

Creating a Business Case Template for Care Coordination and Transition Management

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This article is the second in a series supporting the business case for care coordination and transition management (CCTM) in health care. The series will support nurses in building business cases that create a positive return on investments and leverage nurses in CCTM or other roles within the healthcare continuum. A business case template was developed to support nurses seeking to transform care and serve as a guide for creating a business case for CCTM.

The healthcare delivery system is transforming from a fee-for-service, segmented, episodic, acute focus to one emphasizing continuous value across a patient's life and the healthcare continuum, focusing on health promotion and disease prevention (American Hospital Association, 2018; Berwick et al., 2008; Schneider et al., 2017). The Quadruple Aim underscores the importance of better outcomes, lower costs, improved patient experience, and improved clinician experience as the foci of current initiatives to achieve this critical transformation to continuous value (Feeley, 2017).

Nursing as a profession has always held a holistic view of the patient. Still, now it is imperative nursing understands the value mandate and leverages this view to contribute to the transformation to continuous value. Creating interventions that improve health, advance equitable and accessible care, and engage patients in designing their health plan are fundamental nursing approaches. Registered nurses (RNs) across the healthcare continuum must be able to articulate business case outcomes when leveraging the role of the RN and other interprofessional team members in care coordination, population health, transition management, and other value-based transformation activities (Haas, Conway-Phillips et al., 2019; Start et al., 2020). Business case outcomes may be realized for improvements in

health outcomes; decreased cost for healthcare organizations or consumer affordability; access to healthcare, consumer, or staff experience; or removal of social determinants that obstruct health – the Quadruple Aim.

In the first article in this series, Start and colleagues (2020) provided a thematic analysis of care coordination and transition management (CCTM). This article is the second in a series supporting nurses to understand the importance of Care Coordination and Transition Management (CCTM) in healthcare focused on value. The series aim is to support nurses in crafting business cases that create a positive return on investments that leverage nurses in CCTM or other roles within the continuum of health care.

Building Tools

The American Academy of Ambulatory Care Nursing (AAACN) and the Collaborative Alliance for Nursing Outcomes (CALNOC) collaborated to create a template to guide nurses in creating a compelling business case for transformative care designed to improve health care. This business case template was developed to support the Quadruple Aim, using the frameworks established in the Institute of Medicine's *Future of Nursing Report* (2010) and AAACN's *Care Coordination and Transition Management Core Curriculum* (Haas, Swan et al., 2019). To establish content

validity, the authors leveraged feedback from nurse leaders across the country to learn from their experiences with transformational business cases (Start et al., 2020).

During January-February 2020, an electronic survey was distributed nationally to the AAACN membership with snowball distribution to interested AAACN and CALNOC professional colleagues. Respondents ($N=302$) represented executives, managers, frontline staff, and academic roles, with 70% representing practice setting operational roles; 46% were from fully integrated health systems.

When asked about appropriate prework activities that could be performed to build a business case, 92% to 96% agreed with the following actions: literature review, brainstorm with partners, engaging the frontline staff, considering data from consumers/patients, assessment of current performance with pre-data, and stakeholder assessment. Consideration for human-centered design with end-users was considered less frequently (89%), and development of personas to describe recipients of the targeted interventions was less supported (70%). The dominant themes in open-ended prework responses related to understanding the program cost or investment and anticipated financial impact. No answers related to engagement of patients or consumers as stakeholders. The top rank-ordered educational needs for organizational prework related to frontline staff engagement, literature review, stakeholder assessment, data assessment, and determination of CCTM fit.

A series of open-ended questions solicited feedback on template domains to understand if the original conceptualization would meet the needs of RNs in a variety of organizations and settings across the continuum. Topics were categorized into three domains: Population Health, Transitions of Care, and Complex Care Coordination. When asked to validate these domains, examples and question responses were clear; domains lacked room for proposals directly impacting the workforce or workplace enhancements capturing technology and the environment of care. Therefore, the template was revised to incorporate a fourth domain for Workforce or Workplace Enhancements.

