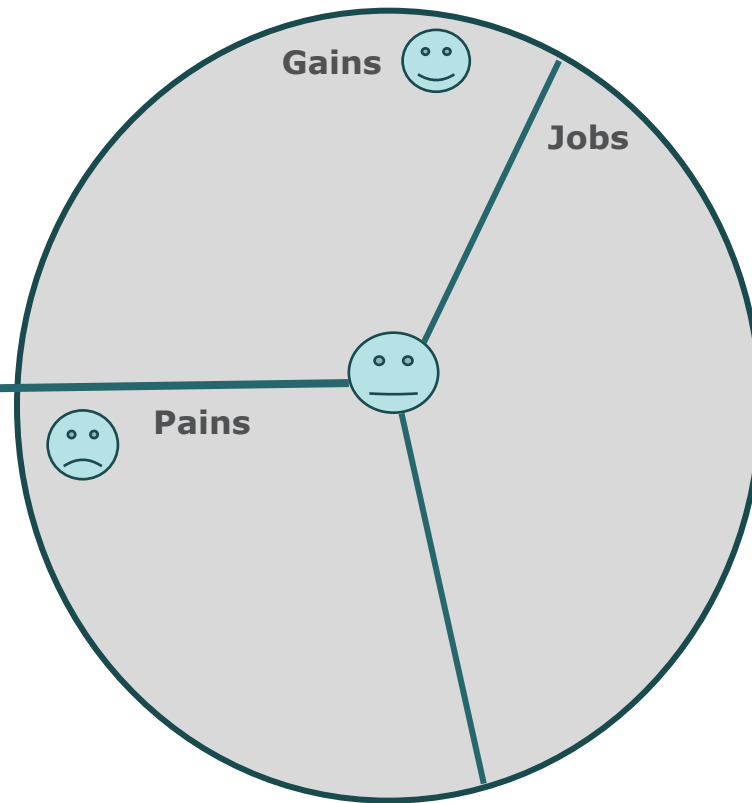
Appendix A: Strategic and Marketing Thinking Canvas



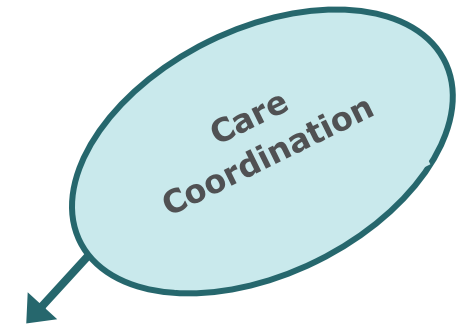
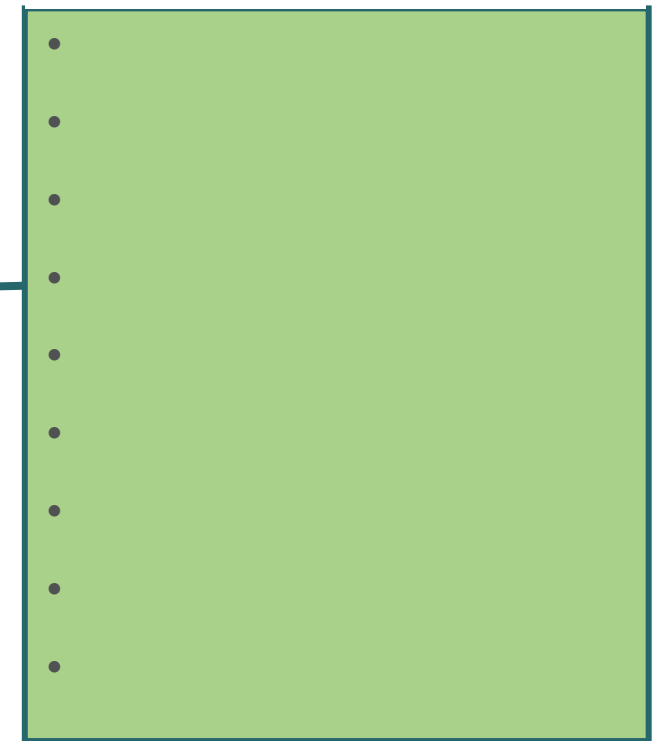
TARGET MARKET BENEFITS AND ENTITIES



