Community Care Coordination:

How to effectively identify, engage and sustain community partners

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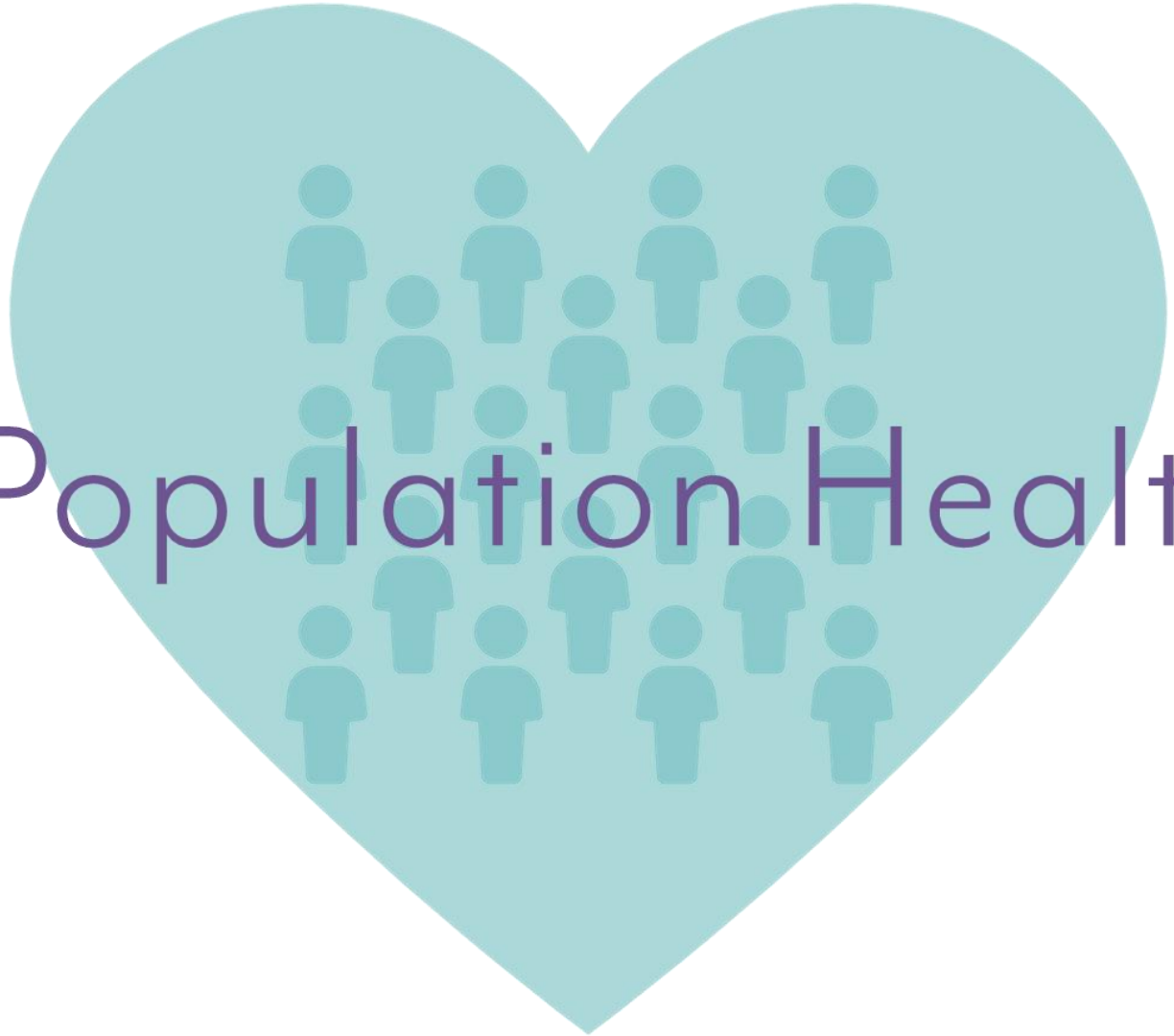
Objectives

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

The Heart



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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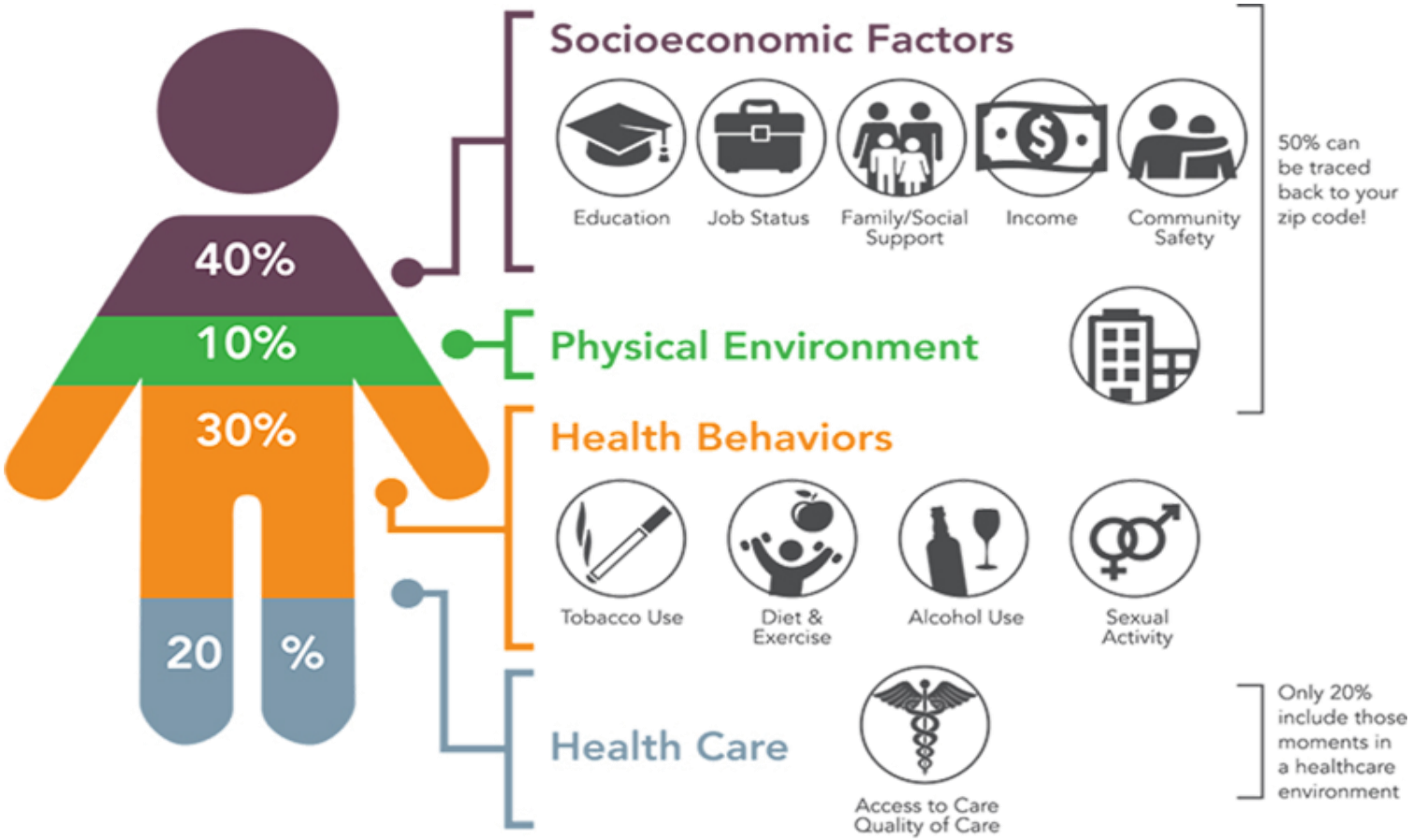
Defining Population Health

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

Population Health has Many Drivers



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

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Social Drivers of Health (SDoH)

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What are Social Drivers?

