The Community Engagement Toolkit Companion Guide

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Companion Guide for the C-TAC Toolkit

An Introduction to the Toolkit

Purpose and Impact Overview

The Coalition to Transform Advanced Care's (C-TAC) purpose is to reorient and reshape healthcare delivery for those with advanced illness. C-TAC desires this delivery to be high-quality, comprehensive, person/family-centered, and supported with aligned payment models.[1]

Achieving this purpose will not be easy and is part of a much longer journey. Always remember, you are not alone. Leaders across the country have been in similar positions or are there now, building coalitions to drive transformational change.

Reorienting and Reshaping Care

In order to accomplish C-TAC's purpose, several things are required:

- Engaging and equipping individuals and communities to change and personalize the healthcare system
- Enhancing the knowledge and awareness of healthcare providers about person/family-centered care
- Improving public and payment models to help support this type of system

Community Engagement

Community Engagement is "the process of working collaboratively with, and through, groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of people."[2]

Community Engagement is accomplished through the creation of partnerships and coalitions that:

- Help mobilize resources
- Influence systems
- Change relationships among partners
- Serve as catalysts for changing policies, programs, and practices.

Quality Care: A Collective Impact Approach

Partnerships and collaborations that result from community engagement often adopt elements of a collective impact approach. These elements include:

- A shared purpose and agenda
- Mutually reinforcing activities
- Continuous communication
- Shared results and accountability

A collective impact approach brings together community leaders and practitioners to improve outcomes.[3] This approach uses:

- Data to integrate effective practices across programs and systems
- Advocacy for best practices to accomplish goals and impact

Helping Hand

The use of a backbone organization may be of benefit to your project. A backbone organization is an organization already in existence, which is already doing similar or complementary work in the area of interest. A backbone organization would consist of staff that coordinates all the initiatives and efforts amongst participating organizations.[4]

Big Idea

Reorienting and reshaping the health care system requires engaging the community and striving for collective impact.

The C-TAC Toolkit Design and Use

The C-TAC Toolkit:

- Will provide an overall framework for community engagement
- Will help guide communities through the process
- Can be digested in bite-size pieces and used at a pace that is self-directed
- Can be used to initiate the process or address a specific issue

The C-TAC Toolkit includes:

- Ideas and suggestions that can help you how to foster and create community engagement
- An overview of resources and tools that can be used to assist with planning and community action
- Templates of the resources and tools

- Instructions and guidelines about how to use the resources and tools
- Case Studies from communities across the U.S. that are creating action

The C-TAC toolkit is designed to help individuals and communities:

- Identify potential candidates and recruit a leadership group
- Establish clear goals
- Communicate those goals and a shared vision
- Develop and implement outreach strategies
- Create and implement a plan of action
- Measure impact and share with stakeholders
- Grow the effort, and evolve plans, as needed
- Manage relationships with stakeholders on an ongoing basis

Helping Hand

Before jumping in, determine where you are in the process. If you are thinking about starting an effort in your area, then Module 1 is the right place for you. If you have groups that are 6 already working on pieces of the agenda or have already brought a group together, Module 1, Chapter 1.2 would be useful to help you think about setting clear goals. If you are looking for ways to communicate your project and its impact, module 2 will provide you with ideas. If you have been underway for some time, you should think about where you have the greatest need and then look to Module 3 and 4.

One of the best ways to assess which modules may be best for you is to scan the summaries and look at the reflection questions and action steps for the chapters and sessions. These give you a sense of the steps that you can take, without having to read through the whole Companion Guide. Included in Module 4 are a series of templates and tools for your reference and use. You may just be looking for one of these, in which case the Companion Guide Appendix is the best place to find these. You may have other tools you have found useful. The most important thing as you do this work is to use the tools that are best suited for your needs.

The C-TAC Community Engagement Toolkit is designed to help you not only get started but also can be used to help drive continuous improvement. It is recommended you periodically assess your goals, make adjustments and plan for your future. This may be done annually. In doing so, it is useful to go back to the relevant sections of this Toolkit.

STOP

Stop the video. Take time to answer the following Reflection Questions.

Reflection Questions

1. Review Helping Hand 1. Is there or are there organizations in your community, already addressing your issue, that you might approach as a backbone organization?

2. Review Helping Hand 2. Where do you see yourself in the process in your effort of change? What chapter are you going to view next?

Companion Guide for the C-TAC Toolkit

Module 1 - Getting Started

Chapter 1.1 - Building a Leadership Team

According to Marshall Ganz[5], community engagement requires a leader, who is willing to step out and help guide and motivate their community to create change.

This requires that a leader who can:

- Share the story of why they were called to lead, the story of those they hope to engage, and their collective story of action.
- Build intentional relationships and recruit a team with a shared purpose, shared goals, and a shared agenda.
- Recruit funders who can help convert their resources to power and their strategy to positive and measurable action.[6]

Goal:

To help you assemble a leadership team, determine your area of focus, identify a preliminary set of goals and hold your initial convening.

Building the Team

Once a leader has been identified, the next step is to identify and recruit a small group of individuals to help lead the effort as a leadership team. Ideally, this group should consist of two to five people who are involved in advanced illness care. In this case, the role of the leadership team is to knit these individual efforts together. You should be aware that in this scenario, it may be important to recognize silos that exist and be prepared to break them down.

With this in mind, use the template in Module 4: Community Contacts to generate the names of individuals to be part of the leadership group. This list serves as a starting point. Those you listed may have recommendations about who else to involve. Be sure to include their affiliations and contact information, and once complete, contact each individual and determine their willingness to participate. You group may include:

- Health insurance companies, health systems, and physician organizations
- Palliative care, and hospice providers.
- Representatives from patient advocacy organizations (e.g., Cancer Support Community, Alzheimer's Association)
- Organizations interested in aging (e.g., AARP, Area Agencies on Aging)
- State health associations, state government, government advisory councils, and quality improvement groups
- The faith-based community.

- It is recommended that you include a person with an advanced illness and a family member or caregiver in the group

Community Contacts

Name	Organization	Email	Phone	Willingness to Participate

Action Step

- Use the Community Contacts to generate the names of individuals to be part of the leadership group and individuals who need to be at the table.

Other Available Resources

As you begin this process, it is important to be aware of other available resources that may make your efforts easier:

- Marshall Ganz and the New Organizing Institute - www.hks.havard.edu/faculty/marshall-ganz
- Respecting Choices - www.respectingchoices.org
- The Conversation Project - www.theconversationproject.org

Action Step

- Review the additional resources links to help you plan and develop your Lead and Leadership Teams.

Leadership Models

Effective leadership models include:

- Shared responsibility and mutual accountability for a common goal.
- Use of ground rules adopted by all participants.
- Listening empathically to community members' personal experiences.
- Diversity that reflects the community's culture, norms, and values.
- Awareness of related work in the community by coalitions and partnerships.

Reflection Questions

- Why am I involved, and why should others also be involved?

- Who else may be willing to help lead the effort?

- Who needs to be at the table to make this work?

- Who knows those individuals and is willing to invite them to participate?

Action Steps

- Review the Snowflake Model of leadership and organization: The Snowflake Model - https://culturalorganizing.org/tag/marshall-ganz/
- Set up your shared leadership model using the following questions as a guide:
    - What are your leadership team's rules?
    - What are each team member's responsibilities?
    - What community stakeholders to we need to hear from?
    - Does our team reflect the diversity of our community?
    - What other organizations and coalitions can we form partnerships?

Bringing People Together

After you have gained commitments from those who have been invited to help lead the effort, you will want to bring the group together to determine where you would like to focus.

In helping reshape and reorient advanced illness care, you may seek to encourage patients to share their stories.

Reflection and Discussion

- Who else needs to be at the table to make this work?

- How will we prioritize stakeholders and competing issues?

- What is our goal and objective?

- How will we measure impact?

Action Steps

- Identify the primary issues you believe should be the focus of the effort, given the issues in the community.
- Generate a list of initial goals, that you can share with the group.
- Be able to describe how you will know you have been successful.
- Review the Portland and Cambia, Louisville, and the Arizona End of Life Partnerships case studies in Module 4 for models and examples.

STOP

Stop the video and review the Chapter 1.1 Summary. Take time to answer the previous questions and begin to complete the listed Action Steps.

Chapter 1.1 Summary

- Community engagement requires at least one or more individuals or organization that is willing to initiate and coordinate the effort.
- The leadership team should include stakeholders from the healthcare system, including a person with an advanced illness and/or a family caregiver.
- Initiatives in Portland, Louisville, and Arizona relied on a small group of people, who helped strategically guide the effort, and help it gain momentum.
- Both the Portland and Louisville efforts help illustrate that an initial community convening is a useful way to create awareness, gain alignment on crucial issues, and generate involvement.

- The Arizona effort demonstrates the value of having a strategic funder involved from the beginning.
- The leadership team should be asking key questions that focus on who needs to be involved, what objectives should guide the effort and how the effort will be funded and assessed, and the Arizona partnership exemplifies this.
- Throughout the entire process, it's also important to consider the various roles and responsibilities that will need to be filled.

Chapter 1:2 - Goals, Focus, and Value Propositions

The next step in getting people and organizations to participate in your work is to develop an initial set of goals, determine a focus, and a value proposition.

- **Goals**:
    - Validate that the group is action-oriented.
    - Provide a suggested map for their work.
- **Focus:**
    - Determines where and among whom you can have the greatest impact.
- **Value Proposition:**
    - Describes the value of the work.
    - Connects the work to interested stakeholders, including funders.

