

Community Care Coordination:

How to effectively identify, engage and sustain community partners



Objectives

- Define Community Care Coordination
- Identify the primary SDoH for individuals cared for
- Identify, engage, and sustain community partners to address various SDoH

The Heart



Population Health

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What is Health?



Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity.

World Health Organization April 7, 1948

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Defining Population Health

Population health serves as a strategic platform to improve the health outcomes of a defined group of people, concentrating on three stages:

1

Distribution of specific health statuses and outcomes within a population

2

Factors that cause the present outcomes distribution

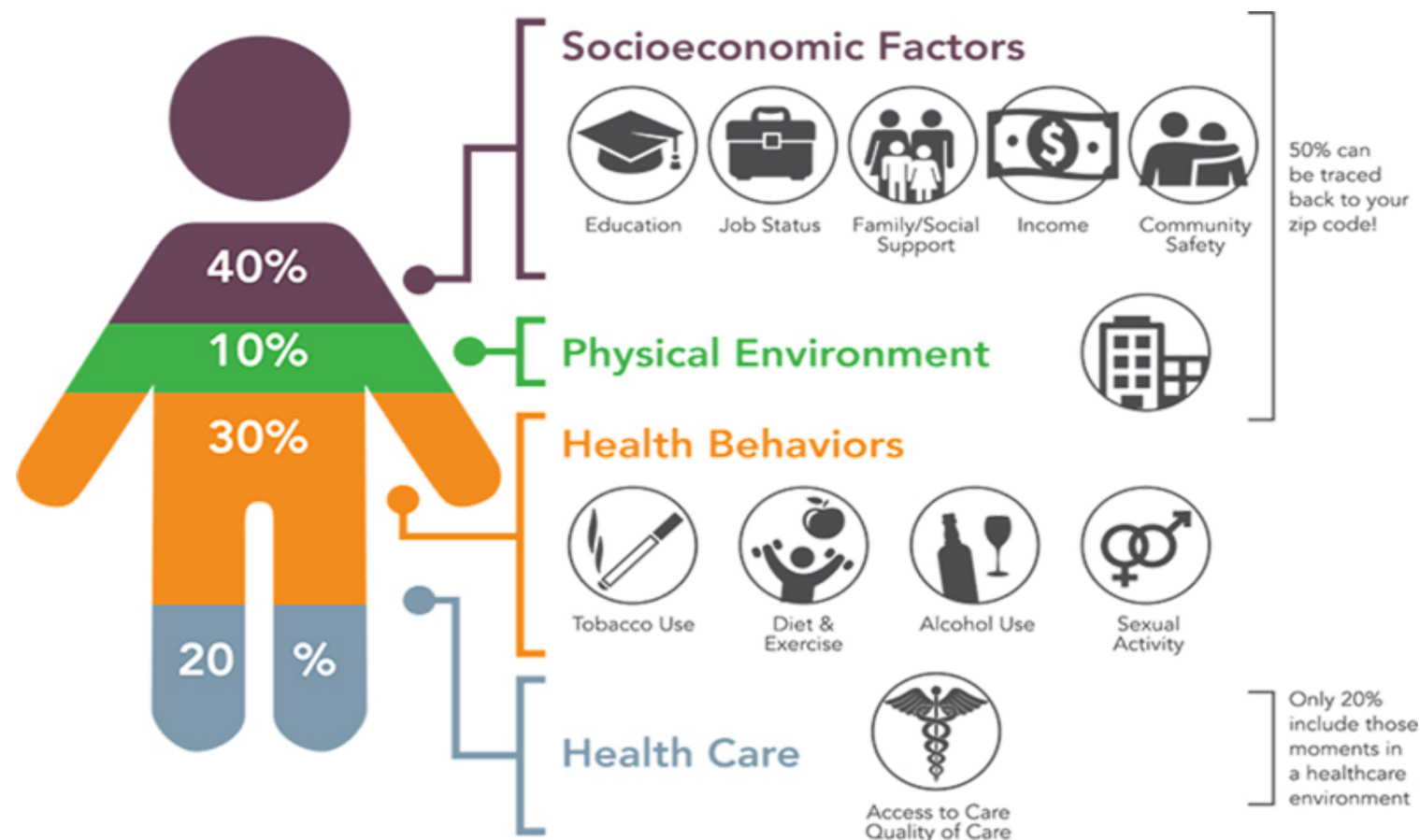
3

Interventions that modify the factors to improve health outcomes

Source: www.aha.org

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Population Health has Many Drivers