TARGET MARKET PROFILE



TARGET MARKET: ORGANIZATION TYPES



Facilitation Guide for Strategic & Marketing Thinking Canvas

Rational Objective: Reach group consensus on the elements of the Strategic and Marketing Thinking Canvas, potential types of organizations in the target market, their needs, and how the care coordination service meets those needs. Identify potential organizations for the care coordination service.

Experiential Objective: Agree that the identified target market organization needs, and potential ways care coordination will meet those needs, will provide guidance to the organization over the coming two-to-three years. Feel comfortable expressing their ideas.

Setup and Materials: Sticky wall or blank wall for displaying notes and writing markers. 100 half-sheets of paper and markers. Colored ½ sheets for naming in step 4 of process. Painter’s tape if needed. Copies of the “Strategic and Marketing Thinking Canvas” worksheet for each participant and a master for Workbook development.

Timing and Audience: 3-4 hours with organizational members.

Opening: Together, we will be considering, *“What type of organizations can benefit from our care coordination service and how will it meet their needs.”* In this discussion, we will begin brainstorming organization types that can benefit from care coordination and then look at the jobs, gains, and pains of these types of organizations. We will move to identifying ways the care coordination service can help meet those needs. And finally, we will identify specific names of organizations in the market segment to reach out to. We’ll then seek consensus in these various areas that will provide guidance to our organization over the coming two-to-three years.

Process: The four-step process outlined below will be repeated seven times. Once for each of the seven elements (target market organization types, jobs, pains, gains, pain relievers, gain creators, organizational names) outlined in the “Strategic and Marketing Thinking Canvas” worksheet. See pages 5-7 for specific guidance for introducing the “Brainstorming” exercise for each element.

<p>Brainstorm: (5 min) Individually brainstorm:</p> <ul style="list-style-type: none"> • Ask brainstorming questions for each element found on pages 5-7 • Have each person compile a list of >10 ideas • After giving time for brainstorming, have each person review their list and star the 4-5 best ideas. 	<p>Small Group Discussion: (5 min) Working in pairs:</p> <ul style="list-style-type: none"> • Compare both lists and select the top 5-6 ideas. <i>(Note: Need 30-35 total data pieces, assumes 6 pairs)</i> • Describe each idea using 3-5 words. Write one idea per half-sheet of paper. • Ask small groups to be ready to share with the larger group, one idea at a time. 	<p>Report Out: (10 min) Synthesize the data to identify key ideas. Sharing from small groups, one group at a time, until all ideas are shared. The intent is to identify the true needs of the target market:</p> <ul style="list-style-type: none"> • Ask: <i>What are the two clearest or most straightforward ideas?</i> (Post on wall or record onto flip chart, moving to next group following a response.) • Ask: What are different ideas or complex ideas? • Continue around the small groups until all ideas have been shared. 	<p>Identify Key Ideas: (10 min)</p> <ul style="list-style-type: none"> • Cluster data into similar ideas. <i>What are the common threads in this data?</i> (If using ½ sheets, move them together. If using a flipchart, use a shape or color to show connection.) • Seek consensus on the key ideas by naming the cluster. Ask, “in this cluster, what is the title that best describes the (element)?”
<p>Repeat the process above, using guidance from the following pages to introduce each element. The information on the wall, or flipchart, should be transferred to a “master” to be used for Workbook development.</p>			
<p>Closing: Focused Conversation</p> <p>O: What is something from the day that you stood out for you or resonated with you? (Go around the room.) What was one thing that was a highlight, new discovery, or a ‘WOW’ moment/idea for you as we did this? (Go around the room.)</p> <p>R: What about the data up on the sticky walls make the most sense – which parts are most clear? Where were you really engaged in the process? Where did you find yourself hanging back or disinterested? What feelings or emotions came up for you?</p> <p>I: Anything that is a question for you or feels confusing or undone? What is the significance of the work we have just completed?</p> <p>D: Where are you the most excited or ‘can’t wait to get started?’</p> <p>Thank them for coming and talk about the next formal steps, such as board approval or when the next meeting will be.</p>			