The process to develop the goals, focus and a value proposition begins with:

- Describing the group's connection to the effort.
- Determining what the group members do professionally.
- Understanding family connections to advanced illness.
- Identify efforts already underway with other groups.

Our goals, focus, and value proposition are best described and developed by answering a series of questions:

- What we hope to achieve?
- What is the strategic focus and scope?
- What roles we want people to play?
- What are the ways to potentially tackle the opportunity?

Sharing Our Stories of Passion and Interest to Build Consensus

As you develop your goals, an important question the leadership group needs to discuss is what it would like to accomplish over time. The following Reflection Questions will guide in this process.

Reflection Questions

- How you would want the future to be different?

- What you would like to accomplish to make this possible?

- What are your motivations and aspirations and those of the leadership team?

- Why is the effort important?

Ultimately, you will want to take each of the shared answers and develop a statement that describes what is driving the group's interest and the value of pursuing such an effort. Understanding what is driving the interest of your leadership team is also critical in narrowing and defining your focus.

Developing Your Goals

In getting started, the leadership team created an initial list of goals. While this is a great starting point, the list that has been created is likely too narrow to allow for maximum impact and engagement from the community. As you go through the process described here, it is best to include a larger group.

Goal:

This chapter will help you identify clear goals by introducing you to a series of tools:

- Present/Future Grid
- Logic Model
- Journey Map

The Present/Future Grid

An important tool in helping identify clear goals is Present/Future grid. It is useful in that it describes the Present situation for those with an advanced illness, and the ideal 'Future,' based on changes the group wishes to bring about.

Present/Future Grid

Present	**Future**
Diagnosis is provided to the patient	
The immediate focus is on treatment and medication management	
No discussion takes place with the health care provider about the person's goals	
The patient is not directed to any other resources	
The patient is frustrated and struggles as only a part of their need is met	

The example shows a series of statements that describe the present. The statements begin with diagnosis and reflect not only facts but also the emotion that comes with unfulfilled expectations. With this as a starting point, it is useful to think about the stages the patient experiences and additional questions that they and their family may have. For instance, the patient may wonder if they should seek a second opinion and how that could affect their relationship with their doctor. The family may wonder if it would be worthwhile to reach out to a third party and get more information about their loved one's illness. Together, they may have even begun to wonder about experimental therapies and clinical trials. The patient could also be wondering about what their quality of life will be during treatment, and whether in the long run to have selected a less aggressive treatment. These only represent some of the questions one might ask.

Based on your experience, use the Present/Future template found in Module 4 to complete the Present side of the grid. Describe what the patient and their family go through in trying to make these decisions. This is important because you will want to think about each of the decisions someone with an advanced illness has to make. It's helpful to understand who else is experiencing this with them and to capture that in the margin. This will also help you later to identify all of the key stakeholders.

Once you have completed the Present side of the grid, generate a corresponding list describing what the Future should look like if patient care is high-quality, comprehensive, person and family-centered, and supported with aligned payment models. The Future statements are often just the reverse of those on the Present side.

Present	**Future**
Diagnosis is provided to the patient	Diagnosis is provided to the patient
The immediate focus is on treatment and medication management	The immediate focus is the patient's beliefs, their values, and their goals
No discussion takes place with the health care provider about the person's goals	The patient, provider, and family discuss the person's beliefs, their values and their goals
The patient is not directed to any other resources	The patient is directed to additional resources including a patient navigator & support group
The patient is frustrated and struggles as only a part of their need is met	The patient feels that they are living well despite their diagnosis

STOP

Stop the video and take time to complete the following Present/Future Grid for your purposes.

Present/Future Grid

Present	Future

Action Step

- Complete the Present/Future Grid.

Logic Models and Goal Setting

A Logic Model is another tool that can help determine your group's final set of goals. The Logic Model was first developed to help assess program effectiveness.[15] It has four major components, as shown below:

Logic Model

Goals	Milestones	Activities	Resources
What outcomes need to occur?	*What milestones need to occur to achieve the goal?*	*Given the milestones and goals, what activities will be undertaken?*	*What resources are needed?*

Typically, the Logic Model is completed left to right and begins with the resources needed rather than goals. This approach limits your goals to only those things that you already have resources to achieve. Because you want to let your goals guide what you do, the model is flipped to begin with goals and end with resources. You will ultimately complete all four columns in the Logic Model as you move through the toolkit. The focus now is to use the list you generated in Chapter 1.1 and your Present/Future Grid to describe what you want to accomplish and to create an initial list of goals. Your initial list of goals should focus on the next year.

Additional tools will be used to refine and evolve both our Present/Future grid and our initial set of goals. The C-TAC State Index will include a series of measures that describe the current situation. Here are some examples:

- Total Medicare spending
- Percent enrolled in hospice
- Hospital days per decedent in the last two years of life
- Hospice days per decedent
- Intensive care days per decedent
- Average co-payments per decedent in the previous two years of life
- Percent of hospitals with a palliative care program
- Home health agency visits per decedent
- Percent readmitted within 30 days of discharge
- CDC deaths at home
- Community Support
- Food Insecurity
- Adults who went without care due to cost
-

These measures, which rely on data from publicly reported sources, available at the state level and can be used to assess the quality and comprehensiveness of the system of care. Data

described in the state measures may not be available locally; however, they may suggest areas that should be examined more closely. With this in mind, it is useful to consider your initial list of goals and determine if any changes are necessary.

STOP

Stop the video and take time to complete the following The Logic Model for your purposes.

Action Steps

- Examine state measures and data for your state to see which of them should be ongoing areas of focus.
- Complete the outcomes column in your logic model.

Journey Maps

Another important tool which can help you refine your goals and plan further is the journey map. The initial goal in using it here to understand the needs of the person with an advanced illness between the time of their diagnosis and death.

Step 1: Use the Present/Future grid and determine the significant decision points.

Step 2: Use the decision points to divide the journey into distinct chapters. The primary decision points that occur between the diagnosis of advanced illness and death, include:

- Diagnosis
- Developing a care plan
- Initial Treatment
- Treatment failures
- Palliative Care
- Forgoing further treatment
- Hospice

Within the journey, you will want to identify:

- Who is involved in the decision-making process?
- Where they found information to inform their choices?
- What are the needs of other decision makers and key questions they may raise?

Step 3: Use the Present/Future grid and other information you have generated to:

- Focus on one of the major decisions that have to be made.
- Create a brief vignette that describes:
    - The person

    - The decision
    - The emotions
    - The patient' values and beliefs.
- Personalize it and include details that allow you to visualize the person and the situation.

Example:

> *Edna is a 72-year-old woman, who has been diagnosed with stage 3 metastatic breast cancer. She is divorced but remains close to her ex-husband, who is also experiencing health issues. Their daughter and her family do all they can to provide support. Edna's prognosis is not good, yet she remains active, in addition to following the directions provided by her doctor. She would like to know more about the resources that she has available to her and to join a support group, but she is not sure where to find them.*

This is only representing one decision and one segment from the journey. You will want to generate similar vignettes for each of the major decision points. These will be used later in your outreach and communication strategies.

STOP

Stop the video and take time to complete the Journey Narrative. Combine these from the group to draft one representing the group as a whole.

Reflection Questions

- What are 4-5 key decision points for the person with an advanced illness?

- What they have gone through in trying to make these decisions?

- Who else has gone through the experience with them?

- What do you want to accomplish on their behalf?

Action Step

- Generate your patient journey with vignettes that reflect the major decision points faced by the patient and family. Write out a rough draft for your use in the space provided. Share your rough draft with others in the group.

Defining Your Focus

Now, with your Journey Map complete, it's time to determine where you want to focus. While your Journey Map may describe the full-care continuum, you must decide if you are going to focus only on areas that you can impact or even limit your work to a specific set of stakeholders. Your focus may also be on specific geographic regions or timepoints in a person's illness. It is useful to consider what is manageable. As you determine your focus, you may need to modify your goals further.

You now have multiple tools that you can use, to help determine your group's goals. By this point, you have developed your Present/Future Grid, examined your state measures, and created a Journey Map to determine your focus. As you lay these out and look at them holistically, you may see common themes and trends emerge. Our goal, now, is to use the collected information you have generated, thus far, to populate the Logic Model with your goals.

Reflection Questions

- What are your motivations and aspirations?

- What will be the organization’s strategic focus?

- What roles do you want people to play?

Creating Your Value Proposition

Few donors are willing to invest time, energy, or money in any cause unless they have a clear understanding of the impact of their efforts. Developing a strong, convincing Value Proposition for your organization or cause is the first step to mapping out a successful development campaign.

What is a Value Proposition?

A Value Proposition describes the exclusive, continuous value your donors will gain by supporting your cause. It answers the questions:

- What makes your cause unique and worthy of support?
- How is aligning with your group/coalition beneficial for patients and families?
- How is aligning with your group/coalition beneficial for the community?
- How is aligning with your group/coalition beneficial for your prospective donors (either individuals or businesses)?

A compelling Value Proposition:

- Sets your organization apart in a competitive market.
- Persuades prospective donors to invest in your worthy cause.
- Explains how prospective donor sponsorship:
    - will make a difference
    - bring a benefit
    - create an opportunity that they won't find elsewhere.

Creating Your Value Proposition

Know your target audience.

- Identify all possible sources of support, including key decision-makers.
- Perform careful research to create a detailed persona of your ideal supporters.
- Use interviews and surveys to identify your prospects' demographics, motivations, and attitudes.
- Use this information to highlight the aspects of your organization that will most resonate with them.

Analyze your current situation.