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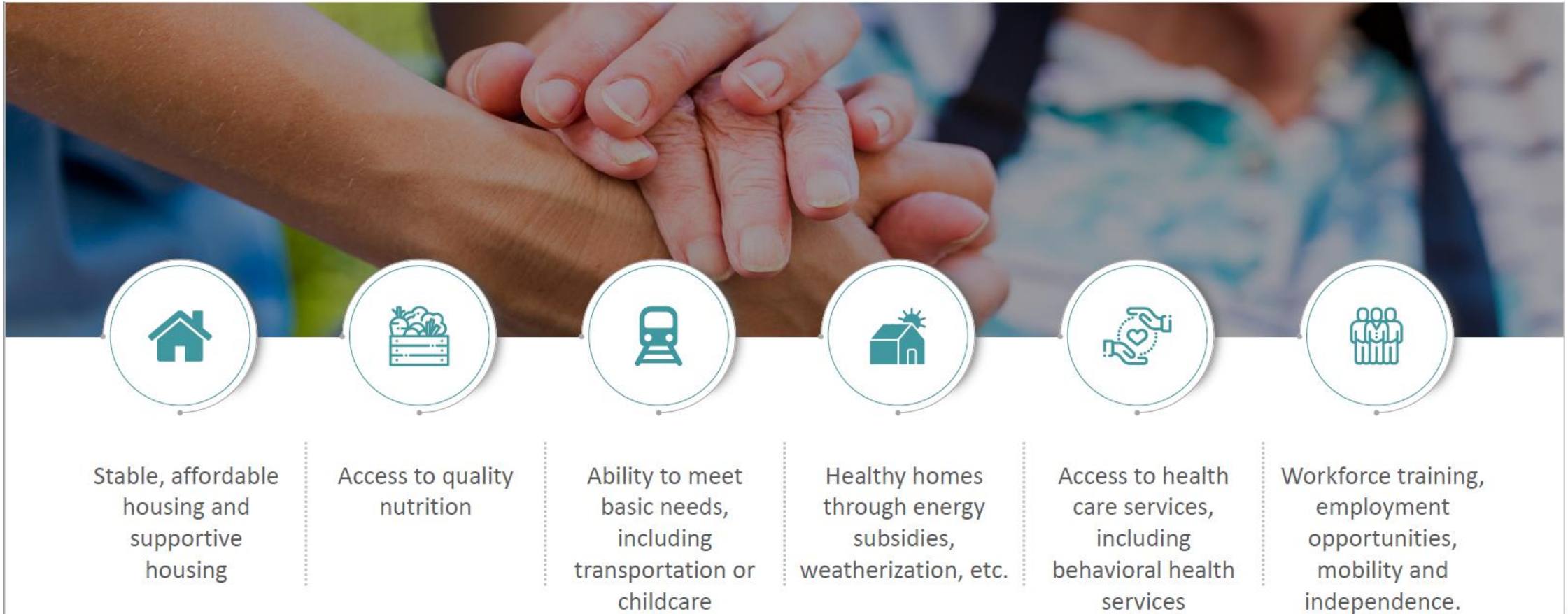
Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

Social Drivers of Health (SDoH)



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What are Social Drivers?



Source: Aligning for Social and Health Needs in the Community Webinar, 9/24/20 American Hospital Association

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The Destination...

A health system that links health care with community stakeholders to create a network of organizations working together to improve population health.



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Community Care Coordination

- “A **collaboration** among health care professionals, clinics, hospitals, specialists, pharmacies, mental health, community services, and other resources working together to provide person-centered coordinated care.”



