

WCMSCHF VALUE PROPOSITIONS FOR FIVE PRIMARY CUSTOMERS

CUSTOMER	LEADERSHIP TEAM DRAFT: May 8, 2018	ALL STAFF DRAFT: July 13, 2018	SYNTHESIS BY COMMITTEE: July 30, 2018	SLT: August 7, 2019	BOARD: August 22, 2018
Pharmacy	<ul style="list-style-type: none"> ○ For: Partnering with community pharmacies ○ Who: To navigate variations in provider health plans ○ Services: By circumventing challenges in meeting medication needs of a vulnerable population ○ Provides: Through streamlining efficiencies, optimizing therapy & building partnerships to improve outcomes ○ Product/Solution: Accomplished by a comprehensive multi-disciplinary, long-standing, cost effective and proven model 	<p>For/Who/Services/Product/Solution: Out CCWJC pharmacy collaborates with CPESN pharmacists to streamline communication, decrease barriers to providing patient care by offering a platform to access information to address social determinants of health, improving patient outcomes, cost savings through a hands on multidisciplinary approach.</p>	<p>Partnering with community pharmacies and provider practices to circumvent challenges in meeting the medication needs of individuals with medical and/or behavioral health complexities through a proven multi-disciplinary cost effective model that streamlines efficiencies, optimizes therapy, and builds partnerships to improve lives.</p> <p>Tagline: Partnering with pharmacies and providers to improve lives through medication management and optimization.</p>	<p>Partnering with community pharmacies and provider practices to address medication needs of individuals with health complexities through a proven multi-disciplinary, cost effective and efficient model that optimizes therapies to improve lives.</p> <p>Tagline: Partnering with pharmacies and providers to improve lives through medication management and optimization.</p>	
Providers	<ul style="list-style-type: none"> ○ For: Primary Care & Specialists (Behavioral Health + Physical) ○ Who: Challenging, poorly adherence, social deficiencies, medical complexities & end of life ○ Services: Practice transformation to value based compensation. Connect challenging members to community resources, disease education ○ Provides: improved clinical outcomes, office efficiencies, patient centered medical home ○ Product/Solution: Non-profit organization with no fees, assess SDH that effects clinical outcomes, comprehensive integrated care, improve patient adherence 	<p>For/Who/Services/Product/Solution: For providers we offer proven comprehensive multidisciplinary support services for high risk populations to transform care delivery that results in high quality outcomes at a lower cost.</p> <p>Tagline: Partnering to achieve high quality outcomes at a lower cost.</p>	<p>Partnering with primary care and specialty providers who experience challenges in caring for high-risk populations by assuring transformation and sustainability to a value-based care delivery model which improves efficiencies and patient-centered clinical outcomes through accomplished by a proven multi-disciplinary cost-effective approach.</p> <p>Tagline: Partnering to achieve high quality outcomes at a lower cost.</p>	<p>Partnering with providers to achieve and sustain a value-based care delivery model that results in high quality outcomes at a lower cost.</p> <p>Tagline: Partnering with providers to achieve high quality outcomes at a lower cost.</p>	

<p>Patients/Members</p>	<ul style="list-style-type: none"> ○ For: Patients/Members ○ Who: have complex needs ○ Services: we provide care coordination & care management services ○ Provide: improved health outcomes at a lower cost ○ Product/Solution: uses a community based approach to meet the needs of the patient using local resources & partnerships <p>Tagline(s): your ins. provider has assigned me to help you</p> <ol style="list-style-type: none"> 1. Manage your unique health care needs 2. Manage your health better & I'd like to talk about... (patient specific episode, condition) 	<p>For/Who/Services: We serve member in our local community with basic and complex health care and social needs by way of personalized care management and care coordination. We strive to promote knowledge and understanding to improve health outcomes and well-being by way of cost effective measure and with a strong local presence.</p> <p>Product/Solutions: We use a community based approach to partner with your local physicians and healthcare team.</p> <p>Tagline: Partnering with your community to address you healthcare needs.</p>	<p>Serving community members with basic and complex health care and social needs with personalized local care management and care coordination. We provide disease education and promote self-management to improve health outcomes and lives through a strong local presence in partnership with physicians, healthcare teams, and community resources.</p> <p>Tagline: Partnering with your community to address your healthcare needs.</p>	<p>Partnering with community members with health and social needs through personalized and local care management. We provide disease education and promote self-management to improve lives through coordination with healthcare teams and community resources.</p> <p>Tagline: Partnering with you in your local community to address your health needs.</p>	
<p>Hospitals</p>	<ul style="list-style-type: none"> ○ For/Who: CCWJC serves the hospital systems of Wake/Johnston counties who experience high utilization rates and preventable re-admissions for medical vulnerable populations ○ Services/Provides: Through risk stratification and whole person transitional care we improve member outcomes which lead to decreased costs ○ Product/Solution: Unlike our competitors, our proven method of impactability, along with the largest provider networks, sets us apart from all others 	<p>For hospitals in Wake and Johnston counties needing complex care management for chronically ill patients to bridge the transition of care by using statewide data and predictive analytics to reduce hospital costs and provide links to the largest established local physician network as well as whole person care.</p>	<p>Serving hospitals in reducing utilization and preventable readmissions <i>(or healthcare costs)</i> through transitions of care promoting timely connections of members back to their community physicians and local resources; driven by, experienced local care management, predictive analytics, and the largest established statewide physician network.</p> <p>Tagline: Partnering with hospitals to ensure effective transitions of care.</p>	<p>Partnering with hospitals to support transitions of care through timely connections of members to their healthcare teams and community resources with experienced local care management, statewide data and predictive analytics.</p> <p>Tagline: Partnering with hospitals to ensure effective transitions of care.</p>	

<p>Collaborators</p>	<ul style="list-style-type: none"> ○ For: Agencies and entities who support the medically underserved in our community ○ Who: Need knowledge of and connection to community wide resources/agencies, patient/member engagement and access to covered care ○ Services: We provide education & detailed information to facilitate access to care & SDOH resources for our mutually underserved members ○ Provides: more knowledge & efficient use of limited resources and decrease in fragmented care through improved communication ○ Product/Solution: we are embedded in the community & offer a robust multi-disciplinary network that connects the collab. & patient/member to needed services and results in empirically supported, improved patient health outcomes 	<p>For/Who/Services/Product/Solution: For Community Partners who need support in serving vulnerable individuals with complex medical and/or behavioral health care needs by providing community based solutions to improve health & self-care through a multidisciplinary approach that includes face-to-face and telephonic encounters.</p>	<p>Supporting community partners in serving vulnerable individuals with complex medical and/or behavioral health care needs by providing community-based solutions that improves lives through a multi-disciplinary approach driven by experienced local care management and predictive analytics.</p> <p>Tagline: Developing strong community partnerships to improve lives.</p>	<p>Partnering with our communities to provide community-based solutions that improve lives of those with health needs through a multi-disciplinary approach driven by experienced local care management and predictive analytics.</p> <p>Tagline: Partnering with our communities to improve lives.</p>	
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