Take a hard look at your group/coalition as it stands, and build a clear, objective picture of how well-positioned you are to achieve your goals. In this self-analysis, two tools are frequently used. The SWOT analysis, which is a framework to capture the group's current Strengths, Weaknesses, Opportunities, and Threats. In this application, it is recommended that you use OTSW (Opportunities, Threats, Strengths, and Weaknesses). Using OTSW forces you to look outside your group first, before looking inside. The use of a PESTLE analysis (Political, Economic, Social, Technological, Legal and Environmental) will help you analyze the external factor that can negatively impact on your group.

- Clearly define your group/coalition's values, mission, structure, and systems. Are they cohesive in their purpose and function? Do they send a message that's consistent with your cause?
- Pinpoint your group/coalition's strengths (what you do well) and weaknesses (what needs work or reevaluation).
- Identify any social, economic, or political factors that can affect your group/coalition, such as community demographics, legal guidelines, or controversial viewpoints.
- Compare and understand your group/coalition's position relative to competing non-profits:
    - What sets your cause apart from that of other similarly minded organizations?
    - How does their work affect their communities?
    - What do their supporters like most about their work?
    - How well do they communicate the benefits of their work to their supporters?

Helping Hand

This position analysis sums up your group/coalition as it is, not as you want your audience to see it. Remember to be objective and factual when gathering your information. An accurate analysis – even if it's not a favorable one – will help you better focus on your distinctive value qualities.

Writing Your Value Proposition

Once you've determined where you want to go and how well-prepared you are to get there, you can shape a powerful message to attract the right supporters. Your Value Proposition should paint a clear, compelling picture of:

- Who you are?
- What significant work you are doing?
- Why prospective donors should support your cause?

Helping Hand

- Speak to your target audience. Tailor your Value Proposition to resonate with the needs, perceptions, and attitudes of your potential donors.
- Focus on a return for investment. Develop a detailed cost analysis to show financial supporters exactly where their money goes, or to illustrate a significant social profit where the overall benefits outweigh the initial cost.

- Emphasize sustainable, continued value. Show donors that the benefits or rewards of supporting your cause go beyond their initial contribution. How do their contributions enhance their businesses or make a lasting difference in the community?

Examples:
"Stand Up to Cancer was created to accelerate groundbreaking cancer research that will get promising new cancer treatments to patients quickly. We won't stop until every cancer patient is a long-term cancer survivor."

- Standup Up to Cancer works relentlessly to offer the newest, most effective, and most promising cancer treatments to patients quickly by bringing together the best minds to collaborate, innovate, and share cancer research.

"To transform the landscape of dementia forever. Until the day we find a cure, we will strive to create a society where those affected by dementia are supported and accepted, able to live in their community without fear or prejudice."

- The Alzheimer Society believes passionately that life doesn't end when dementia begins.

STOP

Stop the video and take time to complete your Value Proposition. Write out a rough draft for your use in the space provided. Again, bring all the group's ideas together to create a strong Value Proposition.

The Convening
Before You Meet

- Generate a list of individuals you would like to involve from the community A Community Contact template is available in Module 4 to help facilitate this step.
- Plan a community convening, where you can discuss the issue, the group's interests, and preliminary things that you and the group hope to achieve. A Convening Checklist can be found in Module 4. It will ensure you have covered all of the key items in your planning. An important consideration in planning the convening is finding a location that is easy to get to, and that has convenient parking.
- When identifying a date, consider the following:
    - Provide 6-8 weeks lead time. This is especially true if you are asking senior leaders in the community to be involved.
    - The meeting should be planned for either first thing in the morning or at the end of the day. For healthcare providers, the end of the day is best, given their schedules.

Once you have the location, the date and the time, you will want to divide the list of desired attendees those you wish to involve amongst the leadership group and then reach out to each person. It is best that each of the leadership group have:

- The vital facts that can be shared by phone and in a follow-up email.
    - What the effort is?
    - Why it is needed?
    - What they can contribute?
    - Ask for them to invite another who they believe need to be involved.

During the Event

- Name tags and name tents should be available to help make it easier for those who have not yet met one another.
- Print the agenda and a copy of the goals to demonstrate that the effort is well organized.
- Collect contact information that can be shared with all of the other members.
- Limit introductions to name and organization to maximize your time.
- Share the goals of the coalition as well as the value proposition and get buy in from everyone who attends.
- Have flipcharts on hand to capture input.
- Generate the names of other people that should be involved.
- Determine key steps that should be taken and a timeline for doing so.

After the Event

Leadership Team members will want to quickly and intentionally follow-up with event participants.

- The group can send out handwritten “Thank You” cards to participants.
- A drafted email can be sent thanking participant for coming is also beneficial.
- Along with the email, you can attach the minutes from the event and participant contact information.
- Also include the date, time, and location of the group’s next convening.

STOP

Stop the video and review the Chapter 1.2 Summary. Take time to answer the previous questions and begin to complete the listed Action Steps.

Chapter 1.2 Summary

- Getting people and organizations to participate in your work requires clear goals.
- Understanding what motivates each person's interest and what they want to tackle over time is vital to the group's success.4
- A Present/Future grid can be used to describe the present situation for those with an advanced illness, and how the future will look based on changes the group wishes to bring about.
- To start the process, you should identify the key decision points for a person with an advanced illness, after they have received a diagnosis.
- It is best to focus first on the present situation, and then look to refine it further. Beginning this process by looking at the soon to be released state index will help define the present situation.
- Use the statements on the Present side of the grid, to generate a corresponding list that describes what the ideal future should look like.
- The state measures give you the ability to see where your state performs poorly, as compared to national averages or to other states.
- While the data described in state measures not be available locally due to laws protecting privacy, the measures which raise concern could suggest areas which should be more closely examined locally.
- The goal is to use the information generated thus far to populate the logic model.
- For the purpose of illustration, a prioritized list of outcomes/impacts has been created, and this was informed by the state index, the Present/Future grid and the patient journey.

Companion Guide for the C-TAC Toolkit

Module 2 - Communication Strategies

Creating awareness, changing attitudes and helping create systemic change requires effective strategies for outreach and sharing impact. This module will focus on how to:

- Identify and map stakeholders.
- Create and use a messaging strategy matrix.
- Engage stakeholders in ongoing dialogue and feedback.

Chapter 2.1 Channels of Communication

Goal:

This chapter will look at the variety of communication channels you may use to keep stakeholders aware of your efforts and impact, and how to set them up prior to your initial outreach efforts.

Big Idea:

Research shows that people need up to seven exposures to a message before they will act.[18]

There are multiple channels you can use to communicate with your stakeholders. The most effective communication strategies will involvement a combination of these:

- **Digital Communication** - the use of websites and social media platforms.
- **Print Media** - the use newspaper and magazine coverage and designed publicity materials for specific audiences and stakeholders.
- **Television and Radio coverage** - the use of paid or public service announcements.
- **Convenings** - meetings with current and potential stakeholders to raise awareness and share stories of impact and data.

Digital Channels

An overview of each digital channel will be provided to help you be more knowledgeable about which one may be best for you.

Websites

Websites are one of the most critical digital channels in that they allow you to communicate impact and connect with prospective members. Establishing a website starts with procuring a domain name. A domain name is reserved through a domain name registrar like GoDaddy or Namecheap. Once you have a domain name, platforms like Squarespace, Wix, or WordPress, are needed to create the website. These platforms help simplify the process, are relatively inexpensive. They do not require design or technical experience. Building a successful website,

however, requires more than just these tools. An engaging website needs an intriguing story which can be informed by the messaging matrix and Logic Model that created earlier.

Social Media

Social media channels like Facebook, Instagram, LinkedIn, and YouTube are also useful digital channels. Each has unique audiences, and it is important to pair the audience and channel to maximize the strengths of each. In order to bolster your knowledge, each of the digital channels is described in more detail below.

Helping Hand

- Optimally, you should post two to three times per week on the Facebook, LinkedIn, Twitter, and Instagram, but at minimum post regularly and consistently.
- Post at different times to catch different audiences.
- Several platforms let you schedule platforms in advance.
- This keeps your project and message "front and center."
- Regular updates to your website keep your project and message in front of your audience.

Facebook[19]

Facebook is useful for sharing content with individuals as well as for promoting business. The channel has widespread use regardless of age with 84% of those 30-49 utilizing the channel. Utilization of Facebook remains high for those between 50-64 (72%) and those over 65 (62%). Use is nearly equally distributed between females (52%) and males (48%). On average, Facebook users spend 35 minutes per day on the platform, and 75% of users spend more than 20 minutes a day. Facebook provides tools to help organizations boost their audience, and Facebook Live now offers the opportunity to share a video from live events. This aids in streaming large convenings or in reporting important news. The channel is both easy to set-up and easy to use, and instructions for getting started are easy to follow.

LinkedIn[20]

While Facebook is focused broadly, LinkedIn is most effective at promoting individuals and organizations and creating links between them. 80% of B2B social media leads come from LinkedIn. While the platform's use is evenly distributed between users 18-64, the gender distribution is more heavily skewed with 54% of users being male and 46% being female. Those who use the channel spend 17 minutes on average per day on the site. Like other channels, the instructions for getting started are easy to follow.

Twitter[21]
Twitter has carved out a unique niche amongst the digital channels in that it is used primarily to share news with stakeholders. Of its users, 75% check the site daily, and 79% of them retweet. However, the time spent on the website is limited to an average of 2.7 min per day. Its audience is evenly distributed between age groups 18-64. Like other digital channels, this is relatively easy to set up, and they provide useful technical support.