Similarly, when describing anticipated outcomes, the original template included the domains Improved Health, Decreased Utilization, Cost Avoidance, and Improved Revenue. Respondents acknowledged utilization was a current priority, but based on the examples they provided, the focus needed to expand to appropriate utilization (over- and under-utilization). Cost containment or efficiency was important, but respondents were challenged with the concept of bringing additional revenue into the organization as an outcome. Based on the responses, it appeared many respondents might have been sheltered from the economics of health care. Queried on specific outcomes respondents had either used or would use for each of the domains, survey results helped identify gaps in the model. It was apparent the template would be best served if outcomes were explicitly aligned with the Quadruple Aim. Based on this feedback, the template was revised to capture the expected outcome domains as Health Outcomes, Consumer Experience, Workforce Experience, and Improved Revenue or Costs.

To understand resources available for nurses writing business cases, it appeared data systems were not consistently accessible. Only 12% had easy access to data for tracking program processes or outcomes. Thirty percent were not sure where to go or didn't have data support, although 58% described knowing who to ask to access. It was encouraging that standardized risk stratification tools were available to 70%. The ability to track social determinants ranged from 40% to 60%, except financial assistance for medications (60%) or access to a primary care provider (80%). The most common population requiring practice model changes were described as mental health (68%), diabetes (62%), congestive heart failure (66%), frail elderly (55%), end of life (50%), and the uninsured (51%).

Respondents shared examples of business cases from their organizations focused on the Quadruple Aim. Examples are organized by business case template domain (see Tables 1-4). These transformational initiatives demonstrate opportunities nurses have identified to improve ambulatory health care.

Table 1.
Population Health

- Diabetes program to improve patient control of laboratory values
- Concierge clinical coordination to assist patients with resistance to cancer treatment to navigate genomic treatment options
- Retinal scanner in primary care to perform diabetic eye exams
- Home telehealth program for blood pressure management
- Home blood pressure monitoring through video visits
- End-stage renal disease program
- RN independent visits for monitoring, education, support, and medication titration
- Billing for RN visits
- Medicare annual wellness visit program with RNs

Table 3.
Complex Care Coordination

- Complex care management program
- Centralized care management department for a large, integrated children's healthcare system
- Integrated care coordination system
- Intervention in emergency department and engagement with community health workers to decrease hospitalizations
- Community workers, social workers, and substance use counselors to Patient-Centered Medical Home staffing mix
- Transitioned adult apheresis infusions from inpatient to outpatient
- Home-based primary care
- Complex case management
- Behavioral health integration
- Care teams established in clinics consisting of nurse case manager, social worker, community health worker for Patient-Centered Medical Homes
- CCTM model included CCTM RNs, social workers, behavioral health providers, and pharmacists.
- Centralized care coordination hub
- Chronic disease management in the emergency department
- Palliative care program
- Advanced care planning

Table 2.
Transitions of Care

- Transition nurse to impact rural patients across transition of care settings
- Home care transitional care nurses to bridge transition hospital acute to outpatient
- Transitional care RN placed in primary care provider's office
- Transition of care program focused on high emergency room utilization and readmissions for adult and pediatric diabetics and cancer surgery
- In hospital visits RN providing education, coaching, support, and scheduling follow-up appointments to post-discharge telephonic case management
- Focus change from complex care coordination to transitional management
- RN care coordinators in primary care changing focus from emerging-risk patients with chronic conditions who could benefit from lifestyle management and education to patients recently discharged from the hospital with a high index hospitalization
- Integration of complex care medicine services with nursing care coordination and transition management services

Table 4.
Workforce or Workplace Enhancement

- Space usage to increase patient flow and clinical and research priorities.
- Creating new vital signs and treatment room; offices to promote patient flow and efficiency
- Involvement of nursing students in primary care and care coordination with plans for new graduate hire upon graduation and passing NCLEX
- Ambulatory nurse residencies
- New Graduate Ambulatory Residency Program
- Repurposed resources include staffing to provide education and established support within primary care providers' offices
- Repurposing video equipment

CCTM = care coordination and transition management, RN = registered nurse

The Template

A template can guide RNs to create proposals that lobby stakeholders for scarce organizational resources (see Business Case Template on pages 312-313 and template examples on pages 314-315). RNs must be able to articulate the potential value added by proposals to those controlling organizational resources. Resources required for transformation may be as simple as permission to try changes in the use of space or personnel time; organizational or regulatory approvals for clinical guidelines; or financial investments in equipment, additional staff, space, or supplies. Organizational leaders with authority to approve resource and funding requests may not be nursing practice experts. RNs can use the business case template to articulate the value of the proposal against other competing bids. Senior leaders have fiscal accountability to governing bodies and will need to appreciate the outcomes proposed to defend resource allocations. A well-written business case can be used for multiple stakeholder audiences to generate acceptance and buy-in to support care transformation.