- Stable, affordable housing and supportive housing
- Access to quality nutrition
- Ability to meet basic needs, including transportation or childcare
- Healthy homes through energy subsidies, weatherization, etc.
- Access to health care services, including behavioral health services
- Workforce training, employment opportunities, mobility and independence.

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

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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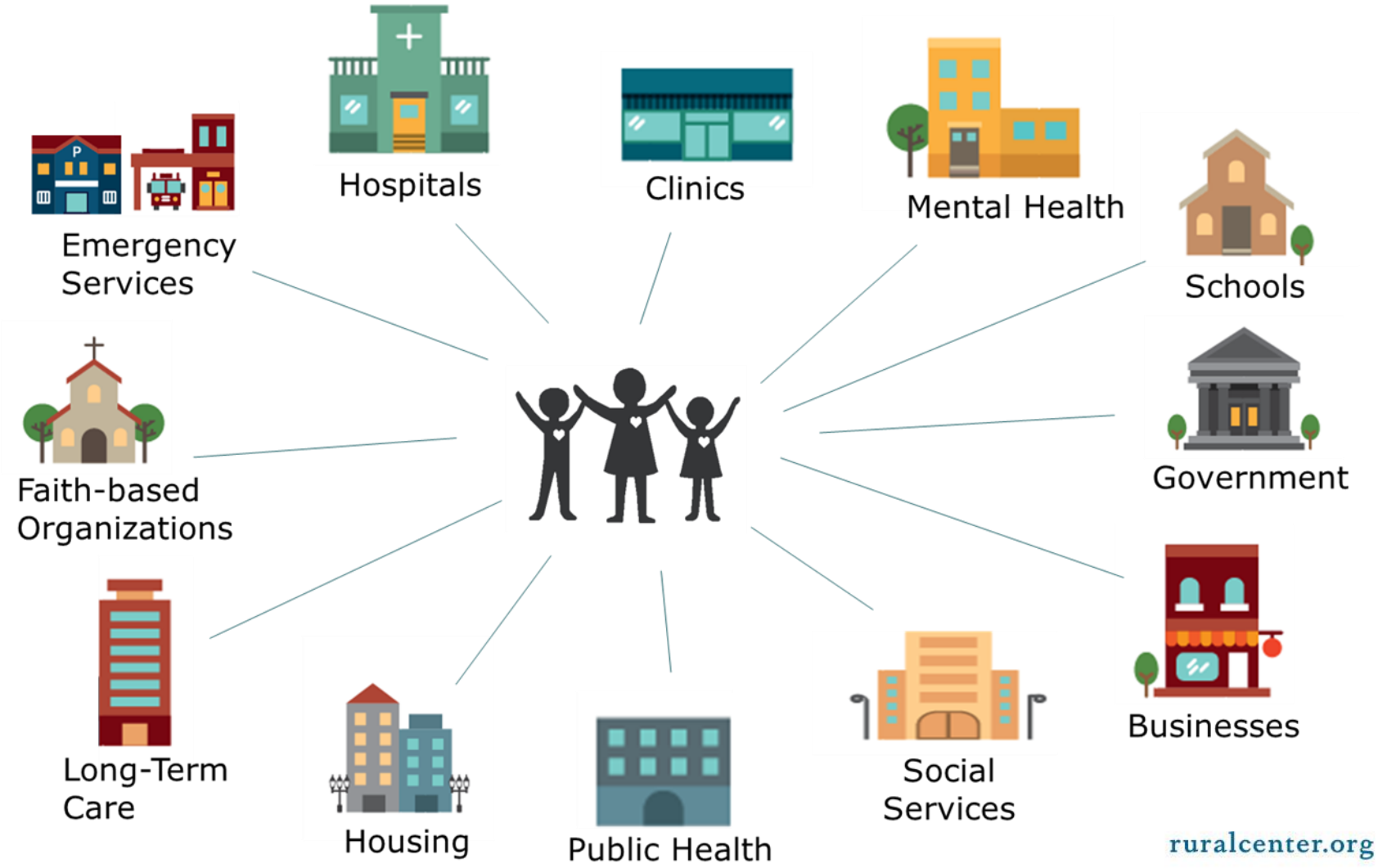
Community Care Coordination

- "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

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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

Value Payment = Quality + Experience / Cost x Population

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

Community Care Coordination Benefits

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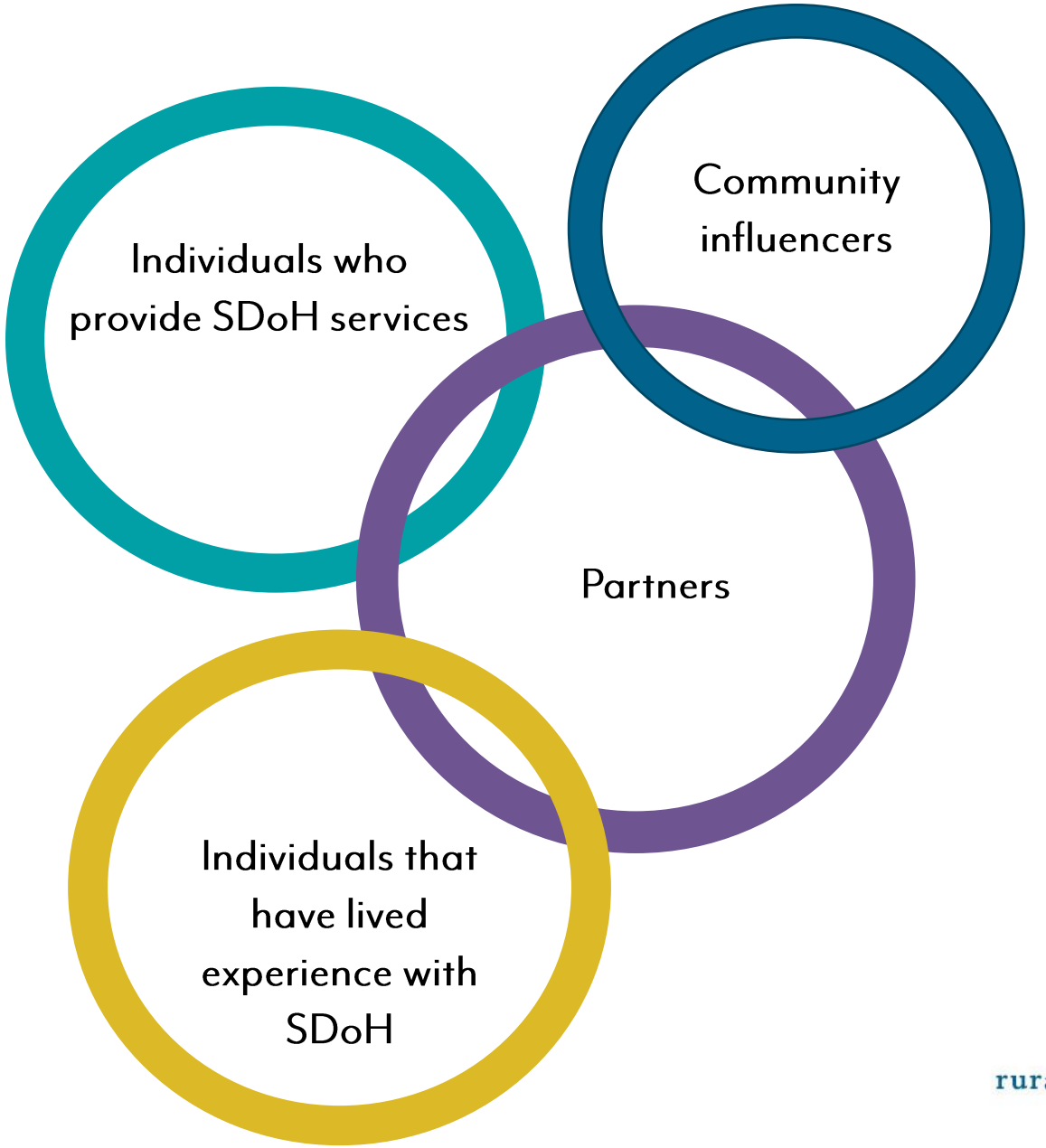
Partners?