ELEMENT DESCRIPTION	TRIGGER QUESTION
<p>Target Market Organization Types: The type of organizations that could benefit from partnering with your care coordination efforts.</p>	<ul style="list-style-type: none"> • What types of health care organizations would benefit from being part of our care coordination effort? (i.e. mental health, clinics, hospitals, long term care) • What community organizations are needed to see increased outcomes? (i.e. faith communities, public health, volunteer organizations)
<p>Jobs: Are there things your organizations are trying to get done, problems they are trying to solve, or needs they are trying to meet?</p>	<ul style="list-style-type: none"> • Go beyond the functional tasks or surface problems and ask “why” – go deeper. • Consider the social jobs; how the member wants to be perceived by others (i.e. looking good with clients). • Go into the emotional jobs, the specific emotion the member wants to feel. (i.e. feel confident, excitement accomplishing a goal).
<p>Pains: Frustrations you experience while trying to achieve the goal, job, or solve the problem. Describe negative emotions, challenges, risks, and undesired costs that members experience before, during, or after getting the work or job done. Make sure to quantify (i.e. waiting 10 minutes).</p>	<ul style="list-style-type: none"> • What are the frustrations, annoyances, or things that give you a headache? • What is missing from the current product and services? • Are there performance issues or annoyances? If so, what are they? • What are the main difficulties and challenges encountered? • What things do you have difficulties doing? • What negative social consequences do you encounter? (loss of face, trust, power or status) • What are your fears? (financial, social, not accomplishing goals, technical risks) • What is keeping you awake at night?
<p>Gains: Benefits and outcomes you experience while achieving the goal, “job”, or solve the problem. They describe the positive emotions, functional utility, social gains, and cost</p>	<ul style="list-style-type: none"> • What savings would make you happy? (time, money, effort) • What quality levels do you expect and what would you wish for more of? • What specific features of a service would you enjoy having available to you? • What would make your jobs or lives easier?

<p>savings that members experience or wish to experience before, during, or after getting the work or job done.</p>	<ul style="list-style-type: none"> • What positive social consequences do you desire? (look good, increase in status, increase in power) • What are you looking for the most? (good design, ease of use, specific features) • What do you dream about? (having, aspiring, bring big relief) • How do you measure success or gauge of performance?
<p>Pain Relievers: What can our care coordination do to relieve the PAINS? How you can eliminate or reduce the things that annoy your members before, during, and after doing their jobs.</p>	<p>How can our care coordination help?</p> <ul style="list-style-type: none"> • Produce savings in terms of time, money, or effort? • Make members feel better by decreasing annoyances and frustrations? • Fix underperforming issues by introducing new features, better performance, enhanced quality? • Put an end to difficult and challenging situations and eliminating obstacles? • Wipe out negative social consequences' members face? (loss of face, trust, power or status) • Eliminate risks or fears? (financial, social, not accomplishing goals, technical) • Help you sleep better at night?
<p>Gain Creators: What can our care coordination do to create the GAINS? How you can create outcomes and benefits your members expect?</p>	<p>How can our care coordination help?</p> <ul style="list-style-type: none"> • Create savings in terms on time, money or effort? • Produce outcomes the exceed expectations? • Make work easier? • Provide a service that would delight our member? • Create positive social consequences? (look good, increase in status, increase in power) • Fulfill a dream? (having, aspiring, bring big relief)

Target Market Organization Names:

The specific names of organizations that would benefit from your care coordination program based on the pain relievers and gain creators; organizations that have the resources to help sustain the care coordination efforts.