The template organizes proposals into key domains that stakeholders can understand as patients or consumers (referred to as patients for ease in this template) transit the healthcare system. For example, the domain of Population Health focuses on health and wellness for a defined population. In contrast, Complex Care Coordination focuses on patients with multiple conditions aiming for their optimal health status. The Transitions of Care domain focuses on patients as they navigate the healthcare system, while the domain Workforce or Workplace Enhancements considers the organization's care delivery infrastructure.

Selecting the primary domain for the proposal helps focus the business case aims. Identifying outcomes aligned with the Quadruple Aim helps focus the business case for stakeholders to understand anticipated improvements in the healthcare delivery system and forces those writing a business case to articulate success. Improved outcomes may be in one or more of Health Outcomes, Consumer Experience,

Workforce Experience, and Improved Revenue or Costs domains. Clarifying what leaders can expect from the business case assists in difficult decisions regarding resource allocation in complex organizations. Translating proposed change to paper can be challenging for anyone. The template breaks the process into defined steps.

Conclusion

Using respondent feedback from the survey, this Business Case Template was developed to support nurses seeking to transform care. Business cases for CCTM activities in the ambulatory care setting are imperative to continue to guide the transformation of the healthcare industry. This tool can guide nurses to develop a well-planned and organized document for use by organizational leaders to invest in change. \$

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Business Case Template

Pework

An essential first step in transforming care begins with investigating the problem you wish to solve to understand better both opportunities and barriers associated with a potential change. Understanding what currently exists and why it exists in the way that it does is a critical step for future success. Gaining full understanding from multiple points of view will shape your business plan.

A good place to start is to perform a thorough current literature review. A query on an Internet search engine will uncover peer-reviewed publications and many blogs, professional organization newsletters, and presentations from conferences or virtual training. Browsing search results will provide contacts for outreach for best practices that have been shared professionally. Making contact with other professionals or organizations that have already approached the same problems can move your work forward much quicker. These searches may also uncover regulatory or reimbursement implications that you were not aware of but require attention in your work.

It is equally important to spend time speaking with key stakeholders in your organization. Engaging frontline staff working around the problem you wish to solve will help surface any workarounds and provide insight into their perspective on the desire for change. Brainstorming with colleagues will help build depth to proposed solutions from multiple perspectives. Evaluating key stakeholders may also identify potential incentives or barriers based on the proposed changes. Engaging others early in developing the

transformation will help develop the proposal and identify future champions who may be instrumental in future success or failure.

Critical review of existing data around the problem is essential for drafting a solid business case. Understanding existing data will assist with defining success measures, including balancing measures to assure no harm, but it will also establish baseline performance to measure future improvements. If data are lacking, it will identify resources needed to capture and analyze for transformation evaluation. Consider data from multiple perspectives: financial, staff, consumers, patients, and performance processes. A thorough literature review may uncover data for benchmarking your organization's performance as well.

Human-centered design should also be considered while problem-solving by engaging end users of the envisioned transformation. Understanding the perspective of those on the receiving end of the transformation, patients or staff, will shed light on what values are most important to honor and what priorities they envision. Engaging them throughout the design process will create models meeting their needs and promote success. As the target population for the transformation becomes clear, creating personas to describe that population's demographics, experiences, challenges, and overall situation, including pictures, will help those seeking to understand the proposal better to visualize the extent of the problem and the human impact.

Step 1: State the Problem to Be Solved and the Domain for Investment

Problem to be solved: *Clearly and concisely write a statement describing what problem this business case aims to address for stakeholders. Create a title for the business case that is concise yet clearly reflects this problem.*

Writing a successful business case requires a clear focus on the proposed intervention to improve the healthcare system or care delivery. Identifying the primary domain for improvement helps the business case focus on the main intervention. There may be overlap in the domains defined below for some business cases but directing stakeholders' foci is an important first step.

- *Population Health:* Any interventions aimed at affecting the health of a group or population of patients.
- *Care Transitions:* Any interventions aimed at positively impacting the transition of care between settings for patients, continuity of treatments across settings, and ability of patients to access and adhere to appropriate and ordered treatments.
- *Complex Care Coordination:* Any interventions aimed at positively impacting care coordination for patients with multiple complexities to their care, including co-morbidities and social determinants.
- *Workforce and Workplace Enhancement:* Any interventions aimed at positively impacting the preparedness of the workforce or workplace to engage in CCTM activities and interventions.