Individuals who provide SDoH services
Community influencers
Partners
Individuals that have lived experience with SDoH

Partners

Social Drivers of Health

- Your personal experience
- Voice of community
- Data

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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?

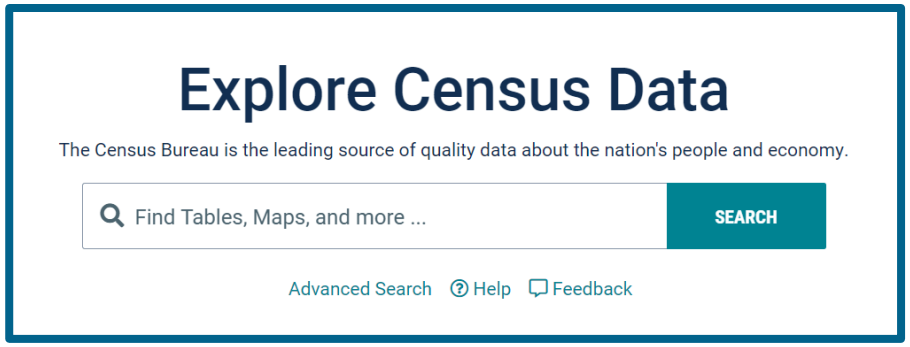
SDOH - Voice of community

SDOH - Data

Data Resources

County Health Rankings

Census



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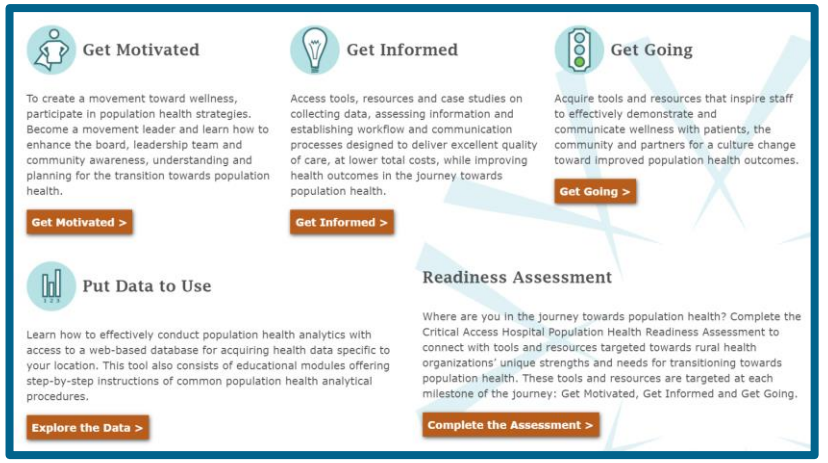
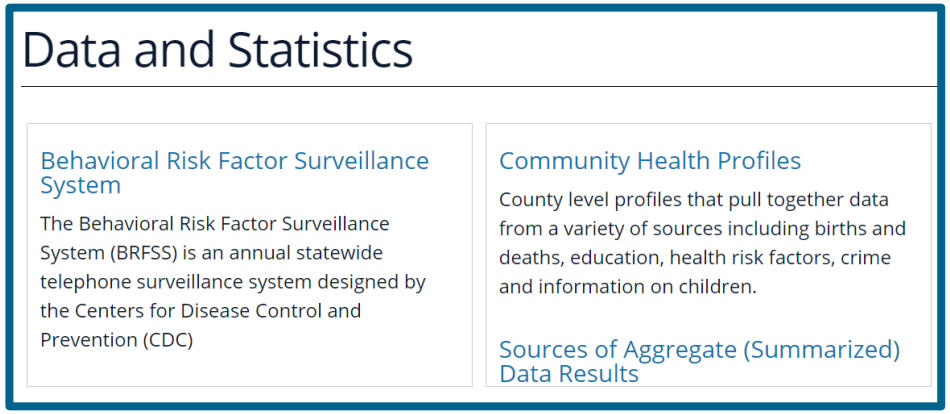