Population Health Has Many Partners



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Benefits of Engaging Community Partners



Better coordination of care that fills gaps in services



Promotes effective communication among providers and social service agencies



Increase effective utilization of local resources



Market services and promote quality of care



Build community awareness of available resources



Improve community perception of the hospital



Reduce out-migration and by-passing of local services



Grow patient loyalty and volume



Reduce duplication of services



Improve reimbursement



Position the hospital for population health for the future

Benefits of Community Care Coordination

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Coordinating Care



Better coordination of services and
care provided to community

Intentional Care Coordination



Greater collaboration and
better communication
among leaders and
providers

Increased Promotion



Increased promotion of local
health care and social
services

Enhanced Marketing



Enhanced marketing to
better promote services and
quality of care

Greater Awareness



Greater community
awareness of available
resources and services

Improved Perception



Improved community
perception of local
businesses, hospital, and
clinics

Reduced By-Passing



Reduced by-passing of local
businesses and health care
providers

Increased Loyalty



Increased patient loyalty
and employee satisfaction

Increased Alignment



Increased alignment of local
services to community needs

Improved Reimbursement



Improved reimbursement,
local revenue, earnings, and
jobs for greater economic
growth

Greater Benefits

$$\text{Value Payment} = \frac{\text{Quality} + \text{Experience}}{\text{Cost}} \times \text{Population}$$



Greater benefits from value-based care programs and better positioned for population health

Community Care Coordination Benefits



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Benefits of Community Care Coordination

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Partners?



Partners

Social Drivers of Health

- Your personal experience
- Voice of community
- Data



SDoH

**Your personal
experience**

From your personal experience, what are the non-clinical things that get in the way of your patients achieving their health goals?

SDOH - Voice of community



SDOH - Data



Data Resources

County Health Rankings



Census

Explore Census Data

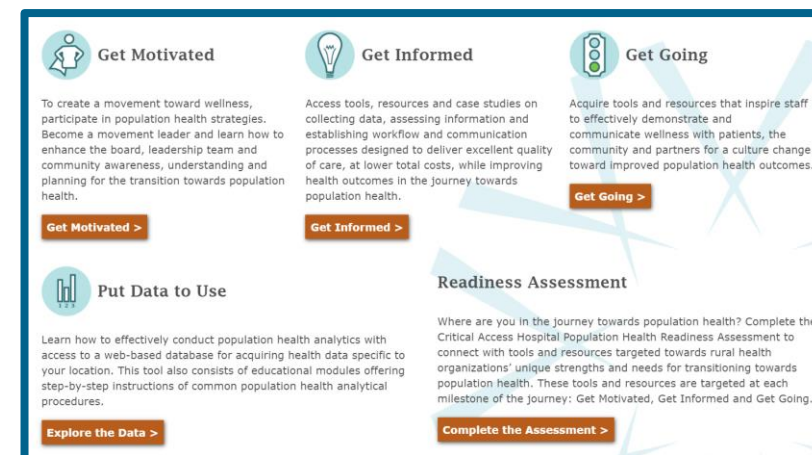
The Census Bureau is the leading source of quality data about the nation's people and economy.

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State Data

Data and Statistics

Behavioral Risk Factor Surveillance System

The Behavioral Risk Factor Surveillance System (BRFSS) is an annual statewide telephone surveillance system designed by the Centers for Disease Control and Prevention (CDC)

Community Health Profiles

County level profiles that pull together data from a variety of sources including births and deaths, education, health risk factors, crime and information on children.

Sources of Aggregate (Summarized) Data Results

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Discovery Tools to Use

1. Discover SDoH by using the *“Social Drivers of Health Discovery Tool”*
2. The *“Below the Waterline Tool”* helps you dive deeper into the root SDOH
3. Discover how community organizations, businesses, government agencies, non-profits, or education entities resolve or meet the SDoH using the *“Potential Partners Discovery Tool”*

Social Drivers of Health (SDOH) Discovery Tool



Social Drivers of Health (SDoH) Discovery Tool

Personal Experience

List all the things you can think of that get in the way of your patients achieving their goals and managing their health.

Hospital Community Health Needs Assessment (CHNA)

List the SDoH identified in your hospital's CHNA.

Secondary Data

List the insights gained from reviewing the secondary data.

