The Transforming Power of Care Coordination - The Care Coordination Canvas

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Objectives

• Understand how a framework builds an effective care coordination program
• Gain insights on how the Care Coordination Canvas tool will help identify strengths and gaps for improvements
• Increase confidence working with care coordination programs
### A Guide

<table>
<thead>
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Source: Rock Health
### Care Coordination Canvas

**Q1: Target Population**
- 1a. Is it specific enough? Further define if needed.
- 1b. How will the target population be identified?

**Q2: Assessment**
- 2a. Is it needed?
- 2b. What is the type or how will it be used?

**Q3: Care Plan**
- 3a. What approach is developing the Care Plan in being taken?
- 3b. What is included (components of)?

**Q4: Care Team**
- 4a. Who is part of your Interdisciplinary Care Team?
- 4b. Who is the coordinator?

### Integrated Components

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Target Population

1. Target Population: Improving the care, health and reducing costs for a specific group of people.

1a. Is it specific enough?
   - Clearly define the goal or outcome of the identified problem
   - Be Specific
   - It Must Be Measurable

1b. How will the target population be identified?
   - Community Health Needs Assessments
   - EHR Data
   - Payor Claims Data
   - Population Focused
   - Registries
   - Referrals

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?

1d. How will technology be used to perform those functions? Technology can be of great assistance to 'mine' data. Communication: Secure messaging, portals.

Case Study Target Population

<table>
<thead>
<tr>
<th>Case Study A</th>
<th>Case Study B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest Risk (top 10%) - high cost/high utilizing Medicare Beneficiaries</td>
<td>Medicare Beneficiaries with Diabetics, COPD, CHF, High Emergency Department utilization</td>
</tr>
</tbody>
</table>
Assessment Tools

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

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.

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?

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.

Case study Assessment tools

<table>
<thead>
<tr>
<th>Case Study A</th>
<th>Case Study B</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Medicare health risk assessment</td>
<td></td>
</tr>
<tr>
<td>- eCW/CCMR (Care Coordination Medical Record)</td>
<td></td>
</tr>
<tr>
<td>- ACO developed care plan templates</td>
<td></td>
</tr>
<tr>
<td>- PHQ-9</td>
<td></td>
</tr>
<tr>
<td>- Health Risk Assessment</td>
<td></td>
</tr>
<tr>
<td>- Mini-Cog – when indicated</td>
<td></td>
</tr>
</tbody>
</table>
Your Organization

Talk with those from your organization:

- What is your **target population**?
- Is it narrow enough or broad enough?
- How will you identify it?
- How will you communicate the target population?
- What technology do you need?
- Is an **assessment tool** needed?
- What type?
- How will results be communicated?
- How will technology be used?

Care Plan

<table>
<thead>
<tr>
<th>3a. What approach to developing the care plan is being taken, so that it is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developed with the person</td>
</tr>
<tr>
<td>Based on assessed needs</td>
</tr>
<tr>
<td>Accounts for medical, behavioral health, wellness and human service's needs (social determinants)</td>
</tr>
<tr>
<td>Incorporates existing care and treatment plan information</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3b. What is included (components off)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal or outcome</td>
</tr>
<tr>
<td>Clinical and Social needs</td>
</tr>
<tr>
<td>Instructions and Interventions</td>
</tr>
<tr>
<td>Interdisciplinary Care Team Members, including Contact Information</td>
</tr>
<tr>
<td>Person Demographics</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>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</th>
</tr>
</thead>
<tbody>
<tr>
<td>EHRs, secure messaging, portals</td>
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</tbody>
</table>
Case study Care Plan

• Components included:
  ◦ Demographics of individual
  ◦ Goals/outcomes
  ◦ Clinical needs
  ◦ Instructions / interventions
  ◦ Care Team names
  ◦ Social needs

• Determination of SDOH

Case Study A
Depends on the practice workflow - currently utilizing CCMR and primarily in-person encounters

Case Study B
• Electronic Health Records
• In-person interviews
• Phone interviews

Care Team

| 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. |
|---|---|
| 4a. Who is the coordinator? | 4b. How will you build collaboration with the provider or partners of the care team? |
| Community Health Worker, Social Worker, Nurses, Physician Assistants, Certified Medical Assistant, Physician, Community Paramedics | • Team meetings to effectively build out the work flow. |
| 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. | • Communicating so each member of the team knows their role, expectations, and hand off. |
| 4d. How will technology be used to perform these functions? EHR, secure messaging, portals, phone, video conferencing.
### Case study care team