State Data



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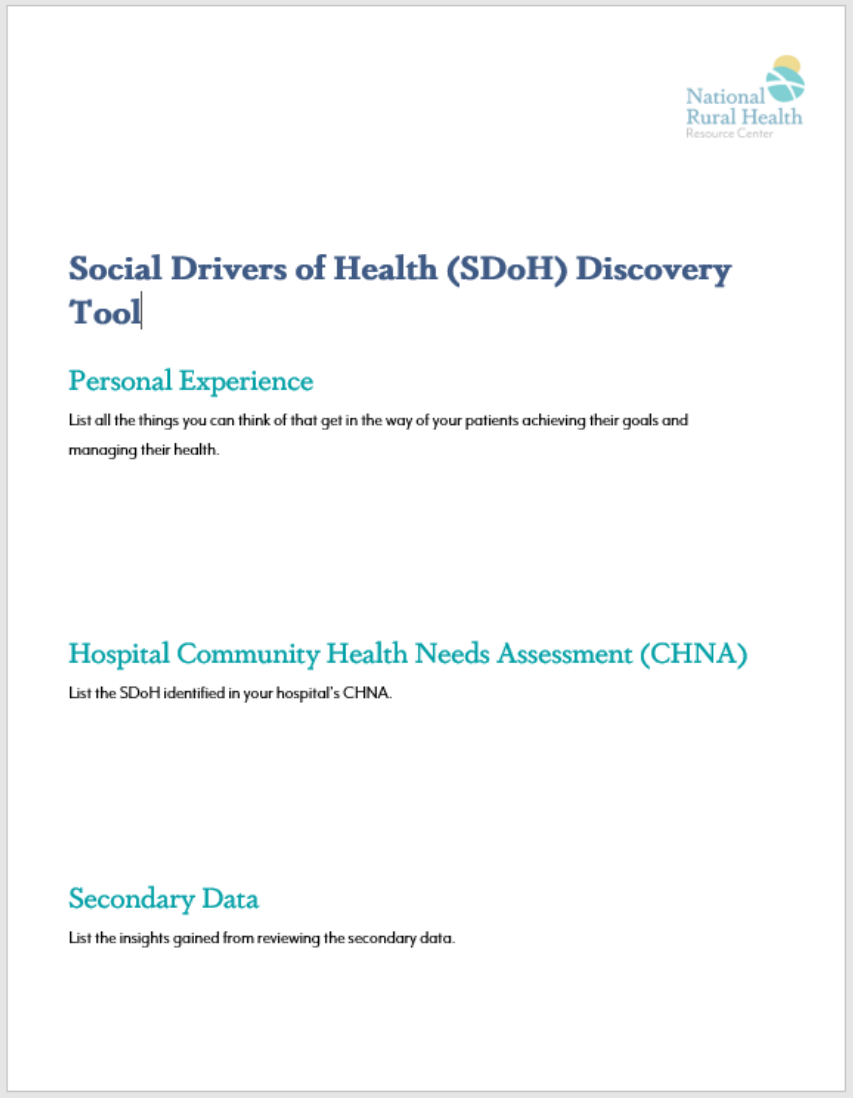
Discovery Tools to Use

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



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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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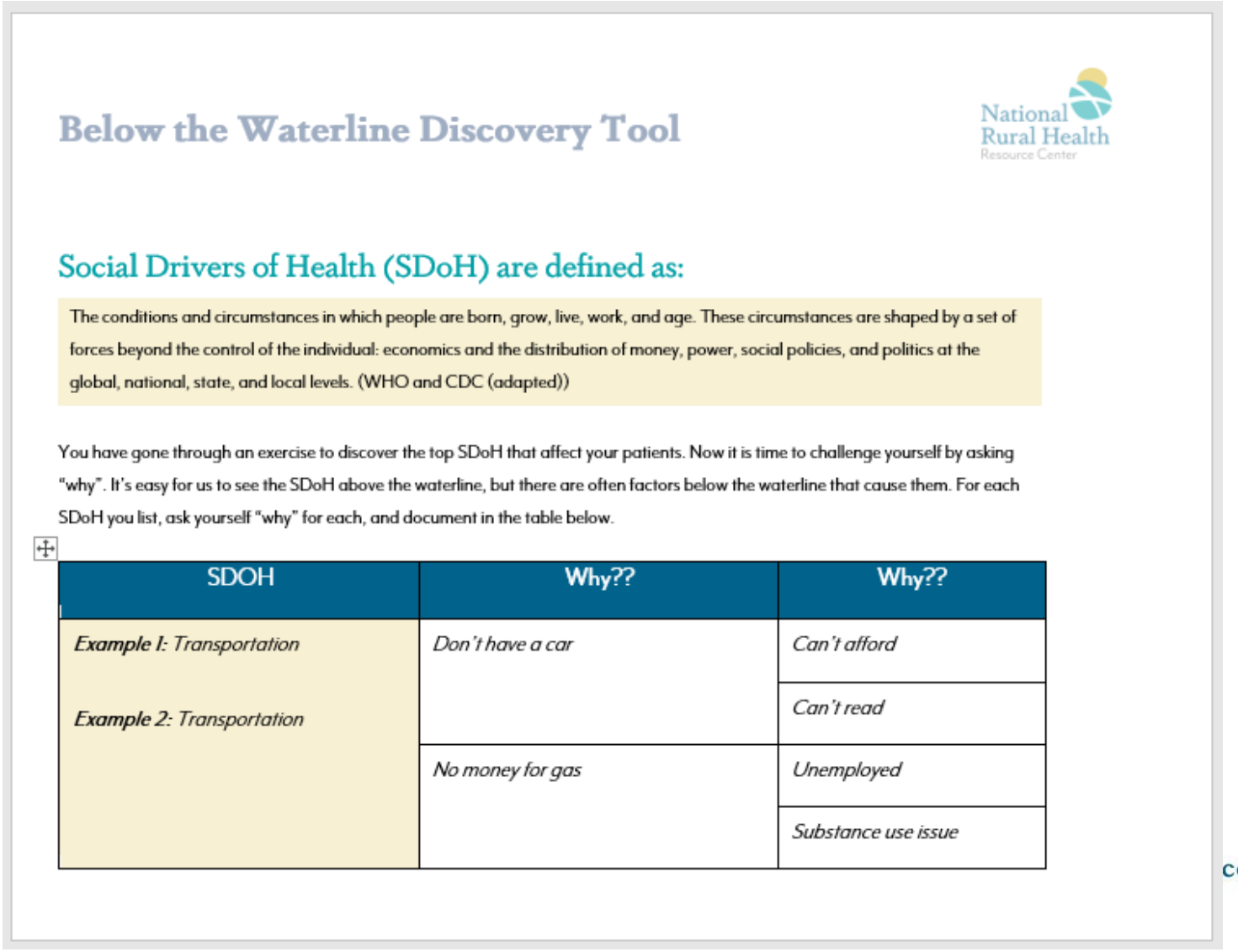
Below the Waterline Discovery Tool



Below the Waterline Discovery Tool

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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??
Example 1: Transportation	*Don't have a car*	*Can't afford*
Example 2: Transportation		*Can't read*
	No money for gas	*Unemployed*
		Substance use issue