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Below the Waterline Discovery Tool

Below the Waterline Discovery Tool



Social Drivers of Health (SDoH) are defined as:

The conditions and circumstances in which people are born, grow, live, work, and age. These circumstances are shaped by a set of forces beyond the control of the individual: economics and the distribution of money, power, social policies, and politics at the global, national, state, and local levels. (WHO and CDC (adapted))

You have gone through an exercise to discover the top SDoH that affect your patients. Now it is time to challenge yourself by asking "why". It's easy for us to see the SDoH above the waterline, but there are often factors below the waterline that cause them. For each SDoH you list, ask yourself "why" for each, and document in the table below.



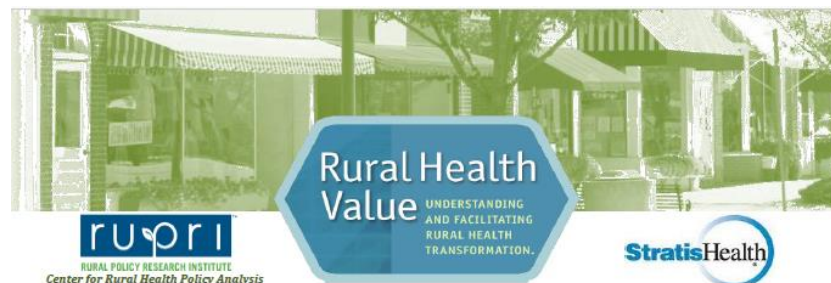
SDOH	Why??	Why??
<i>Example 1: Transportation</i> <i>Example 2: Transportation</i>	<i>Don't have a car</i>	<i>Can't afford</i>
		<i>Can't read</i>
	<i>No money for gas</i>	<i>Unemployed</i>
		<i>Substance use issue</i>

Social Drivers of Health



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Helpful Starter Tool



Understanding the Social Determinants of Health *A Self-Guided Learning Module for Rural Health Care Teams*

GOALS

This tool is designed with two goals in mind:

1. **Learning:** To help people who work in (or are concerned with) rural health learn more about the concept of social determinants of health.
2. **Acting:** To enable rural health leaders and care teams to act to improve health outcomes in their communities by addressing factors that contribute to the social determinants of health.

INTENDED AUDIENCE

We use the term *care teams* in the title to indicate that this tool is appropriate for a very broad group—essentially anyone who cares for patients (including patients themselves and their families), or who works in care coordination, social work, or other patient/family support fields, including all those who work on or are concerned with the health of people in rural communities. The module is primarily designed to be used by a group, but individuals will find it useful as well.

HOW TO USE

This learning module is designed to be interactive. To get the most out of the learning experience, we suggest you follow the instructions provided and use the opportunity to research health information about rural America and your local county. You can then compare this information to other U. S. counties or regions.

Cooperative Agreement funded by the
Federal Office of Rural Health Policy:
1 U87 RH25011-01

On the go? Use the adjacent QR code
with your smart phone or tablet to view
the RuralHealthValue.org website.



[Click to use tool!](#)

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Potential Partners Discovery Tool

Potential Partners Discovery Tool



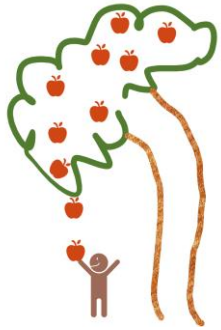
As a team, use this worksheet to record the Social Drivers of Health (SDoH) for your defined population. Use your individual brainstorming worksheets and discuss each other's discoveries as a group. Aim for documenting at least the top five agreed upon SDoH. Your next task is to research and record the community organizations, agencies, and institutions that address the SDoH for that defined population. Use the last two columns to record these.

This will be a key piece in determining community partners.

Identified SDoH	List all organizations (community and regional) that address the given SDoH	
	<ul style="list-style-type: none">	<ul style="list-style-type: none">
	<ul style="list-style-type: none">	<ul style="list-style-type: none">



Health Equity



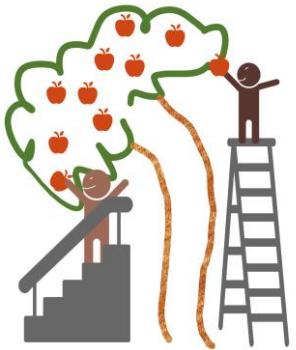
Inequality

Unequal
access to
opportunities



Equality

Evenly
distributed
tools and
assistance



Equity

Custom
tools
that identify
and address
inequality



Justice

Fixing the
system to
offer equal
access to
both tools
and
opportunities

“Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.”