Instagram[22]
Instagram has carved out a unique niche amongst the digital channels in that it is best used to share pictures or video content. It is rarely used alone and is probably best used as a support tool for one of the other digital channels. It tends to be mainly used by younger audiences (59% of 18-29) and dominated by women (58% to 42%). On average, users spend 15 minutes per day using Instagram.

YouTube[23]
YouTube is best used to promote an archived video and is probably best used as a support tool for one of the other digital channels. The channel has a broader reach than cable networks with those 18-49 years old. Those individuals between 25 and 44 most heavily use it. On average, users spend 40 minutes per day on the platform.

Blogs, Digital Newsletters, and Emails
Blogs, digital newsletters, and emails are also useful tools that can be used to highlight the work of individuals and organizations and the progress that is made. Blogs allow you to create a running commentary that can be useful to the reader. If your goal is to reach a broad audience, email platforms like Constant Contact and MailChimp can be used for pushing out content and for email blasts to those on your list.

Print Channels
Print Media
Print Media, such as newspaper and magazine articles, can be an excellent means to provide awareness for your project. Reaching out to a local newspaper and or community magazine can be profitable. Newspaper and magazines can highlight your cause through a story of interest or at least share your planning meetings in the public service announcements.

Designed Print Materials
It will be important to create and produce print materials that share your project's purpose, call to action, and intended impact. These are accomplished with promo folders, graphically rich information sheets or cards. It is beneficial to have these professionally produced with a graphics designer to achieve maximum impact. There are several online or application tools, such as Canva, Adobe Suite, and Publisher that allow you to create and produce low cost, but high-quality print materials

Convenings
Convenings are useful ways to engage both those who are involved in the efforts and the community at large. Organizers should consider using a mix of the three types of convenings for effectiveness:

In-person meetings:

- Are extremely useful in creating a sense of community
- Allow for more social interaction, potentially leading to a more robust set of ideas
- Are most effective with a third-party moderator
- Can have the limitations of being geographically and time bound

On-line meetings:

- Can either be implemented using tools like Zoom or Google Docs that allow for discussion and community building, or with Google docs. Note: both have their advantages and disadvantages.
- Allows for live and future collected dialogue.
- Are not geographically limiting

A mix of these methods will allow you to effectively generate ideas and create community.

Convenings are also useful ways to engage both those who are involved in the efforts and the community at large. Organizers should consider using a mix of the three types of convenings for effectiveness:

- Large-scale public meetings (>100) can be used to generate awareness of your efforts and to share results with the broader community.
- Smaller convenings (15-100) can be used to get input, gain ideas and reinforce why individuals should be involved.
- A task force (5-15) can be used for project related work focused on topics like community-based education, community outreach, healthcare provider education.

Television and Radio Coverage
Both television and radio reach vast audiences. The cost to plan, produce, and place an awareness piece on either of these channels will be expensive. Investigate local stations to determine if your project may have free exposure through public service announcements.

STOP

Stop the video and review the Chapter 2.1 Summary. Take to answer the Reflection Questions and begin to complete the listed Action Steps.

Reflection Questions

- What types of communication are we using to reach our target audiences?

- Are there other vehicles that we could be utilizing to reach these audiences?

- Which digital channel is right for the audiences we want to reach?

Actions Steps

- Use the Reflection Questions to help your leadership team determine the modes of communication you might use in your communication strategies.
- Set up social media accounts for the channels you plan to use.
- Seek a communication and marketing volunteer to assist you on your communications strategies.
- Investigate printers and print costs for your printed material needs.
- Contact local television and radio stations to determine if there are ways to publicize your project through them.

Chapter 2.1 Summary

- Multiple types of communication are necessary to reach different audiences
- Digital channels play a significant role in continually keeping stakeholders aware of your efforts.
- Blogs, Digital Newsletters and Emails are tools that can be used to highlight the work of individual and organizations and the progress that is being made.
- Convenings are ways to engage both those who are involved in the effort and the community at large. They can be used to help those involved in the effort feel rejuvenated and reconnected, provide an opportunity to share input and reinforce why individuals should be involved or help those who are most involved be part of the leadership of the initiative.

Chapter 2.2 Developing Communication Strategies for Outreach

Big Idea

The success of your communication strategies is measured by awareness, the number of people who are communicated with, and the number who then engage. The degree to which stakeholders share the message with others, demonstrate changes in attitudes and actions, and help create change, are also signs of effective outreach.

Stakeholder Mapping

Goal:

Developing outreach strategies begins with understanding individuals and organizations who have a stake in the outcome and who may benefit from being involved.

Action Step

Complete the Stakeholder Mapping Grid below:

- Identify and list individuals and organizations who are actively involved in advanced illness care. Include their contact information.
- Record their priorities, their values and the resources they can contribute to the overall effort.
- Use you completed Present/Future Grid, to add individuals and organizations who play a significant role in patient-centered care.

Stakeholder Mapping Grid

Stakeholder Name	Key Contact	Email	Phone	Role	Relationship to Other Stakeholders	Priority

As you consider others to add, key stakeholders could include those individuals and/or organizations who:

- Provide medical care from the time of diagnosis until death.
- Determine what medical care can be provided.

- Provide social support from the time of diagnosis until death.
- Determine what social supports can be provided.
- Provide mental healthcare from the time of diagnosis until death.
- Support the faith of the person with an advanced illness.
- Provide legal counsel.
- Pay for services and supports.
- Consider the role that each stakeholder plays. These include:

Stakeholder Roles

Role	Definition
Budget Holder	Those who hold ultimate budget responsibility
Payor	Those who determine the value of care and process payments to care providers
Provider	Those who provide direct patient care
Navigator	Those who provide navigation through the system, and provide answers to questions
Supporter	Those who provide support for the person and the family throughout the illness.
Influencer	Those who influence care delivery including patient advocacy groups and professional medical organizations

The value of stakeholder mapping is that it helps you understand the connections that exist between stakeholders and how they can influence one another to take action. In prioritizing make the following considerations:

- Who can positively impact your goals?
- Who has an interest in advanced illness care?
- Who can influence others to take action?
- Who may have unique knowledge or relationships that can benefit the effort?

Once the relationship column has been completed:

- Rate each stakeholder's impact, interest, influence, and knowledge on a scale of 1-10 with one being lowest and ten being highest.

- Total the Scores for a priority score.
- Rank the stakeholders in order of priority.
- Analyze the highest scores for individuals and organizations that score the highest, as well as, the stakeholder roles. This will be important later in this chapter as you begin developing your messaging strategy.

Stakeholder Prioritization Grid

Stakeholder	Role	Impact	Interest	Influence	Knowledge	Priority
State of KY	Budget Holder					
Passport Health Plans	Payor					
Hosparus Health	Provider					
UL Physician Group	Provider					
Cancer Support Community	Supporter					
Louisville CEO Council	Influencer					

Reflection Questions
Who are your key stakeholders?

- Do individuals on the leadership team have existing relationships with them?

- Do these stakeholders already work with one another/have existing relationships with each other?

Action Step

- Create a drawing that shows the relationships among your stakeholders.

Messaging and the Messaging Strategy Matrix

The Messaging Strategy Matrix helps you determine what and how you will communicate with prioritized stakeholders. Its structure enables you to look across audiences, and plan messaging, supporting evidence, the call to action and ways to engage.

In creating your Messaging Matrix, you will want to consider:

- The information you wish to share.
- The information you would like to learn.
- The actions that you want to encourage by:
    - Identifying the role played by your primary stakeholder group(s).
    - Having a clear objective.
    - Describing what each of your groups need to know.
    - Understanding what supporting evidence may be required for stakeholders to confidently make a decision.
    - Knowing the actions, you would like to stakeholders take.
    - Using a channel(s) that effectively communicates with your stakeholders.

Messaging: Identifying the Stakeholder Audience

As you start to develop the messaging matrix, it is important to first determine your primary stakeholder audience. The best approach is to look at the stakeholder grid you completed earlier and choose the one you which is the highest priority. This is also the group you should communicate with most frequently. Most often, those who are represented will include the payor, the provider, the supporter and the influencer. You will also want to include the patient/family and funders. Then order them on the grid based on the level of priority. If a stakeholder group is not a priority, you should omit it from the matrix. It is possible, however, that all of the stakeholder groups could be included.

Messaging Strategy Matrix

Stakeholder Group	**Patient/ Family**	**Payor**	**Provider**	**Supporter**	**Influencer**	**Funder**
Objective						
Pt/Family Need						
Message						
Supporting Evidence						
Call to Action						
Channel						

Reflection Questions

- What are the different audiences that you identified?

- Which stakeholders would you connect to each audience?

- Do you know of existing patients/family members that would be willing to share their story?

Messaging: Identifying Your Objective and Message

Once you have chosen the primary stakeholder audience, you will want to determine your objective for outreach and communication. The easiest way to do this is to think about what it is you want those who hear the message to do. For example, at the outset, your objective could be to generate awareness of your efforts and get others to participate. The audience, the message, and the call to action would be different for this objective than it would be if your aim was to secure funding.

The Present/Future grid and the patient journey, along with your overarching goals, are helpful in guiding your choice of objective. In the patient journey excerpt below, there seems to be a clear need for a patient navigator.

> *Edna has been diagnosed with stage-3 metastatic breast cancer. She wants to take an active role in her care and would like to know more about what she can do. Since multiple organizations provide resources, she and her family need help to navigate through the system.*

This is reflected in the objective section of the message strategy matrix as well as the patient/family need.