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Social Drivers of Health

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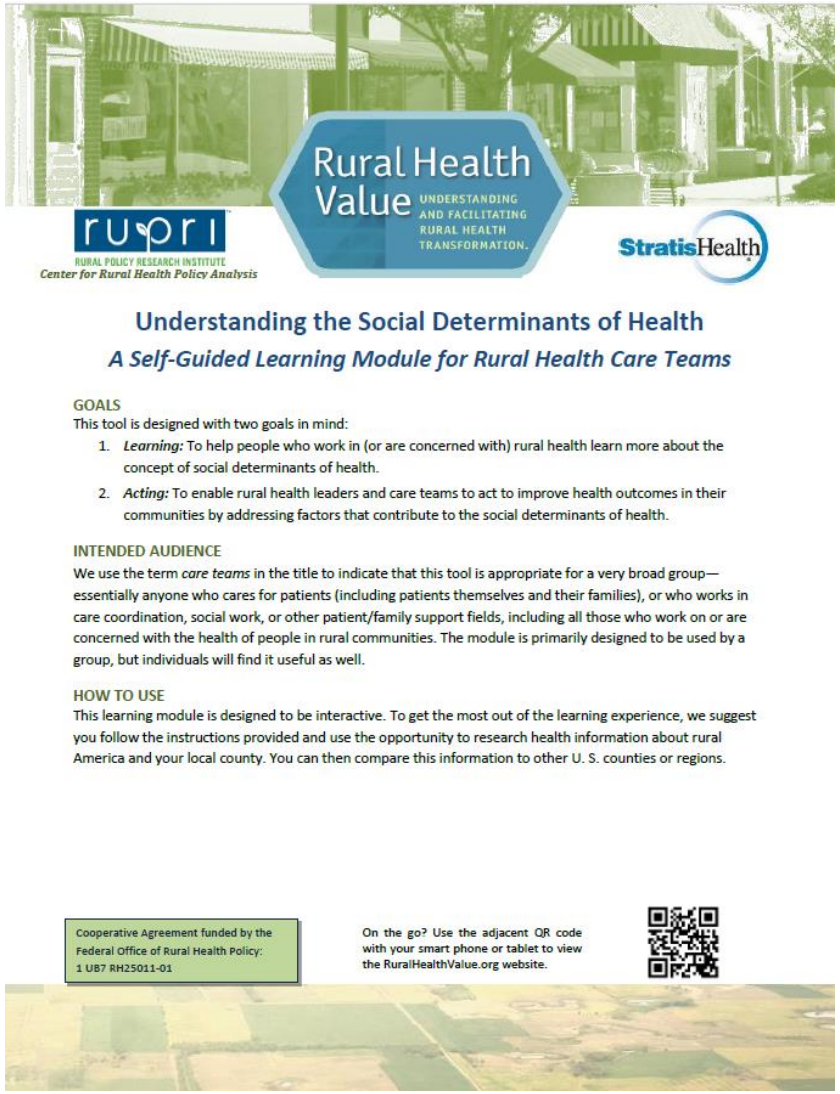
Helpful Starter Tool



Click to use tool!

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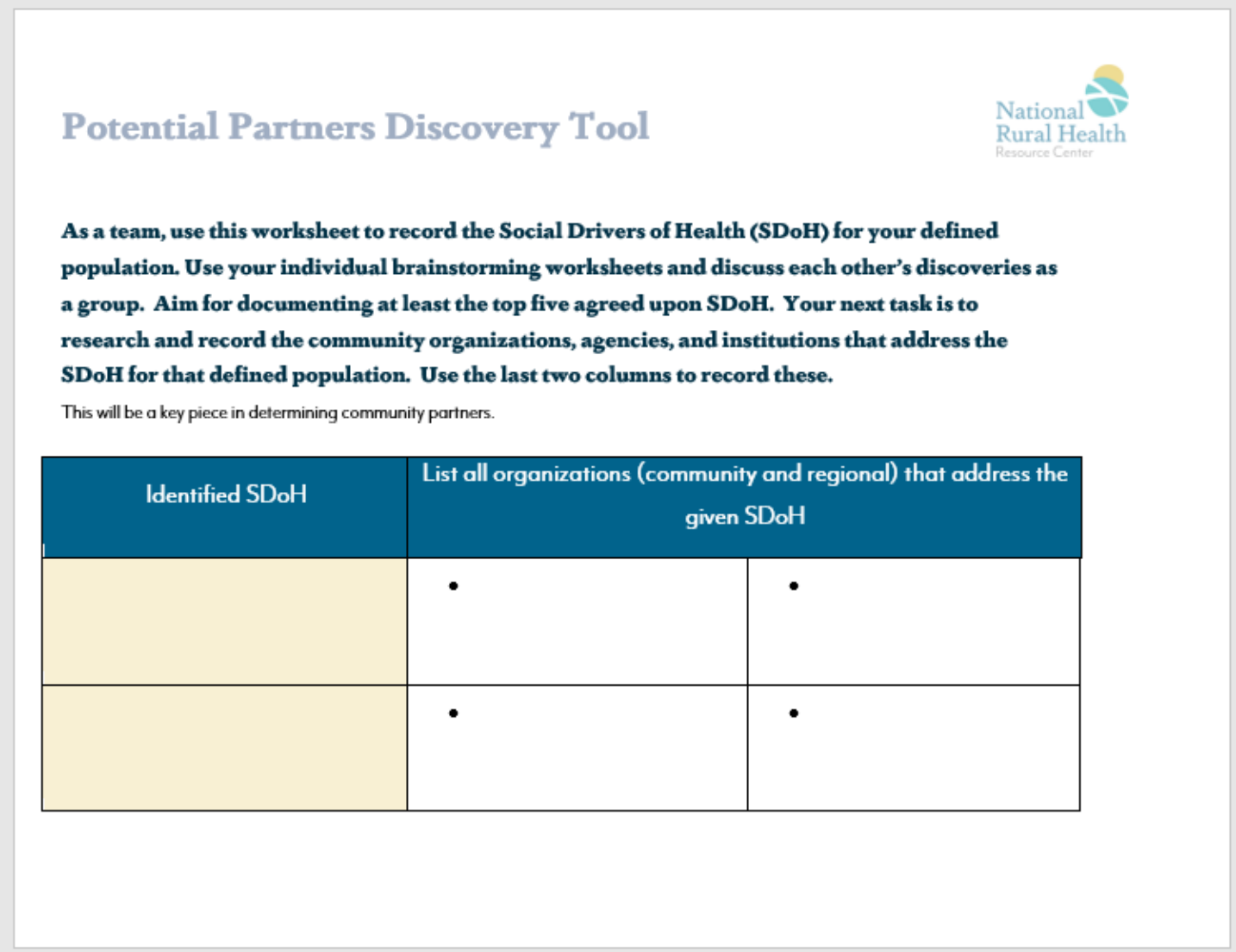
Potential Partners Discovery Tool



Potential Partners Discovery Tool

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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	
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	•	•

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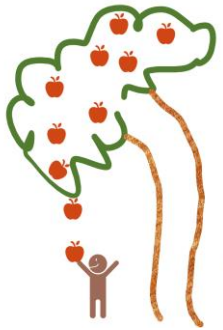
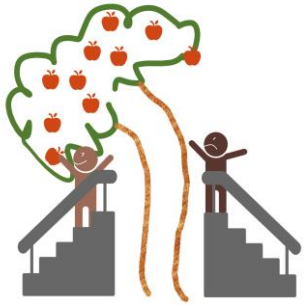
Health Equity