- Robert Wood Johnson Foundation


Switching gears



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Potential Partner Message Worksheet

Potential Partners Message Worksheet



Potential Partner Organization	Organization Representative	Potential Role or Contribution in Care Coordination	Message to Engage Partner	Message Communication Method	Person Delivering Message

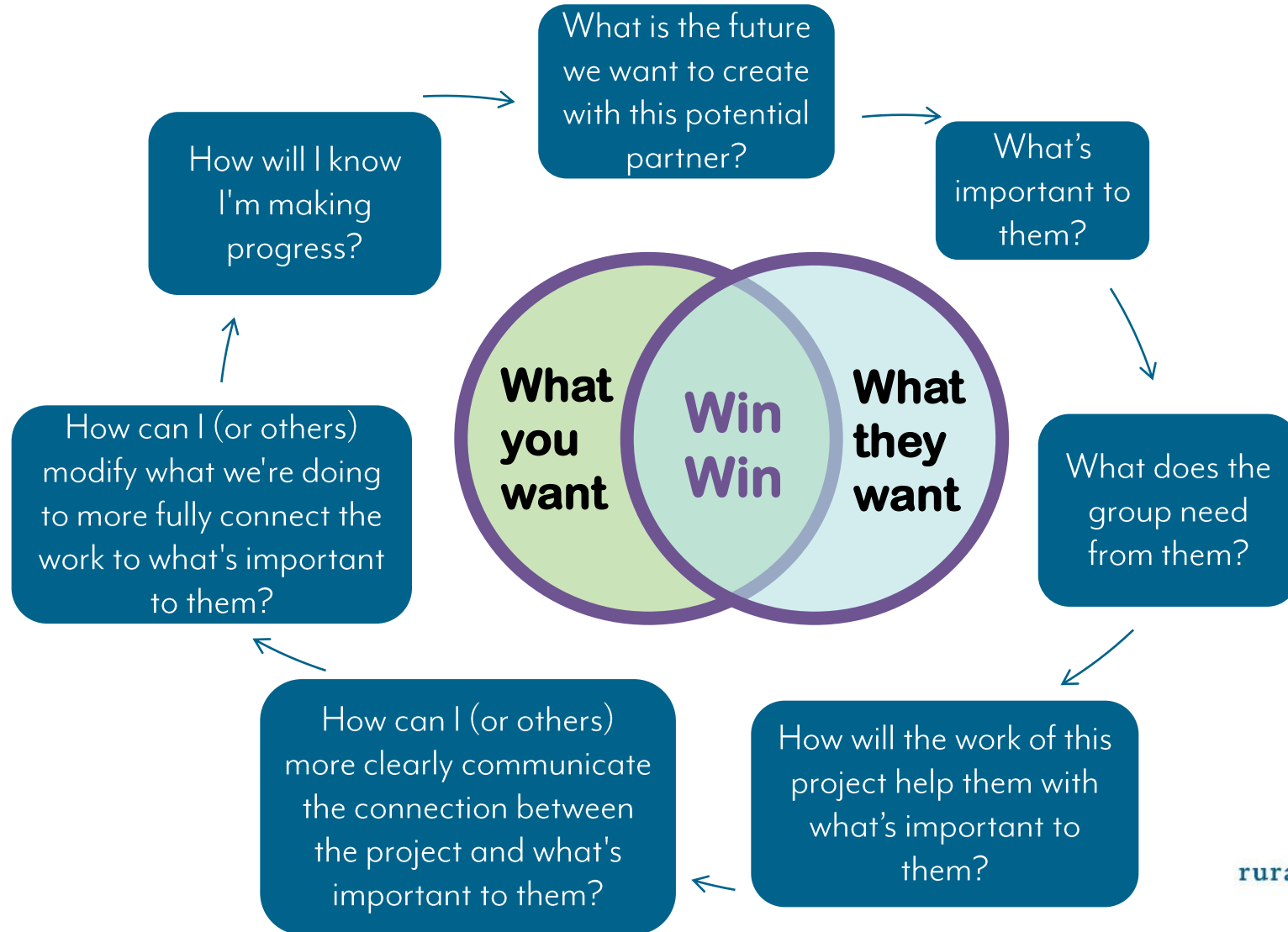
Partner Conversation Preparation Worksheet