<table>
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<tr>
<th>Case Study A</th>
<th>Case Study B</th>
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<tbody>
<tr>
<td>• Huddle with Case Managers</td>
<td>• Informal / drop in meetings</td>
</tr>
<tr>
<td>• Part of clinical teams</td>
<td>• Meet with PCP’s</td>
</tr>
<tr>
<td>• Lead from hospital is</td>
<td>• Primarily telephone contacts</td>
</tr>
<tr>
<td>part of care coordination</td>
<td>• Everything is charted in patients records</td>
</tr>
<tr>
<td>training</td>
<td></td>
</tr>
<tr>
<td>• Primarily face-to-face contact</td>
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### Your Organization

**Talk with those from your organization:**

- How is the care plan being developed?
- What is included in the care plan?
- How will you communicate to the person and care team?
- What technology do you need?
- Who is the care team coordinator?
- How will you build collaboration amongst care team?
- How will care team communicate with each other and the person?
- How will technology be used?
Other Considerations

**CARE COORDINATION CANVAS TEMPLATE**

1. What is your Target Population?  
2. What dimensional focus to your organization need?  
3. How will the target population be identified?  
4. In what scenario?  
5. What is the type of data will be used?  
6. How will you communicate with target population?  
7. How will you communicate the results to those who need it?  
8. How will technology be used to perform these functions?  
9. What is your Business Model?  

**Collaboration**

10. What is the focus of your Care Plan?  
11. What approach in developing the Care Plan is being taken?  
12. What is included (components of)?  
13. What is the coordinator?  
14. How will you build collaboration with the provider or partners of the Care Teams?  
15. How will the Care Plan be communicated to engage the chosen population and include the Care Teams?  
16. How will Care Teams communicate with the chosen population, coordinator and assigned themselves?  
17. How will technology be used to perform these functions?  
18. What is your Business Model?  
19. Social Determinants of Health (SDoH)...

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**Uses Of Canvas**

- Problem
- Evaluation
- Expansion
- New program
### Using the Care Coordination Canvas

#### Needing to pull weeds: problem situation
Using the Care Coordination Canvas

Taking a soil test: evaluation

Using the Care Coordination Canvas

Breaking ground for more space: expansion
Using the Care Coordination Canvas

Adding veggies: developing a new program

Clinical
School Linked / Based

From Volume

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Source: Rock Health
New Business Model

First Curve
- FFS Reimbursement
- Quality Not Rewarded
- Volume Rewarded
- Fragmented Care
- Acute Care Focus
- Stand-Alone Providers Thrive

Second Curve
- Value Payment
- Coordinated Care
- Population Health
- Providers at Risk for Payment
- IT Centric
- Requires Physician Alignment

Straddle
- Revenue Pressure
- Minimal Reward for Quality
- Volume Decreases

Care Coordination is the Key

Care Coordination
Framework

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<tr>
<td>1. What is your target population?</td>
</tr>
<tr>
<td>2a. Is it a special challenge? (if needed)</td>
</tr>
<tr>
<td>2b. How will the target population be identified?</td>
</tr>
<tr>
<td>3a. How will you communicate with and engage the population?</td>
</tr>
<tr>
<td>3b. What is the type of care needed?</td>
</tr>
<tr>
<td>3c. How will you communicate the results to the patients?</td>
</tr>
<tr>
<td>3d. How will providers collaborate to perform these functions?</td>
</tr>
<tr>
<td>4. What is your interdisciplinary care team?</td>
</tr>
<tr>
<td>5. How will you build collaboration with the provider or partners of the care team?</td>
</tr>
<tr>
<td>6. How will the care plan be disseminated to the patients?</td>
</tr>
<tr>
<td>7. How will the care plan be coordinated?</td>
</tr>
<tr>
<td>8. How will the care plan be executed?</td>
</tr>
<tr>
<td>9. Leadership and buy-in?</td>
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A common Language

Resources for You

Care Coordination Canvas Materials
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Get to know us better:
http://www.ruralcenter.org

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