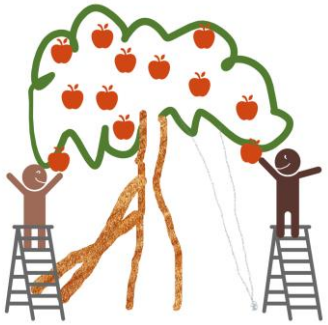


Inequality
Unequal access to opportunitie



Equality
Evenly distributed tools and assistance

Equity
Custom tools that identify and address inequality



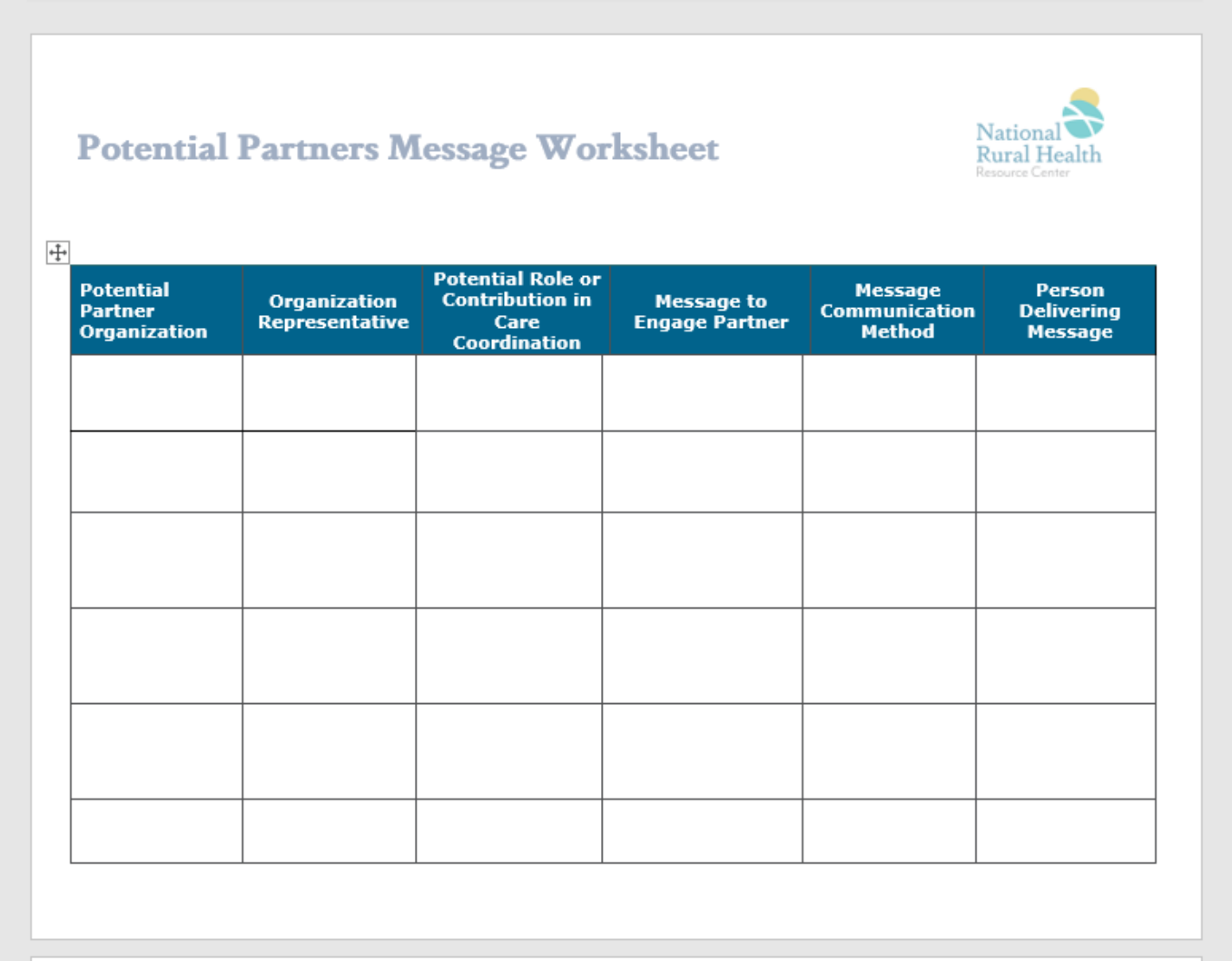
Justice
Fixing the system to offer equal access to both tools and opportunities

"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

Potential Partner Message Worksheet



Potential Partners Message Worksheet

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

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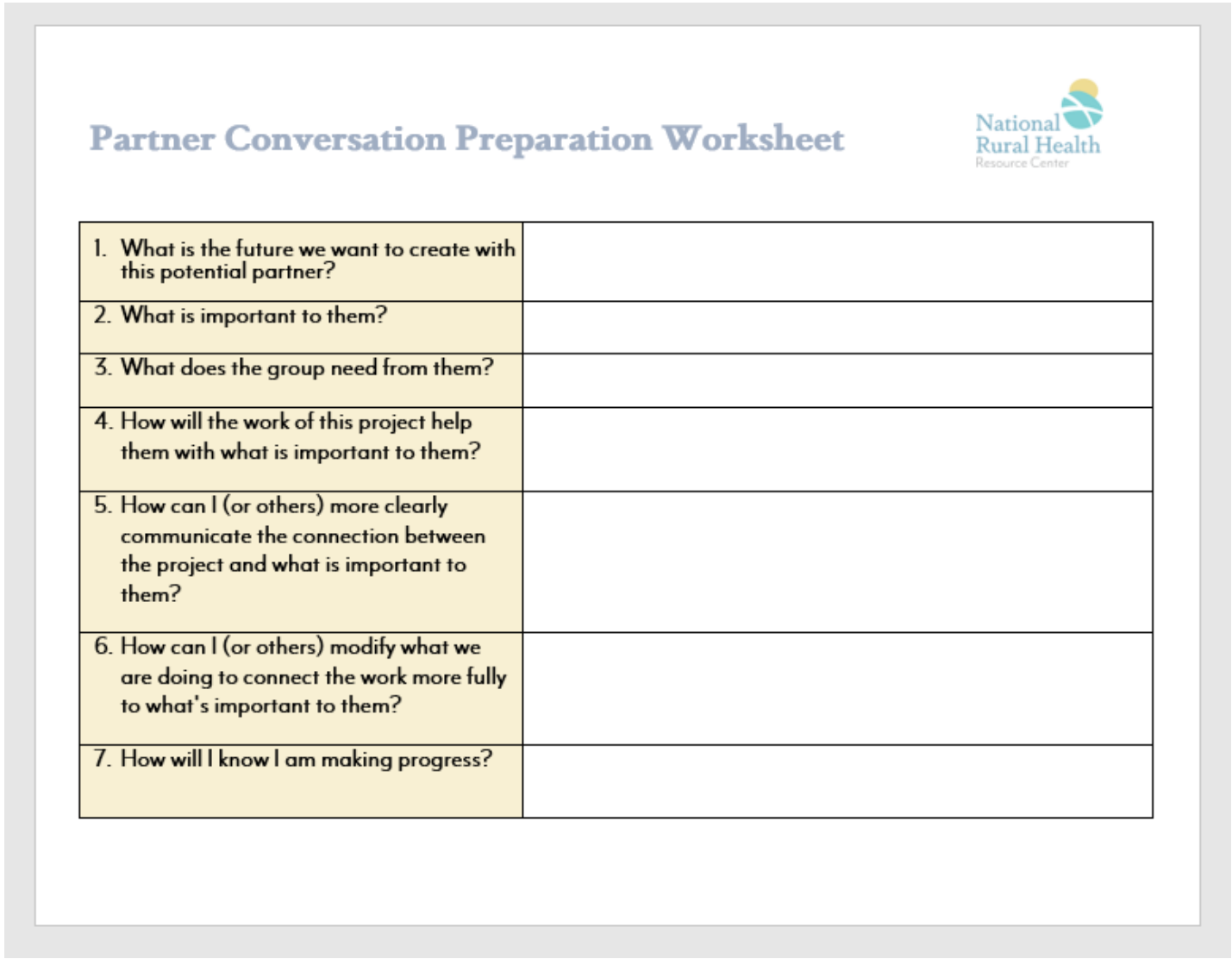
Partner Conversation Preparation Worksheet