Partner Conversation Preparation Worksheet



1. What is the future we want to create with this potential partner?	
2. What is important to them?	
3. What does the group need from them?	
4. How will the work of this project help them with what is important to them?	
5. How can I (or others) more clearly communicate the connection between the project and what is important to them?	
6. How can I (or others) modify what we are doing to connect the work more fully to what's important to them?	
7. How will I know I am making progress?	

Tailoring Your Approach



Invitation

- **What is the invitation we can make for people to participate in creating a future that is distinct from the past?**
- **The invitation is more than simply a request to attend; “it is a call to create an alternative future”, and to join in creating a new possibility.**



Issue the Invitation

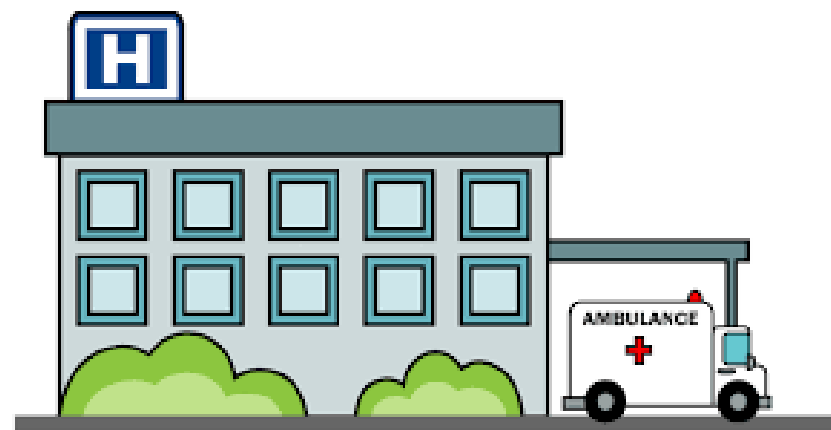
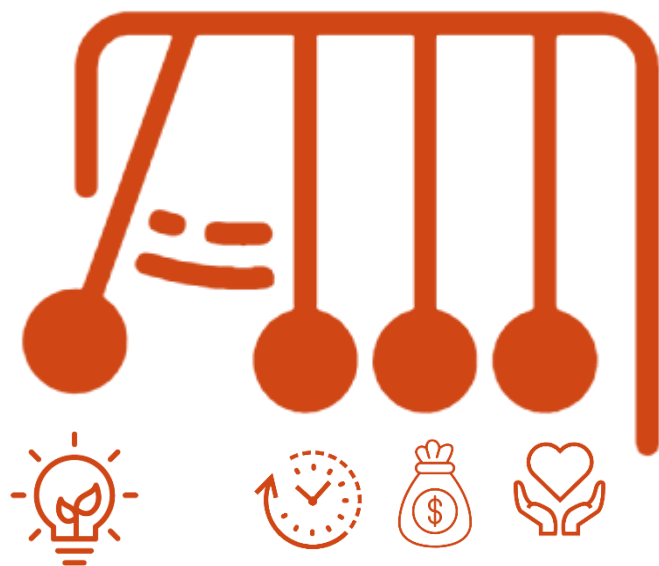