Business Case Template (continued)

Step 2: Identify How Success Will Be Measured

Primary success measure: State the primary outcome that describes what this business case aims to improve for stakeholders.

It is critical for the business case to establish how success will be measured if the proposal improves the health-care system or care delivery. Selecting the primary outcome category for the improvement helps focus clearly on what leaders could expect with successful execution. There will likely be other secondary outcomes identified in the proposal, but directing stakeholders' understanding of the possible improvement is also an important step. As organizations prioritize improvement investments, this step helps capture interest and attention for the business case.

- **Health Outcomes:** Health outcomes are changes in health that result from specific healthcare investments or interventions.
- **Consumer Experience:** Patient experience encompasses the range of interactions patients have with the health-care system, including their care from health plans and doctors, nurses, and staff in hospitals; physician practices; and other healthcare facilities.
- **Workforce Experience:** Workforce experience encompasses the range of experiences of healthcare providers, clinicians, or support staff in response to care delivery or the workplace environment.
- **Improved Revenue or Costs:** Improving the organization's cost structure by increasing funds coming into the organization or decreasing funds going out. Revenue growth comes from increasing billing for services by increasing volumes or adding billed services to generate new or additional revenue or procurement of grants or payer-funded resources. Cost improvements come when costs associated with care delivery or visits are decreased, making care delivery more efficient and less costly to the organization.

Step 3: Place an "X" in the Grid Below for the Identified Primary Domain for Investment and Outcome

This grid provides a visual for an executive summary that helps stakeholders quickly understand the business case's intention and the primary expected outcome.

Domain for Investment	Expected Outcomes			
	Health Outcomes	Consumer Experience	Workforce Experience	Improved Revenue or Costs
Population Health				
Care Transitions				
Complex Care Coordination				
Workforce and Workplace Enhancement				

Template Examples

Population Health	Transitions of Care
<p><i>Definition:</i> Any intervention aimed at affecting the health of a group or population of patients.</p> <p>Business cases around this domain might consider the following:</p> <ul style="list-style-type: none"> • Risk adjustment to understand disease burden and targeted strata for intervention • Prevailing outcome indicators of the disease • Health determinants • Health-promotion and disease-prevention strategies with outcome tracking • Best practice interventions of team • Availability of community resources • Financial impact of positive or negative outcomes relative to interventions <p>Outcome examples:</p> <ul style="list-style-type: none"> • Health Outcomes <ul style="list-style-type: none"> ◦ Hemoglobin A1C, diabetic retinal scan, blood pressure, renal function, depression screen status, body mass index status ◦ Improved access to care, improved referral rates for health determinant driven metrics such as transportation, access to primary care provider (PCP), access to fresh food, access to medical record • Consumer Experience <ul style="list-style-type: none"> ◦ Consumer Assessment of Healthcare Providers and Systems (CAHPS) ◦ Organizational survey measures • Workforce Experience <ul style="list-style-type: none"> ◦ Certification in CCTM or other programs that enhance understanding of population health ◦ Organizational survey measures • Improved Revenue or Costs <ul style="list-style-type: none"> ◦ Additional revenue from intervention visits ◦ Ability to lower costs by bundling intervention visits ◦ Leveraging different clinician skill sets ◦ Procurement of grant and payer-funded resources to support CCTM services 	<p><i>Definition:</i> Any intervention aimed at positively impacting the transition of care between settings for patients, continuity of treatments across settings, and ability of patients to access and adhere to appropriate and ordered treatments.</p> <p>Business cases around this domain might consider the following:</p> <ul style="list-style-type: none"> • Risk adjustments to understand illness burden which may impact interventions and outcomes • Financial implications from payer sources • Community resources primarily related to social determinants of health, transportation options, and caregiver supports • Integration of healthcare system and patients' ability to navigate between settings • Communication between settings • Ability to conduct virtual or home visits • Outreach as a strategy across settings <p>Outcome examples:</p> <ul style="list-style-type: none"> • Health Outcomes <ul style="list-style-type: none"> ◦ Utilization measures post transitions such as emergency department (ED) visits, readmissions, or transitions required for more assistance or care ◦ Adverse events post-transition such as falls, infections, or medication events • Consumer Experience <ul style="list-style-type: none"> ◦ CAHPS ◦ Engagement in the transition plan ◦ Organizational satisfaction survey measures • Workforce Experience <ul style="list-style-type: none"> ◦ Ability to communicate across settings related to a patient's plan of care ◦ Improved ability to facilitate safe transitions ◦ Resources appropriate to facilitate outreach ◦ Organizational survey measures • Improved Revenue or Costs <ul style="list-style-type: none"> ◦ Reduced unwarranted utilization: ED utilization, readmissions, clinic visits ◦ Procurement of grant and payer-funded resources to support CCTM services ◦ Regulatory compliance and value-based measures <ul style="list-style-type: none"> - Healthcare Effectiveness Data and Information Set (HEDIS) process measures: evidence of inpatient admission documentation to PCP, receipt of discharge information on the day of discharge or following day, patient engagement provided within 30 days after discharge, medication reconciliation on date of discharge - Centers for Medicare & Medicaid Services and other measures: evidence of completion of health risk assessment, high-risk medication assessment in elderly, advanced care planning documentation, bilateral exchange of necessary patient information, longitudinal care management for patients at high risk for adverse health