Partner Conversation Preparation Worksheet

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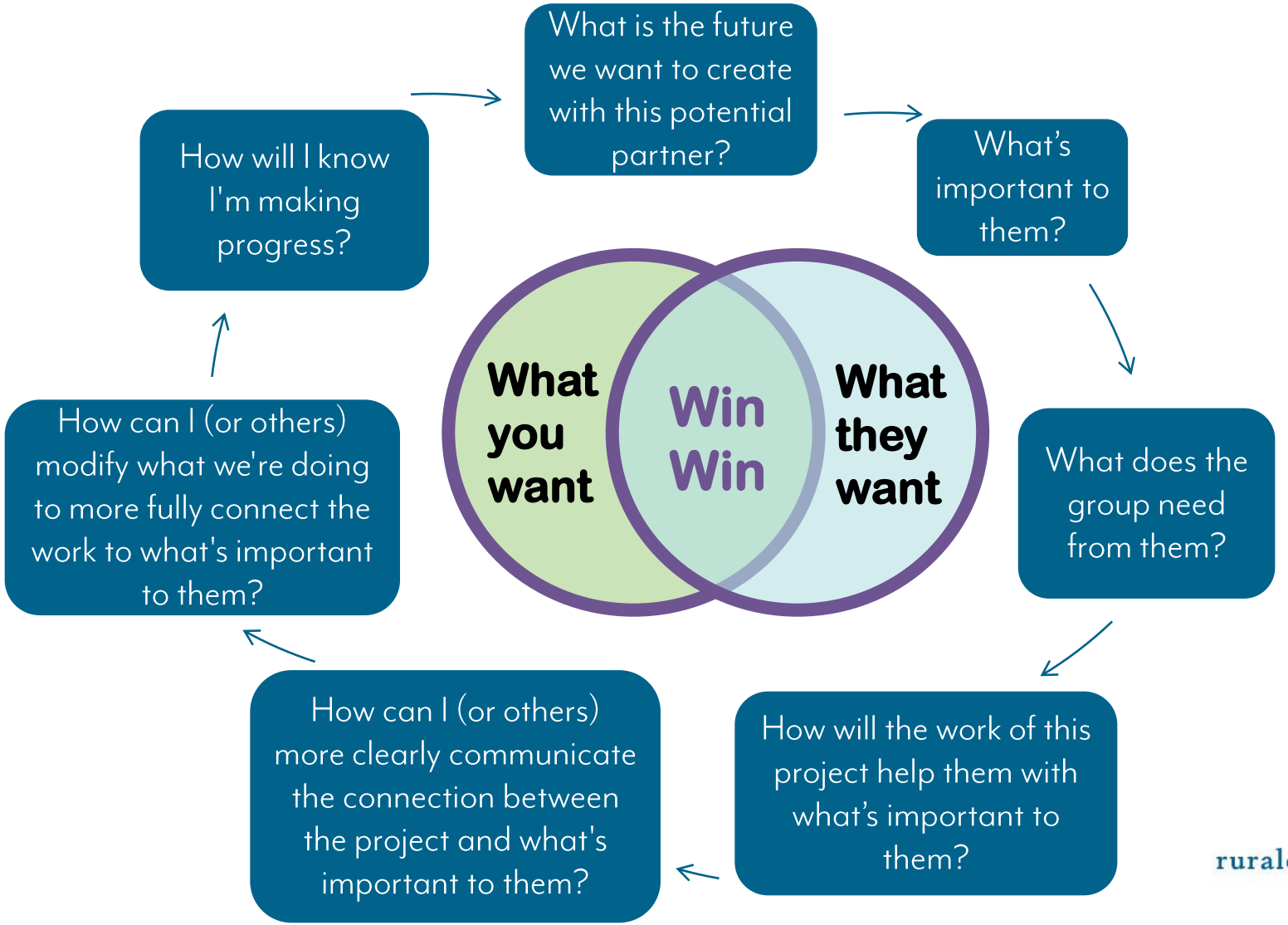
1. What is the future we want to create with this potential partner?	
2. What is important to them?	
3. What does the group need from them?	
4. How will the work of this project help them with what is important to them?	
5. How can I (or others) more clearly communicate the connection between the project 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



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Invitation

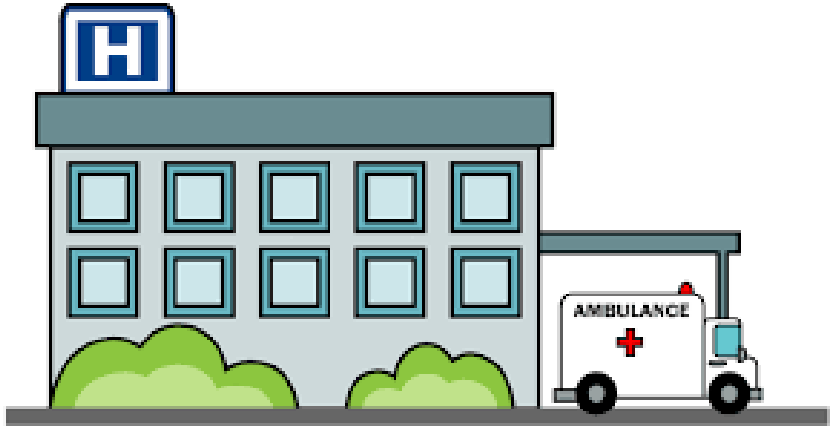
- What is the invitation we can make for people to participate in creating a future that is distinct from the past?
- The invitation is more than simply a request to attend; “it is a call to create an alternative future”, and to join in creating a new possibility.