Stakeholder Group	Patient/ Family	Payor	Provider
Objective	Awareness that the need is not unique, and pts and families must advocate for their needs and goals of care	Awareness of the need and of the shared benefit realized by both pts/families and payors	Awareness of the need and of the shared benefit realized by both pts/families and providers
Pt/Family Need	Patient Navigation	Patient Navigation	Patient Navigation

The Present/Future grid and the patient journey will also be helpful as your craft your messages. The message you choose needs to:

- Connect with your audience on an emotional level.
- Should describe a particular decision point or challenge for the patient, their family or the provider.
- Each message should describe the patient, their family or the provider; the action taken, the result and the impact.

Example:

The following message was designed for a provider and it describes the patient, her goals and the issue she is encountering. For the provider, the objective is to help them recognize and understand the problem and how it is impacting the patient.

Stakeholder Group	Provider
Objective	Awareness of the need and of the shared benefit realized by both pts/families and providers
Pt/Family Need	Following her diagnosis for metastatic breast cancer, Edna needs care navigation to ensure the best care
Message	A patient navigator is needed to advocate for her life goals, provide patient and caregiver education/support, facilitate care coordination and serves as a liaison to members of the treatment team. Patients with care navigators experienced improved health outcomes and increased patient satisfaction
Supporting Evidence	
Call to Action	
Channel	

Supportive Evidence

Supporting evidence is an important part of the messaging strategy because it brings in data from outside sources to support the claims being made.

- Evidence being drawn upon may help define the concept or be used to demonstrate value.
- Evidence that includes quantitative data and focuses on patient satisfaction or cost reduction is best. When used correctly, qualitative data can also be effective.
- Evidence obtained from well-known healthcare sources like the New England Journal of Medicine may be perceived as being stronger and harder to refute.

Stakeholder Group	**Provider**
Objective	Awareness of the need and of the shared benefit realized by both pts/families and providers
Pt/Family Need	Following her diagnosis for metastatic breast cancer, Edna needs care navigation to ensure the best care
Message	A patient navigator is needed to advocate for her life goals, provide patient and caregiver education/support, facilitate care coordination, and serves as a liaison to members of the treatment team. Patients with care navigators experienced improved health outcomes and increased patient satisfaction
Supporting Evidence	According to a report by the Center for Health Affairs, integrating patient navigation into healthcare delivery presents an opportunity to improve quality and lower costs by reducing readmissions, improving health outcomes, increasing patient satisfaction and reducing disparities in care.
Call to Action	
Channel	

Call to Action

In the example you have seen here, Edna needs help navigating the system. The oncology center where she receives care has assigned her a patient navigator. The supporting evidence helps describe what patient navigators are, and what value they provide to the patient, their family, and the provider. Now that you have built the case, with the key message and supporting evidence, you want your target audience to take action. Assume for illustration, that the target audience consists of directors of population health for the health systems in the region.

Determining Frequency

It is common not to receive a positive response with the initial Call to Action. Receiving no response or a negative response may reveal that the message isn't strong enough, that the supporting evidence is lacking, or that the target audience needs time to consider the ask. Research shows that messages often have to be delivered up to seven times to get traction. [20]

Having patients and families tell their story, or showing visuals, will generally help reinforce your case. Providing additional data may also increase your odds of success. When it can be printed and left with the target audience, those odds increase further.

Stakeholder Group	**Provider**
Objective	Awareness of the need and of the shared benefit realized by both pts/families and providers
Pt/Family Need	Following her diagnosis for metastatic breast cancer, Edna needs care navigation to ensure the best care
Message	A patient navigator is needed to advocate for her life goals, provide patient and caregiver education/support, facilitate care coordination and serves as a liaison to members of the treatment team. Patients with care navigators experienced improved health outcomes and increased patient satisfaction
Supporting Evidence	According to a report by the Center for Health Affairs, integrating patient navigation into healthcare delivery presents an opportunity to improve quality and lower costs by reducing readmissions, improving health outcomes, increasing patient satisfaction and reducing disparities in care.
Call to Action	Will you help us ensure that every patient like Edna who receives a diagnosis of advanced illness is assigned a patient navigator to help them live well with their illness?
Channel	Face to face meetings, conferences, smaller task force mtgs
Frequency	Up to 7 times over a 12-month period

Messaging Follow-Up

After you go through the message with its intended audience, it is important to be prepared with some follow-up questions. It can be useful to ask:

- Is the issue as a compelling problem?
- What additional information might be helpful?
- Are there are others who could also benefit from hearing the message?

If the response seems positive, it is wise to move to the call for action. Since your goal is to partner with them to improve care, this process should build toward a relationship rather than feel transactional. It is important to thank them for their time and send a note of thanks after.

Engaging in Ongoing Dialogue

Engaging communities requires more than messaging:

- Ongoing dialogue and feedback are required through a one-to-one meeting, focus groups, task forces and other convenings.
- Questions should be clear and focused on things that you plan to act upon.
- Have plans for data you gather.
- Establish trust and an ongoing commitment to the community by demonstrating how stakeholder feedback is used.

STOP

Stop the video and review the Chapter 2.2 Summary. Take time to answer the Reflection Questions and begin to complete the listed Action Steps.

Action Steps

- Map out stakeholders and existing relationships
- Match target audiences with appropriate stakeholders
- Brainstorm ideas of the message the group wants to send
- Narrow the list of possible messages down to 4-5.
- Identify the specifics for each (target audience, which stakeholders might help, type of distribution.

Chapter 2.2 Summary

- The first step in developing the outreach strategy is to identify and map these organizations and individuals and their relationships with one another.
- As you begin developing the messaging matrix, it is important to look at your stakeholder grid. The best approach is to look at the roles that are represented there and choose the most frequent for your messaging matrix.
- It is critical to begin with determining your objective for outreach and communication. The easiest way to think about this is what do you want those who hear the message to do. The message you choose needs to first connect with your audience on an emotional level and describe a particular decision point for the patient, their family or the provider.

- The goal of supporting evidence is to provide data from outside sources that supports the claim being made.
- Growth requires nurturing and patience. Research shows that messages will often have to be delivered multiple times for us to get traction with most messages needing to be delivered 7 times.
- Having patients and families tell their story or showing visuals will generally help reinforce your case.
- After you have gone through the message, it is important to be prepared with some follow-up questions.

Chapter 2.3 Developing Communication Strategies for Sharing Impact and Growing the Effort

Big Idea

Communicating impact starts with keeping it front and center. To maintain and grow the effort requires continuous care and feeding. This chapter will look at how to keep stakeholders aware of your efforts, and how to use digital channels to help achieve this.

Revisiting Your Outreach Communication Strategy

Your impact communication strategy will use the same channels as your outreach communication. These should include:

- Convenings of stakeholders
- Email and/or eNews updates
- Print Materials
- Use of Digital Channels

Revisit Chapter 2.1 to review the Communication Channels and their use.

Messaging

Use your impact communication to highlight one or two of the following ideas:

- Share stories of progress and impact.
- Revisit the project objective and "Call to Action."
- Highlight partners alliances that move the project's completion and impact**.**

Reconvening

Reconvene your stakeholders to share stories, either in testimonies or video form. This sharing will display that your project is moving forward with its desired impact. Use these events to acknowledge and thank stakeholders and partners for their participation.

Emails and eNews Updates
Sending out periodic emails or eNews updates to your stakeholders and partners keeps them connected to you, your and your project's progress and impact on its target audiences.

Print Materials
You can also send "Thank You" notes to your stakeholders and partners. Handwritten notes provide a personal touch. Sending a prepared and printed "fact sheet" update with a short-handwritten note is another option.

Digital Channels
Use the different social media platforms to tell your stories and to share data and impact. Continue to reinforce the need and "call to action." Use your social platforms to drive your audience to your website where you can give more details about your projects.

STOP

Stop the video. Take time to answer the Reflection Questions and begin to complete the listed Action Steps.

Reflection Questions

- How might we expand our audience?

- Are there specific examples we want to use to guide our efforts?

- Have we created an intriguing story that has been informed by the messaging matrix and logic model that we created earlier?

- What level of convenings would be appropriate for our goals?

- What is our goal in hosting a convening?
    - feel rejuvenated and reconnected,
    - provide an opportunity to share input and reinforce why individuals should be involved, or

- help those who are most involved be part of the leadership of the initiative.

Action Step
Determine which communication channels will most effectively reach your audiences to keep them aware, informed, and engaged?

Companion Guide for the C-TAC Toolkit

Module 3 - Plan of Action

With your goals and messaging in place, the next steps are to pull all of the pieces together and identify the resources that will meet your objectives, implement your plan, and begin to focus on collecting, storing and analyzing data.

Chapter 3:1 Creating and Implementing Your Plan of Action

Goal:

In this chapter, the four tools previously discussed will be revisited: the Present/Future grid, the patient journey, the Logic Model, and the messaging matrix - and they will be used to create the remainder of your plan.

Action Step

- Review the four tools you created.

Reflection Questions

- Are you still in agreement about the information in the tools?
- Are there any details that need to be changed/adjusted in one, or more, of the tools? If yes, who in the group will do so?

Step 1: Collaboration - Recognizing Existing and Complementary Efforts

As described in Module 1, likely, some members of your community may already be engaged in efforts focused on advanced illness or advanced care planning. As you create your plan of action:

- It is essential that you recognize them for their efforts.
- Ask for their input and acknowledge both their efforts and results
- Look to build on their efforts rather than duplicate them.
- Research coalitions and partnerships that focus on a specific disease or condition that are complementary to work together.

Collaborative efforts can be focused at different levels – within a city, a region, or even at a state level. This effort will focus on efforts undertaken at a state or regional level.