- What are the specific names of the organization types in our region?
- What specific organization is in most need of our care coordination service?
- What organizations can we partner with to make a difference for the communities we serve?
- What organizations have common clientele with us and could benefit from care coordination?

Strategic & Marketing Thinking Canvas Worksheet

The goal of the Canvas Worksheet is to discover what is important to potential partners in a care coordination service, identify how the care coordination service will meet their needs, and articulate what really is important to these potential partners. This worksheet is designed to be used with the Strategic & Marketing Thinking Canvas Facilitation. **Note:** Each member should use a worksheet during this process. Use a copy of the worksheet to summarize the work of the process. This will be used in your sustainability planning.

Step 1: Target Market Organizational Types

Brainstorm a list of organization types that could benefit from participating in your care coordination service. Go beyond the obvious. Dig deeper, try to make some unusual connections.

Target Market Organization Types: What are the categories or types of organizations (not specific entities) that could benefit/benefit you from participating in your Care Coordination Service?
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Step 2: Target Market Profile

Brainstorm a list of “jobs” the target market organization types are trying to get done, the problems they are trying to solve or the needs they are trying to meet. Go beyond the functional tasks or surface problems and ask “why” – go deeper. Consider the social jobs, how the member wants to be perceived by others (i.e. looking good with clients). Go into the emotional jobs, the specific emotion the member wants to feel. (i.e. feel confident, excitement accomplishing a goal).

Summarize for organizational use: Make a list of the jobs your target market is trying to get done and/or the problems they are trying to solve.

Member Jobs: What are the “jobs” the target market organization types want to complete, problems they are trying to solve, needs they are trying to satisfy, or tasks they are trying to complete? (Remember to go deeper, look beyond functional tasks, consider social and emotional jobs)

1.

2.

3.

4.

5.

6.

7.



8.

9.

10.

For each target market type, what are pains and gains experienced? From the list of jobs, brainstorm any Pains or Gains that they experience while doing their “jobs”. Pains and Gains are not opposites or on a continuum. Then rate the Pains and Gains according to their intensity or relevance.



Summarize for your organization’s use: Compile a list the Pains and Gains that the target market experiences with the associated jobs they are trying to get done and/or the problems they are trying to solve. Include the perceived intensity or relevance of each listed pain and gain.

Pains: Frustrations your target market experiences while trying to achieve the goal, the job, or solve the problem.  Describe the negative emotions, challenges, risks and undesired costs that members experience before, during or after getting the work or job done. Make sure to quantify (i.e. waiting 10 minutes)		Gains: Benefits and outcomes your target market experiences while achieving the goal, “job” or solve the problem. Describe the positive emotions, functional utility, social gains and cost savings that members experience or wish to experience before, during or after getting the work or job done. 	
Rate	List of Pains	Rate	List of Gains
Rate each pain according to the intensity it represents for your members and/or how often it occurs. (3= intense, 1= light)		Rate each gain according to its relevance to your members. (3=essential, 1=nice to have)	

Step 3: Target Market Benefits and Entities

The objective of the Target Market Benefits and Entities is to identify how your care coordination service relieves the pains and create the gains for your target market. It is also about identifying names of organizations who can benefit from partnering with your care coordination efforts. In identifying and understanding, from the organization’s perspectives, the care coordination service benefits and provides value.

Identifying Pain Relievers and Gain Creators: Ask yourself, “what can the care coordination service do to relieve the pains and create the gains the target market is seeking?” From the summarized list of Pains and Gains in [Step 2: Target Market Profile](#), brainstorm a list that identifies Pain Relievers and Gain Creators that the care coordination service can provide to the target market. Then, rate the Pain Relievers and Gain Creators according to how essential they are for your target market.