Template Examples (continued)

Complex Care Coordination	Workforce and Workplace Enhancement
<p><i>Definition:</i> Any intervention aimed at positively impacting care coordination for patients with multiple complexities, including co-morbidities and social determinants.</p> <p>Business cases around this domain might consider the following:</p> <ul style="list-style-type: none"> • Risk adjustment to understand disease burden of population and targeted strata for intervention • Prevailing outcome indicators of that disease for measurement of success • Health determinants • Health-promotion and disease-prevention strategies with outcome tracking • Best practice interventions of team • Availability of community resources • Financial impact of positive or negative outcomes relative to interventions • Financial impact of positive or negative outcomes relative to interventions • Integrating services that promote a holistic approach to patients, such as behavioral health, educational needs, etc. • Outcomes reflective of improved health status, risk status, appropriate use of health system <p>Outcomes examples:</p> <ul style="list-style-type: none"> • Health Outcomes <ul style="list-style-type: none"> ◦ Similar to health outcomes noted in Population Health domain but may be specific to complex and chronic patient populations or inclusive of social determinants • Consumer Experience <ul style="list-style-type: none"> ◦ CAHPS ◦ Organizational survey measures ◦ Streamlined, integrated care delivery with clarity on primary care (lack of fragmentation) • Workforce Experience <ul style="list-style-type: none"> ◦ Organizational survey measures ◦ Ability to communicate care plan across the care continuum and systems ◦ Ability to access system resources for holistic care, including social determinant support • Improved Revenue or Costs <ul style="list-style-type: none"> ◦ Reduced unwarranted utilization ◦ Additional revenue from intervention visits for education ◦ Procurement of grant and payer-funded resources to support CCTM services ◦ Ability to lower costs by bundling intervention visits ◦ Leveraging different clinician skill sets 	<p><i>Definition:</i> Any intervention aimed at positively impacting preparedness of the workforce or workplace to engage in CCTM activities and interventions.</p> <p>Business cases around this domain might consider the following:</p> <ul style="list-style-type: none"> • Educational programs that can support workforce <ul style="list-style-type: none"> ◦ Residencies and transition to practice programs ◦ Professional development ◦ Specialty certification • Structuring staffing based on care of patients and populations • Creating space or contiguous space, leveraging technology, maximizing systems to support the workforce • Provision of support staff to allow practice at top of license • Building team cohesiveness and resilience to manage challenging populations <p>Outcomes examples:</p> <ul style="list-style-type: none"> • Health Outcomes <ul style="list-style-type: none"> ◦ Based on the population served, Population Health, or Complex Care Coordination outcomes as above • Consumer Experience <ul style="list-style-type: none"> ◦ Organizational survey measures • Workforce Experience <ul style="list-style-type: none"> ◦ Organizational survey measures ◦ Space usage ◦ Programs and tracking of success within ◦ Employee engagement ◦ Employee satisfaction ◦ Nursing students facilitated and partnership with colleges of nursing or other disciplines ◦ Staffing ◦ Workload measurement ◦ Turnover or vacancy rates • Improved Revenue or Costs <ul style="list-style-type: none"> ◦ Decreased turnover ◦ Decreased vacancy ◦ Increased efficiencies to manage larger panels or more visits ◦ Additional revenue for increased visits ◦ Procurement of grant and payer-funded resources to support CCTM services

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