Knowing your community will also help your group identify the individuals and organizations whose support is necessary. You need to take into account your community's culture, social networks, political structures, norms, values, and strengths, and the barriers to collaboration

and engagement these often create. This knowledge will make decision making and consensus building easier and will translate into improved program planning, design, and execution.

Available resources drive the work of the collaborative. Your work may require funders, and an important place to start is to consider partners who are already part of the effort. It is also essential to understand which grant-making organizations align with your work and what their grant-making process is. Another method to extend resources is to invite others to join currently funded projects where their expertise or labor may be needed.

Action Steps

- What needs to happen in order to reach your goal?
- Is there a plan in place for funding?

Step 2: Determining Milestones and Outcomes
A Working Example
In the Logic Model below; that you saw in Module1, you see goals/outcomes derived from the State Index measures.

The State Index

- Can help provide you information about how your state is performing on key measures
- Can help guide both your choice of outcomes and activities
- Assist a group focused at the community level to see where the state performs poorly, compared to national averages, or to other states
- Includes the calculator and the best practices library that provide tools that can assist in your quality improvement effort. As a reminder, these measures include:

    - Percent enrolled in hospice
    - Hospital days per decedent
    - Hospice days per decedent
    - Intensive care days per decedent
    - Percent of hospitals with a palliative care program
    - Percent readmitted within 30 days of discharge

Logic Model

Goals	**Milestones**	**Activities**	**Resources**
What outcomes need to occur?	*What milestones need to occur to achieve the goal?*	*With the milestones, what activities will be undertaken?*	*What resources are needed?*
50% increase in enrolled hospice			
50% increase in average days in hospice			
50% increase in community involvement			
100% of health systems have patient navigators for their pts with advanced illness			

Look at local process measures, especially when you are focused on trying to ensure access to services or growth in community capabilities. These may include:

- The number of available support groups
- The number of support group members
- The number of physician champions for hospice
- The growth in calls to advocacy organizations

Together this information can help guide the milestones, the activities, and the needed resources, which will be described next.

The goals/outcomes entered into the Logic Model are preceded outputs and milestones. Reaching your desired goals/outcomes is a progressive process. So, you should determine ahead of time what those outputs and milestones should occur. You can arrive at these outputs and milestones by asking what needs to take place for you to reach the end goal. With a larger group of stakeholders in place, this can now be a robust process. These outputs and milestones result from the activities you carry out but are defined before the activities. The list of outputs and milestones you generate will help determine both the activities and the budget needed for them. Let's look at the first outcome you want to achieve – a 50% increase enrolled in hospice.

To accomplish this, you likely need to increase the number of hospice referrals. As you brainstorm what might be required to get to that 50% increase, several things are evident. Referrals come from an awareness of the hospice benefit, as well as knowledge of the hospice providers. Referrals are likely to come from hospitals as well as physician practices. Referrals from these sources could likely require partnerships and some awareness event. See the example of a milestone list in the Logic Model.

Logic Model

Goals	**Milestones**	**Activities**	**Resources**
What outcomes need to occur?	*What milestones need to occur to achieve the goal?*	*With the milestones, what activities will be undertaken?*	*What resources are needed?*
50% increase enrolled in hospice	# of referrals # of partnerships established # of attendees who attend open houses		
50% increase in average days in hospice	# of facility tours # of support group presentations # of attendees		
50% increase in community involvement	# of attendees at annual convening # of people involved in leadership roles		
100% of health systems have patient navigators for their pts with advanced illness	# of referrals # of partnerships # of attendees who attend open houses		

Step 3: Creating Your Activities' List

The project's activities are linked with your outcomes and milestones. With the desired outcomes and milestones listed, it is time to generate a list of activities that will get us there. In creating your activities list, it is vital to consider the following:

- **Target Audience** - Like your messaging matrix exercise, you need to make sure it's clear who that target is.
- **Prioritize** - With limited resources the number of activities may have to be reduced.

- **Collective Impact** - everyone who is part of the effort may be carrying out activities on their own that will move the community to achieve the outcomes successfully. These activities should be listed.

Creating your activities list is best achieved by either at an in-person convening or online. Each of them can be useful, and they can be used singly or together, to create your plan. Review Module 2 for best practices.

After generating your activities list, you will need to prioritize them. To prioritize the activities list, you should consider the questions below:

- What activities are most urgent?
- Do they build on one another?
- Is the timeline affected by funding?
- Do you have a proposed timeline in mind?

The easiest way to denote priority in the plan is to rank order them or color-code them, by highlighting the most important and urgent activities in red, important less urgent in yellow, and important but-not-urgent in green.

Now a look at how these activities might be listed in the Logic Model.

Logic Model

Goals	**Milestones**	**Activities**	**Resources**
What outcomes need to occur?	*What milestones need to occur to achieve the goal?*	*With the milestones, what activities will be undertaken?*	*What resources are needed?*
50% increase enrolled in hospice	# of referrals # of partnerships established # of patients from practices # of attendees who attend open houses	Partnership Established B/T Oncology Practices and Hospices Review of Hospice Benefits For Oncology Practice Nurses	Outreach Materials Budget for Location and Food
50% increase in average days in hospice	# of facility tours # of support group presentations # of attendees	Overview of palliative care and hospice provided to disease support groups	
50% increase in community involvement	# of attendees at annual convening # of people involved in leadership roles	Conduct convenings that help inform and energize the community around person centered care	
100% of health systems have patient navigators for their pts with advanced illness	# of referrals # of partnerships established # of patients from practices # of attendees who attend open houses		

STOP

Stop the video and review the Chapter 3.1 Summary. Take to answer the Reflection Questions and begin to complete the listed Action Steps.

Action Steps

- List the activities that needed to be done to reach your goal.
- Order these activities by importance.

Chapter 3.1 Summary

- As you create the plan, it is important to recognize the expertise of those who had been working before the formation of your group.
- Your work will require funders. Consider partners who are already part of the effort. Examine which grant-making organizations are aligned with your work.
- Partner with like organizations in their efforts and/or invite them to join projects that are funded but require additional resources.
- Identify promotional events that are already scheduled as potential opportunities for partnerships.
- In developing the plan, you will use the present/future grid, the patient journey, the logic model and the messaging matrix.
- Reaching desired outcomes is a progressive process.
- Outcomes and milestones determined first. These are arrived at by asking what needs to have happened for us to achieve our end goal.
- The list of activities can be generated either at an in-person convening or online.
- In-person meetings are extremely useful in creating a sense of community, and they allow for more social interaction.
- On-line sessions could either be implemented using tools like Zoom that would allow for discussion and community building or with Google docs.
- The easiest way to denote priority in the plan is to rank order the items either by color or number.

Chapter 3:2 Measuring Impact

Goal:

Throughout this toolkit, a considerable amount of time has been spent developing the Logic Model. This chapter will focus on collecting, storing and analyzing data, along with the frequency of collection. Translating the data will also be discussed.

Data: Using the C-TAC State Index

The C-TAC state Index will provide you with annual data updates which will allow you to assess improvement and identify ongoing opportunities. The critical thing is to connect this information to locally recognized measures, which are specific to the area where efforts are undertaken and measured on an ongoing basis. Data from the state index allows you to assess improvement more frequently and make adjustments, rather than depending solely on the state data.

Data: Using Local Data

A considerable amount of local data is restricted by the Social Security Administration or the Center for Medicare and Medicaid Services (CMS), to provide adequate privacy protection for individuals. With just four or five data points, such as age, the number of children, and geocode, it is possible to narrow down to only a few people with these characteristics in a city/county. Larger sample sizes protect individual privacy. The critical thing is to connect the State Index

data to locally identified measures to the specific area where efforts are undertaken and regularly measured. This may apply primarily to outputs but can apply to goals/outcomes as well. This allows you to assess improvement more frequently and make adjustments, rather than depending solely on the state data.

It is essential to work with members of your group locally to determine what data they collect and may be willing to share. Other sources of local data include advocacy organizations and social service organizations. While you will likely be able to find data, it is unlikely that you will find one aggregated source.

Data that may be accessible can include, the number of available support groups, the number of support group members, the number of physician champions for hospice, and the percent increase in calls to advocacy organizations. You can also include the number of people who are attending large convenings, and the number of people who become actively involved in task forces and other relevant activity. As you gather data, it is important to understand the process of how the data is collected.

Members of your coalition are often great sources of data. Asking coalition members several key questions will be beneficial. These include:

- What data are you collecting related to advanced illness and caregiving?
- What is the purpose of collecting the data?
- How often is the data collected?
- How large is the sample?
- Is your data quantitative or qualitative?

Once you determine which of the data aligns with your needs, then ask if the organization is willing to share it regularly. If they will then create a data dashboard to assess your progress. Remember, it is important to periodically share your data with your funders, partners, and stakeholders through the communication channels outlined in Module 2.

Logic Model

Milestone	Sources	Goals	Sources
# of referrals # of partnerships established # of attendees who attend reviews # of patients from practices	Hospice providers Oncology Practices	50% increase enrolled in hospice	State Index
# of facility tours # of support group presentations # of attendees	Hospice providers Advocacy groups	50% increase average days in hospice	State Index
# of attendees at annual convening # of people involved in leadership roles		50% increase in community involvement	Combined Event Attendance

STOP

Stop the video and review the Chapter 3.2 Summary. Take to answer the Reflection Questions and begin to complete the listed Action Steps.

Reflection and Discussion

- Why is it important to measure impact?
- Why are annual updates from the State Index important?
- Why is locally sourced data sometimes difficult to find?
- How can we encourage more local organizations and groups to start collecting data on their initiatives?