Pain Relievers: What can the care coordination service do to relieve the PAINS? How you can eliminate or reduce the things that annoy the target market before, during and after doing their jobs? 		Gain Creators: What can the care coordination service do to create the GAINS? How you can create outcomes and benefits the target market expects? 	
Rate		Rate	
Rate each pain reliever according to the importance it represents for your members. (3=essential, 1=nice to have)		Rate each gain creator according to its relevance to your members. (3=essential, 1=nice to have)	

Step 4: Find the Fit

Find the fit between what the organizations really care about and what the care coordination service offers: Select the most important organizations from the previous page. Write those into the chart below; this chart is designed for information gathering to write the key messages. Refer to the Pains and Gains from the Target Market Profile ([Step 2](#)) and to the Pain Reliever and Gain Creators from the Target Market Benefits and Entities ([Step 3](#)). You will be making a list. For each organization, there may not be both pains and gains.

Relieve Pains: What are the Pain Relievers that care coordination addresses? What are the Pains that care coordination alleviates? What is the rating of intensity for each?	Create Gains: What are the Gains that care coordination addresses? What are the Gains that care coordination creates? What is the rating of intensity for each?
1. Organization	
<ul style="list-style-type: none"> • • • • • 	<ul style="list-style-type: none"> • • • • •
2. Organization	
<ul style="list-style-type: none"> • • • • • 	<ul style="list-style-type: none"> • • • • •
3. Organization	
<ul style="list-style-type: none"> • • • • • 	<ul style="list-style-type: none"> • • • • •
4. Organization	

<ul style="list-style-type: none"> • • • • • 	<ul style="list-style-type: none"> • • • • •
5. Organization	
<ul style="list-style-type: none"> • • • • • 	<ul style="list-style-type: none"> • • • • •
6. Organization	
<ul style="list-style-type: none"> • • • • • 	<ul style="list-style-type: none"> • • • • •
7. Organization	
<ul style="list-style-type: none"> • • • • • 	<ul style="list-style-type: none"> • • • • •

Appendix B: Potential Partners

Worksheet

A Checklist for Organizing Partnership Engagement

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

Potential Partners Worksheet

Segment of Target Population: _____

Potential Partner Organization	Organization Representative	Potential Role in Partnership	Potential Contribution to Partnership	Message to Engage Partner	Method of Communicating Message	Person Delivering Message
School	Principal Dan	<ul style="list-style-type: none"> Care Team Member Advisory Taskforce 	<ul style="list-style-type: none"> Referrals Care plan development 	<ul style="list-style-type: none"> Improve low attendance Decrease behavior issues Improve low test scores Reduce teacher stress/burnout 	<ul style="list-style-type: none"> PTSA Mtg Email Phone School Board Mtg 	Janice

Appendix C: Population Health Revenue Opportunities

- Initial Preventative Physical Exam
- Annual Wellness Visit, Initial
- Annual Wellness Visit, Subsequent
- Preventative Health Screening
- Depression Screening
- Alcohol and Drug Screening
- Alcohol/substance abuse Assessment and Intervention
- Tobacco Use Counseling
- Advanced Care Planning
- Initial Preventative Physical Exam
- Annual Wellness Visit, Initial
- Annual Wellness Visit, Subsequent
- Preventative Health Screening
- Depression Screening
- Alcohol and Drug Screening
- Alcohol/substance abuse Assessment and Intervention
- Tobacco Use Counseling
- Advanced Care Planning
- Chronic Care Management
- Transition of Care Management
- Diabetes Self-Management Education
- Diabetes Self-Management Training
- Integrated Behavioral Health
- Remote Patient Monitoring
- Telehealth Originating Site Facility
- BMI Above Normal
- Behavioral Therapy for Obesity

Master Hierarchical Conditions Category Coding - [webinar](#)

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