The Invitation

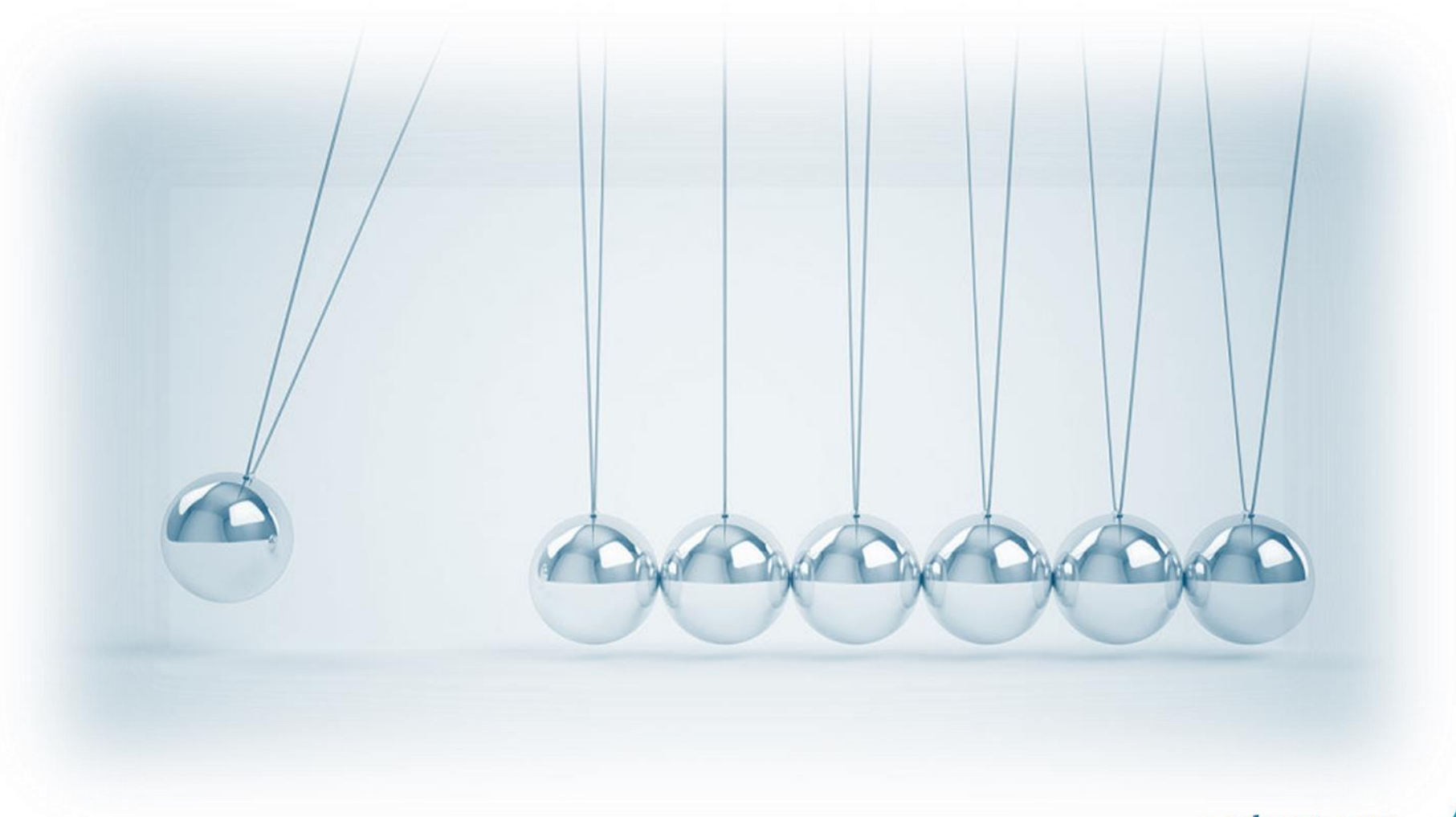


- Make a concrete connection between the partner and the community care coordination work of your health care organization
- Explicit, not implicit

Making an Investment in Your Community



Plan Ahead to Keep the Momentum Going



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Invite Many Voices to the Table



Buy-in: Asking for someone's buy-in indicates that you have an idea that you didn't involve them in or discuss with them, but you want them to embrace it anyway.

Ownership: What people feel around an idea, improvement, or decision because they've been included in the process of coming up with it on some level, at some point.

Responsibility = Ownership

Responsibility equals accountability equals ownership. And a sense of ownership is the most powerful weapon a team or organization can have.