Action Steps

- Understand the importance of measuring impact and data use.
- Learn how to use the State Index.
- Identify sources of local data that are useful.

Chapter 3.2 Summary

- The soon-to-be-released, state index will provide you with annual data updates which will allow you to assess improvement and identify ongoing opportunities.
- The critical thing is to connect this information to locally identified measures, which are specific to the area where efforts are being undertaken, and that can be measured on an ongoing basis. This may apply primarily to outputs but can apply to outcomes as well.
- A considerable amount of local data is restricted by the Social Security Administration or the Center for Medicare and Medicaid Services (CMS), in order to provide adequate privacy protection for individuals.
- Data from the state index allows you to assess improvement more frequently and make adjustments, rather than depending solely on the state data.
- To measure impact, we look at collecting, storing and analyzing data.
- The frequency of collection will also have a bearing on the results of any analysis
- The state index provides annual updates, that will allow for the assessment and identification of ongoing opportunities.
- It is important to connect data found in the state index to items that are measured at the local level.
- While understanding how to use data is important, it is equally important to understand how the data is collected.

Companion Guide for the C-TAC Toolkit

Module 4 Case Studies, Tools and Templates

This module contains several case studies of the work other coalitions have completed in the area of advanced illness. You will also find additional tools and the templates for Community Contacts, Present/Future Grid, the Logic Model, Convening Checklist, Stakeholders Mapping Grid, Stakeholders Prioritization Grid, Messaging Matrix, and additional examples.

Chapter 4.1.1 Case Studies: Getting Started

The Portland and Arizona examples help illustrate different approaches to getting started. Portland held an initial community convening to generate awareness, gain alignment on critical issues, and gain commitment for involvement. The Arizona effort was initiated by a vital funder who helped bring key stakeholders together. Each of the efforts relied on a small group of people to get things started and to provide the leadership to help it gain momentum.

Once the groups come together, they may take different paths in determining their strategic focus. In Portland, the focus areas - public education, care delivery, and policy advocacy - became more evident as a result of the roundtable discussions. All efforts relied on a small group of people, who helped strategically guide the undertaking, and help it gain momentum. In both Louisville and Arizona, the organizers had a clear idea of where they would like to focus from the outset.

Portland and Cambia

As active members of C-TAC, Cambia Health CEO, Mark Ganz, and Peggy Maguire, President of the Cambia Health Foundation, believe that Oregon could benefit from the formation of a Serious Illness Care Coalition. They were willing to help initiate the effort and took the first step by bringing together stakeholders from a variety of organizations. Their goal was to create a shared knowledge about palliative and hospice care, gain feedback on the idea of collaboration, and confirm the willingness of others to participate.

In doing this, stakeholders were invited to attend a screening of “End Game,” a 40-minute documentary that weaves together stories about individuals and families facing serious illness. A networking reception and roundtable dinner, where Mark and Peggy shared their vision of bringing organizations together, to improve care for those with serious illness followed the screening. Those in attendance were then asked to share what they thought of the idea, and if they were, they willing to be part of the effort. Organizations, including AARP Oregon, all voiced their support for the idea and expressed their willingness to be involved. The next day, a small group gathered at Cambia Health to debrief the stakeholder meeting and draft a vision statement, principles, and strategic focus. These will be examined in an upcoming chapter.

Arizona End of Life Partnership[24]

The Arizona EOLCP began as a small community coalition comprised of passionate people from community non-profit organizations. The coalition received an initial $10K Convening grant from the David and Lura Lovell Foundation for community stakeholders to address Strengths, Opportunities, Aspirations, and Results/Resources for end of life in Tucson. The convening led to a $30K Planning Grant and a $3 Million Grant to ten organizations to lay the groundwork for the creation of the Arizona End of Life Care Partnership (Az EOLCP). Nine of the ten grantee organizations are in Pima County/Tucson and one, the Arizona Hospital and Healthcare Association.

The United Way of Tucson and Southern Arizona (UWTSA) was designated as the backbone organization and Senior Director, Sarah Super Ascher leads the effort on their behalf. The initiative includes the following members:

- Arizona Hospital and Healthcare Association
- Interfaith Community Services
- Southwest Folklife Alliance
- Tu Nidito
- Tucson Medical Center Foundation
- The University of Arizona Center on Aging
- United Way of Tucson and Southern Arizona
- Casa de Luz Foundation
- The Tohono O'odham Nursing Care Authority Foundation
- Pima County Council on Aging

The partnership has sought to develop and implement a broad-based collaboration with a shared vision. This shared vision calls for all individuals to have excellent healthcare at all points in their life transitions; to die with dignity, meaning, and respect. The shared vision further calls out our communities and health systems to meet those expectations. As a result of its membership, the partnership offers a community hub for a network of services and resources; human-centered community education, advocacy, and support; healthcare provider education and support; caregiver workforce development; workplace initiatives; public policy advocacy, statewide leadership and global models for community collaboration

Chapter 4.1.2 Case Studies: Goal Setting

Portland and Cambia

Cambia Health held a meeting with organizations in the community interested in advanced illness care, caregiving, palliative care, and hospice. Those in attendance were excited about working together to focus on these items. Based on their feedback, a smaller group drafted a vision statement for others in the community to review. Their draft vision is:

All Oregonians with serious illness receive comprehensive, high-quality, person- and family-centered care that is consistent with their goals and values and honors their dignity.

Several things are worth noting in the vision statement. First, the vision describes the group of people who will be affected. Second, it represents a future state that the group hopes to achieve. Finally, it provides a detailed description of the future state.

Arizona End of Life of Partnership[25]

The End of Life Partnership seeks to develop and implement a broad-based collaboration with a shared vision. This shared vision calls for all individuals to have excellent healthcare at all points in their life transitions; to die with dignity, meaning, and respect. The shared vision further calls out our communities and health systems to meet those expectations.
The partnership offers:

- A Community hub for a network of services and resources
- Human-centered community education, advocacy, and support
- Healthcare provider education and support
- Caregiver workforce development
- Workplace initiatives
- Public policy advocacy
- Statewide leadership
- Global models for community collaboration

Chapter 4.1.3 Case Studies: Communication Strategies

Massachusetts Coalition for Serious Illness Care [26, 27, 28]

The Massachusetts Coalition for Serious Illness Care has effectively used digital tools to share their message. They have adopted a portfolio approach that allows them to use a variety of outlets to maintain energy up and drive involvement. Their website (http://maseriouscare.org) has played a central role in their efforts. It has several components that have been used to help them grow to their current 103 members. These include a research tab that provides access to surveys that the Coalition conducted in 2016, 2017 and 2018, and a news/events tab providing summaries of the summits and examples of media coverage of the coalition.

In addition to the website, the coalition uses a variety of communication means with members about current activities and opportunities for engagement. Of the social media channels, the Coalition uses Twitter exclusively (https://twitter.com/maseriouscare.) The group also hosts two meetings each year are a dynamic way of connecting with and updating members. The sessions generate considerable enthusiasm and energy.
The coalition uses Constant Contact to disseminate email updates and an e-newsletter. A key component of each newsletter is a feature article highlighting the work of a member organization. Members appreciate the coverage and the interaction involved in preparing the stories.

Massachusetts Coalition for Serious Illness Care: Communicating Impact

- 2018 Summit, including videos: http://maseriouscare.org/news/summit-2018
- 2017 Summit, including videos: http://maseriouscare.org/news/summit-2017
- Nov. 2017 Meeting Photo Collage: https://spark.adobe.com/page/4N5KgcC0v70cP/
- 2018 Research: http://maseriouscare.org/2018-consumer-survey-full-results

A sample of media coverage is available at http://maseriouscare.org/news. An example of media coverage is available at http://maseriouscare.org/news

Their Annual Summit, the largest of the meetings, attracts 300-400 people. It is intended to energize the movement by providing a place where people who share a passion for a serious illness can gather and connect with their colleagues. The event also features marquee speakers who share updates and insights from the latest research. The Coalition also hosts a smaller fall meeting that draws 60-70 attendees. Its purpose is very different. At this more intimate session, participants share ideas about goals and strategy, often using design thinking methods. This meeting is used not only for input but also as a means to reinforce why individuals should be involved. The coalition also occasionally convenes task forces focused on specific initiatives. Participants are typically active members who have particular expertise to share. These types of convenings help make participants feel part of the group's leadership.

Arizona End of Life Partnership[29]

The Arizona End of Life Partnership has also effectively used digital channels to share their message. Their website (https://www.azendoflifecare.org) has several components that have also been useful in growing their effort. The first tab on their website focuses on the vision, values, and purpose of the partnership and even includes investment opportunities.
The site also provides useful resources from the Partnership and its members. Another notable feature of their website is a focus on inspiring stories which contain videos, articles, and websites as well as an opportunity for people to share their stories. They also have a survey they are fielding about advanced care plans. The current website represents phase one of website design. Plans include navigation through resources in the community with a goal of the site being a hub for all resources.

While their effort is still young, the Arizona End of Life Partnership has focused three of their six pillars on outreach and impact. These include community-based education, community outreach, and healthcare provider education. Their community-based education efforts include scheduled community workshops, train the trainer sessions, and coaching. Their community outreach efforts include a helpline, info line, and calendar as well as conferences and presentations. Their healthcare provider education is focused on Professional Development.

Chapter 4.1.4 Case Studies: Plan of Action - Creating, Implementing, and Measuring Impact

What Matters: Caring Conversations About End of Life[30]

What Matters: Caring Conversations About End of Life has sought to create a community that is guided by Jewish values and embraces advance care planning as a natural part of life. Where the end of life decision is known, respected, and honored.