Issue the Invitation

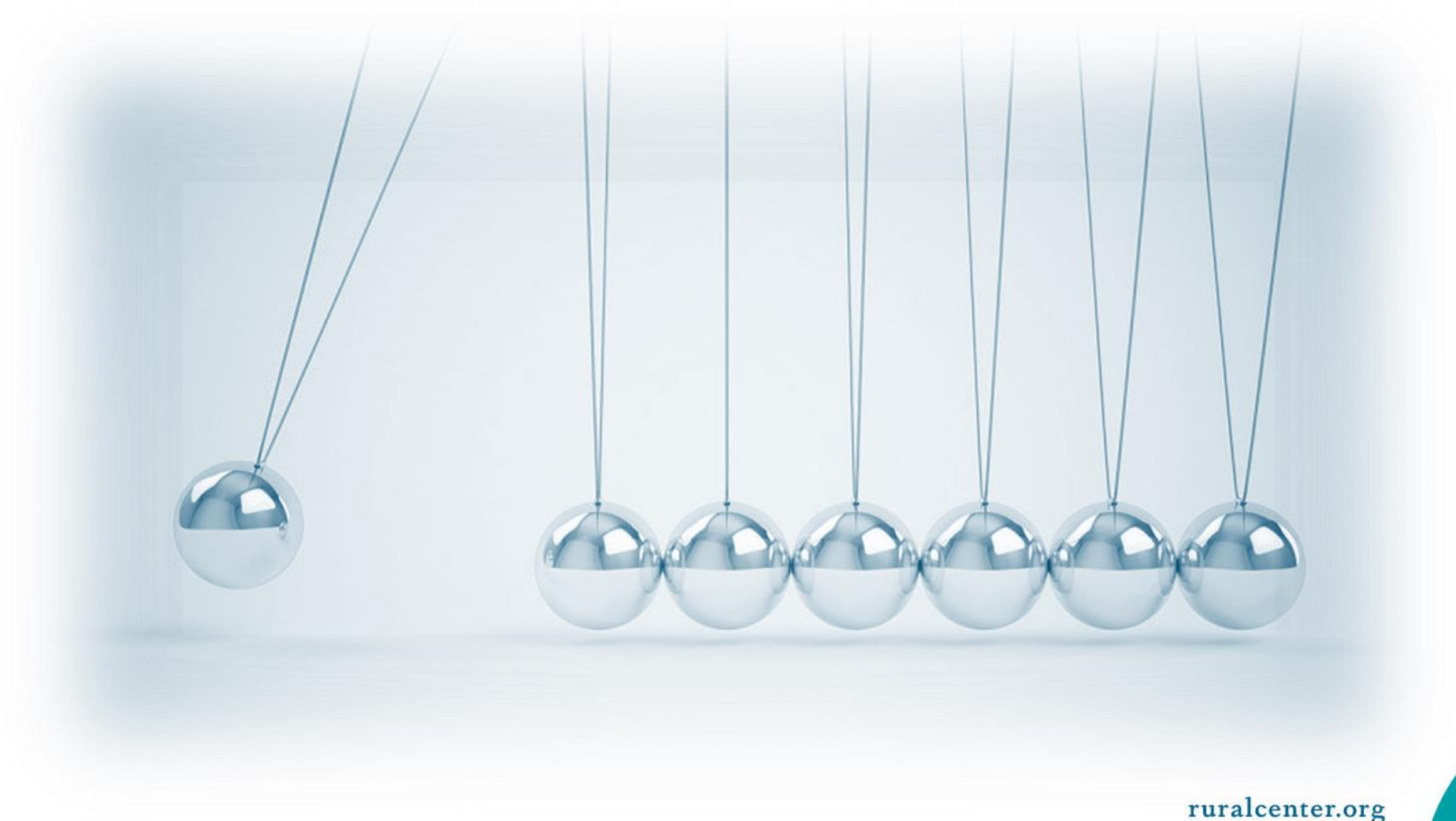
The Invitation

- 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

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Celebrate and Share Accomplishments

Build Relationships and Community

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Set Goals to See Progress

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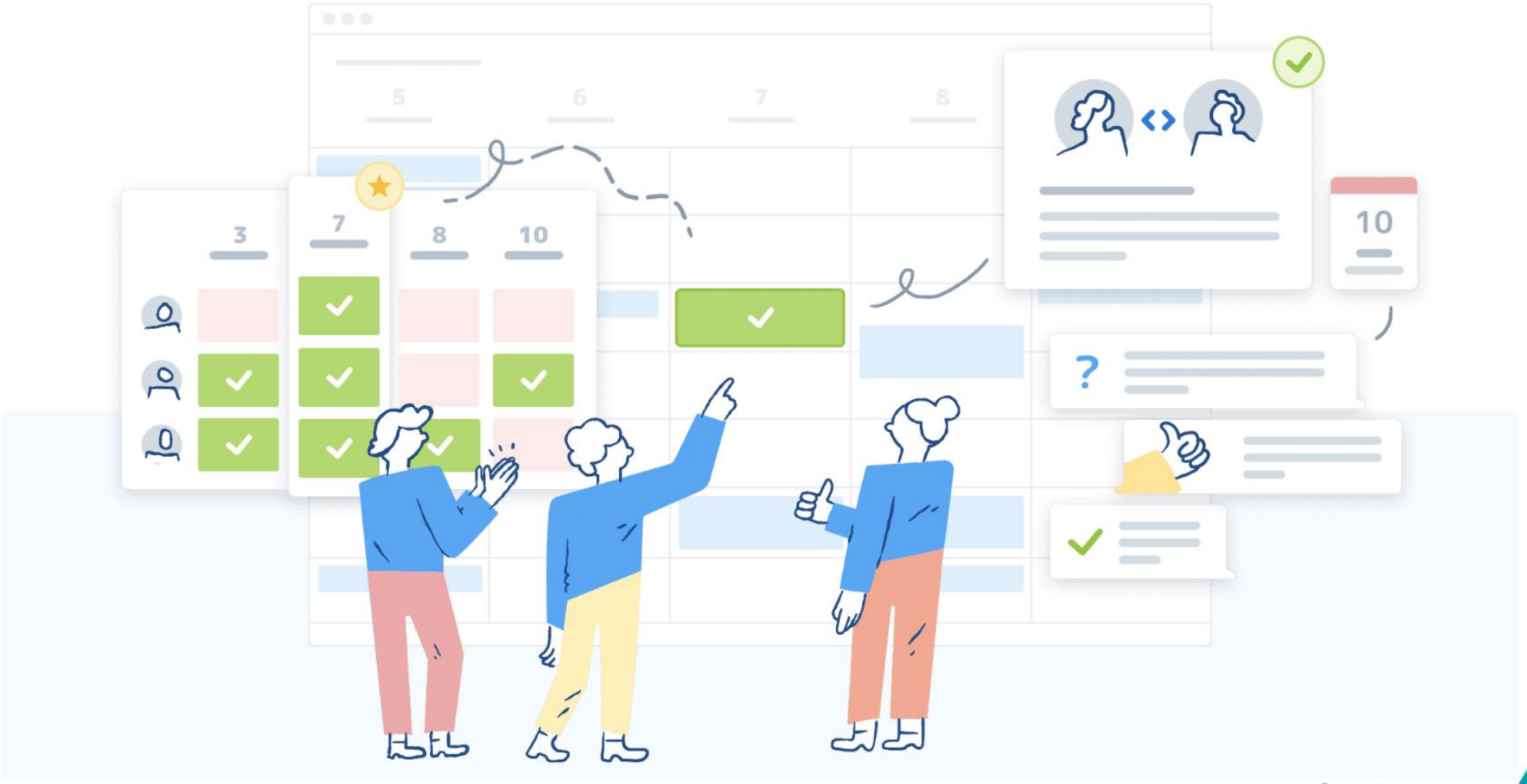
Secure Meeting Dates Early



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Continuous Planning

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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