Pat Summitt

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Celebrate and Share Accomplishments



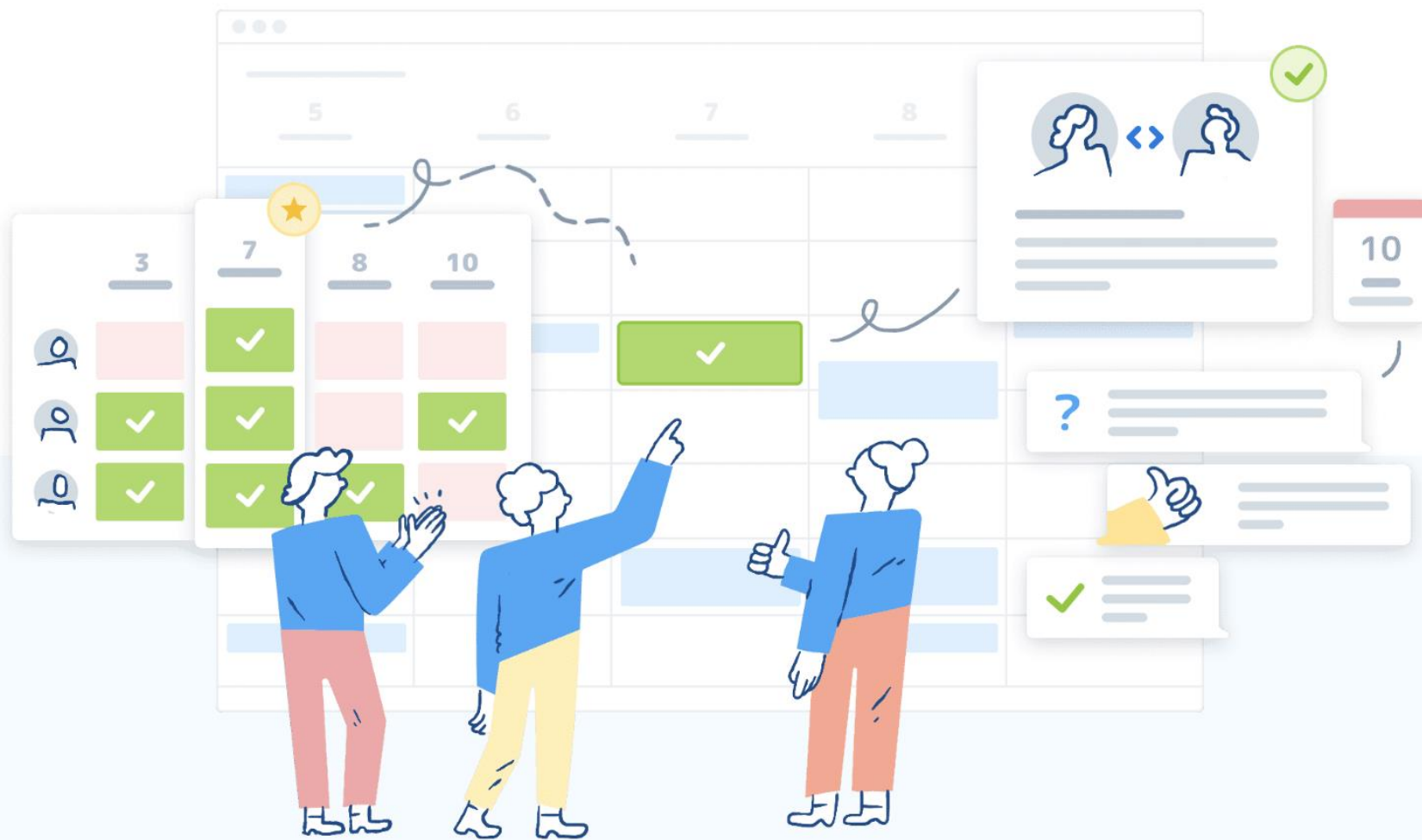
Build Relationships and Community



Set Goals to See Progress



Secure Meeting Dates Early



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Continuous Planning



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What Did You Learn Today?

- ✓ Define Community Care Coordination
- ✓ Identify the primary SDoH for individuals cared for
- ✓ Use the tool to identify, engage, and sustain community partners to address various SDoH



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