The initiative is a collaboration between the Marlene Meyerson Jewish Community Center in Manhattan, The New Jewish Home, and the Center for Pastoral Education at the Jewish Theological Seminary. It builds upon Respecting Choices, and its success can be attributed to their ability to start small but think big. To share best practices, they hold regular meetings between the site leaders who share best practices, facilitate support sessions, and engage the community.

Under the leadership of Sally Kaplan, *What Matters* aims to accomplish three things. First, it seeks to heighten awareness about the importance of completing advance care directives. Second, it enables individuals to consider and document their end of life preferences thoughtfully. Third, it engages Jewish values as part of the process.

Unlike other programs, *What Matters* has trained sites and allowed them to build on their own culture and organization. As a result, trained and certified facilitators walk individuals through the process and encourage them to discuss their wishes with family members, loved ones, and physicians. It is spiritual, relational, and emotional.

During its 4-year existence, the initiative has grown from five sites initially to nine program sites with a goal of fifteen. The current sites include six synagogues, one community center, one communal organization, and a nursing home. They represent three different denominations and other theological approaches.

Honoring Choices Pacific Northwest[31]

Honoring Choices Pacific Northwest is a collaboration between the Washington State Hospital Association and the Washington State Medical Association. This collaboration has sought to inspire adults of all ages to create their end-of-life care plans and connect people to the tools they need to get started.

The Washington State Hospital Association is a membership organization representing community hospitals and several health-related organizations. The Washington State Medical Association is a professional organization that represents physicians, physician assistants, residents, fellows, and medical students throughout the state. Together they have provided resources to guide people through sharing those plans with their loved ones and with their health care professionals. They have also gathered professionals together from various organizations across the region to promote advance care planning through increasing awareness, knowledge, and resources. Their program consists of has five components – advanced care planning, community engagement, professional development, advocacy, and a central repository.

Organizations participating in the Honoring Choices Pacific Northwest Program offer facilitated advance care planning conversations to patients based on the Respecting Choices® First Steps® model. Included in this program are certified facilitators who speak with people of all ages and stages of health regarding concerns about end-of-life care. These facilitated discussions define how to identify a healthcare agent, someone the person believes is willing and trustworthy to make medical choices if he or she is unable. Most importantly, when religious and cultural beliefs are revealed, attendees often leave these discussion forums with advance directives completed.

Arizona End of Life Partnership[32]

As the United Way of Tucson and Southern Arizona and the Arizona End of Life Partnership has begun their work, they have identified a series of benefits and learnings from their plan of action**.** A shared mission, vision, and values that have been adopted by key community stakeholders and cross-sector organizations involved in the work has helped create trust amongst the partners. Having a well-respected organization like the United Way serve as the backbone has helped them better connect the different facets of their work and increases visibility both inside and outside of the Partnership. The organizations and leaders involved have adopted systems thinking which has helped them look at problems differently and to be open to unexpected opportunities for expansion. They also allow themselves to think big, which requires them to start with why and then listen; think creatively and challenge assumptions.

The pillars they created to guide the work have helped create connection and show overlap between the work of their action groups and decrease duplication.

The End of Life Partnership is aligning their 6 Pillars shown below to Action Groups that consist of members across Partnership organizations.

COMMUNITY-BASED EDUCATION	**WORKFORCE DEVELOPMENT**
Scheduled Community Workshops	Identify Gaps In Professional Education Programs
Train the Trainer Sessions	Plan for Meeting Increase In Demand
Coaching	Serving Vulnerable Populations
Special Populations	
COMMUNITY OUTREACH	**FACILITY BASED INITIATIVES**
Strategic Marking Plan, Including Branding & Advertising	Identify Quality Measures and Workflows for Health Care Professionals
Helpline, Infoline, and Calendar	Pilot Projects
Public Relations	Workplace "Inside Out" Wellness Advance Care Plans
Conferences & Presentations	
HEALTHCARE PROVIDER EDUCATION	**POLICY & ADVOCACY**
Professional Development	State Advocacy for AzMOST
CME/CEU for EOL and Advance Care Planning	Advocacy for Health Plan Coverage
Curriculum Development	Partnership Outcome Measures
Partnership Educators and/or Providers	

The approach has led them to create products that have benefited both Partners and the community at large. From the outset, they have collected and shared data between the organizations that have helped lead to quality outcomes and continuous improvement. Sara Ascher and the partner organizations have also encountered challenges which have also led to significant learning. There remains a need to break down silos and help change the mental model for change for partnership organizations. There is also a need to adopt a more significant community mental model to achieve the Partnership mission.

Massachusetts Serious Illness Coalition[33]

More than 100 Massachusetts-based organizations have come together to form the Massachusetts Coalition for Serious Illness Care. Working at these groups are dedicated physicians, nurses, hospice workers, counselors, clergy, hospital, and health plan administrators, social workers, attorneys, policymakers, researchers, and other health

professionals. Ultimately, people need to be at the center of discussions with family and others concerning all aspects of their care. The coalition's mission is to ensure healthcare for the people of Massachusetts is aligned with the goals, values, and preferences at all stages of life and care.

• Complete a health care proxy - Everyone in Massachusetts, 18 or older, has designated a health care decision-maker (known as a health care "agent").
• Engage in ongoing conversations with your health care agent - Everyone in Massachusetts, 18 or older, has had a conversation (and continues to have conversations) with their agent to communicate their goals, values and preferences for care at the end of life.
• Ensure appropriate training for clinicians - All Massachusetts clinicians have appropriate training to facilitate high-quality communication with patients on advance care planning and serious illness.
• Have an informed conversation with your care team - Everyone in Massachusetts facing a serious illness has had a high-quality, informed goals and values conversation with their care team.
• Create a system to elicit and document wishes - All Massachusetts health care providers have systems in place to elicit and document goals, values, and preferences for patients with serious illness.
• Ensure that preferences can be shared, regardless of place of care - All Massachusetts health care providers have systems in place to share patient goals, values and preferences across care settings and ensure they're accessible regardless of place of care.

The Coalition held its third annual summit on May 15, 2018, at the John F. Kennedy Library in Boston. The day featured a discussion with Jonathan Bush about the experiences of serious illness and end-of-life-care with his aunt, Barbara Bush and his uncle, George H.W. Bush. Also included was a presentation of the coalition's 2018 consumer research, as well as an in-depth panel discussion on lessons that can be learned from significant public health and social change success stories.

MASSACHUSETTS COALITION FOR
SERIOUS ILLNESS CARE

Summit Agenda

10:00am Registration/Refreshments

10:30am Welcome/Introduction

Andrew Dreyfus, President and CEO,
Blue Cross Blue Shield of Massachusetts

"Honoring Barbara Bush's Wishes:
A Conversation About Serious Illness"

Atul Gawande, Executive Director, Ariadne Labs;
Surgeon, Brigham and Women's Hospital; Professor, Harvard T. H. Chan School of Public Health and Harvard Medical School

Jonathan Bush, CEO, athenahealth, Inc.

Presentation of 2018 Survey Results

Atul Gawande

Update on Coalition Activities

INTRODUCTION: **Vicki A. Jackson**, MD,
Chief, Division of Palliative Care and Geriatric Medicine,
Massachusetts General Hospital

Maureen Bisognano, President Emerita and
Senior Fellow at the Institute for Healthcare Improvement

Jennifer Reidy, MD, Chief, Division of Palliative Medicine,
UMass Memorial Medical Center; Associate Professor,
University of Massachusetts Medical School

Laurence Stuntz, Director, Massachusetts eHealth Institute
at MassTech (MeHI)

continued on next page

MASSACHUSETTS COALITION FOR
SERIOUS ILLNESS CARE

Summit Agenda *continued from previous page*

Panel: "What It Takes To Make Progress
on Major Public Health and Social Issues"

Ellen Goodman (Moderator), Co-Founder and Director,
The Conversation Project

Sandro Galea, MD, DrPH, Dean,
Boston University School of Public Health, Robert A. Knox Professor

Zamawa Arenas, Founder & CEO, Flowetik

12:55pm Lunch

1:25pm Audience Breakout Session

2:15pm Commentary

Maureen Bisognano

2:30pm Closing

Chapter 4.2 Tools and Templates

Community Contacts

Name	Organization	Email	Phone	Who Knows Them	Connection to the Project

Present/Future Grid

Present	Future

Logic Model

Goals	Milestones	Activities	Resources
What outcomes need to occur?	*What milestones need to occur to achieve the goal?*	*Given the milestones and goals, What activities will be undertaken?*	*What resources are needed?*

Convening Checklist

Action Step	**Person Responsible**	**Action Taken**
List of Invitees Generated		
Identify a date,		
Location Identified		
Location Confirmed		
List of Invitees Divided		
Invitees Contacted By Phone		
Invitees Confirmed By Email		
Agenda and Goals Copied		
Agenda and Goals Distributed		
Name Tents and Name Tags		
Flip Charts		
Scribe Identified		
Notes Taken		
Notes Distributed		
Follow-Up Date Determined		

Stakeholder Mapping Grid

Stakeholder Name	Key Contact	Email	Phone	Role	Relationship to Other Stakeholders	Priority

Stakeholder Prioritization Grid

Stakeholder	**Role**	**Impact**	**Interest**	**Influence**	**Knowledge**	**Priority**

Messaging Matrix

Stakeholder Group	Patient/ Family	Payor	Provider	Supporter	Influencer	Funder
Objective						
Pt/Family Need						
Message						
Supporting Evidence						
Call to Action						
Channel						

End Notes

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