Advisory Board

Building the Business Case for Community Partnership

Lessons from the BUILD Health Challenge

Population Health Advisor

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Executive Summary

About this Report

Health care extends well beyond care settings—into homes, schools, and neighborhoods. Transforming health outcomes requires a coordinated effort to tackle such contributing factors as socioeconomic conditions, transportation, housing, environmental issues, and access to healthy food.

Partnerships among health systems, public health bodies, and community organizations are the most effective ways to address community health. However, most organizations are traveling on separate but parallel paths toward building healthier communities, and as a result, valuable data, information, and resources are often siloed.

Increased collaboration among key stakeholders will unlock tremendous power and drive better health outcomes. This research highlights innovative partnerships across the country to transform community health.

Specifically, there are four critical steps to build the business case for community partnership:

1. **Engage leadership**—build a compelling business case to garner executive buy-in and needed resources
2. **Prioritize initial focus**—determine what services or programs to start with, recognizing process will be iterative
3. **Strengthen partnerships**—leverage unique strengths of community organizations to extend care team reach
4. **Design seamless screening and referral protocols**—clearly link these two steps to ensure timely follow-through and improved patient and provider satisfaction

About The BUILD Health Challenge

Teaming up to Improve Community Health and Promote Health Equity

The BUILD Health Challenge is an initiative designed to foster and expand meaningful partnerships among health systems, community-based organizations, local health departments, and other organizations that impact health in the community.

The funding partners behind the challenge seek to catalyze meaningful progress toward total population health. Upstream factors—often referred to as the social determinants of health—include influences as diverse as early childhood development, economic opportunity, regulation and policy, the built environment, transportation and infrastructure, educational attainment, public safety, and housing.

The BUILD Health Challenge: BOLD. UPSTREAM. INTEGRATED. LOCAL. DATA-DRIVEN.

BUILD Health projects take upstream approaches to improve community health and promote health equity. In addition to funding, the selected communities gain access to a comprehensive package of technical assistance and support services to further their implementation efforts.

More information can be found at buildhealthchallenge.org.

Tremendous Innovation Driven by Community Partnerships

Focus on Social Determinants of Health Driving Short- and Long-Term Impact

Overview of the BUILD Health Challenge Communities

Source: Population Health Advisor research and analysis.

CMS Signals Increasing Interest in Community Partnership

Transformation Efforts Expanding to Broader Stakeholder Group

Accountable Health Communities Model

- **Overview:** grant program designed to test whether addressing Medicare and Medicaid beneficiaries' non-medical needs can help improve outcomes and total cost of care
- **Key focus areas**: housing instability, food insecurity, utility needs, interpersonal violence, transportation needs
- **Eligible applicants**: community-based organizations, health care provider practices, hospitals and health systems, institutions of higher education, local government entities, tribal organizations, and for-profit and not-for-profit local and national entities
- **Use of funds:** funds cannot pay directly for any community services (e.g., housing, food) received by beneficiaries and instead must be used to fund interventions intended to connect people to those offerings
- **Awards announcement:** planned fall 2016

By the Numbers

$157M	CMS funding available to bridge clinical care and social services
3 Tracks	Awareness, assistance, and alignment with community service
44	Total awards available to "bridge" organizations
5 Years	Program duration; participants must renew annually
$4.5M	Maximum funding per each of 20 track 3 bridge sites

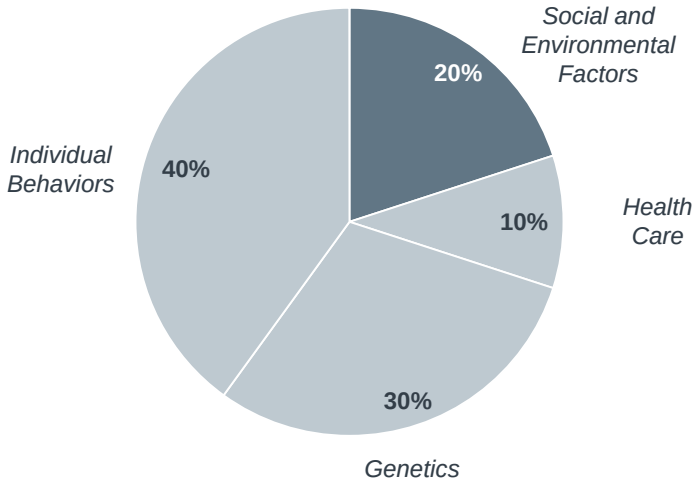
For additional information, visit
https://innovation.cms.gov/initiatives/ahcm

Source: "Accountable Health Communities Model Fact Sheet," CMS, 2016, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-01-05.html; Population Health Advisor research and analysis.

Surfacing and Addressing Social Needs Critical to Effective Patient Care

Care Teams Lack Access to Critical Resources

Impact of Different Factors on Risk of Premature Death



Examples of Social and Environmental Factors Influencing Health:

- *Income and employment status*
- *Housing and transportation*
- *Literacy and language*
- *Hunger and access to healthy food options*
- *Social integration and support*
- *Safety*

For our latest research on Incorporating Non-clinical Risk Factors for Ongoing Management, email tyrrellr@advisory.com

Closing the Gap on Social Determinants of Health

80-90%
Health status attributable factors other than clinical care

85%
Physicians reporting that unmet social needs lead directly to poorer health outcomes

20%
Physicians who are confident in their ability to address unmet social needs

Source: Schroeder SA, "We Can Do Better – Improving the Health of the American People," *NEJM*, 357, (2007): 1221-8; "Health Care's Blind Side," *Robert Wood Johnson Foundation*, http://www.rwjf.org/en/library/articles-and-news/2011/12/health-cares-blind-side-unmet-social-needs-leading-to-worse-heal.html; Population Health Advisor research and analysis.

Hospitals and Health Systems Critical Partners to Tackle Social Determinants

Success an Iterative Process Requiring Leadership Buy-In, Prioritized Focus, Integration in Clinical Care

1	**Engage Leadership**	Build a compelling business case to garner executive buy-in and needed resources
2	**Prioritize Initial Focus**	Determine what services or programs to start with, recognizing process will be iterative
3	**Build or Strengthen Partner Relationships**	Leverage unique strengths of community organizations to extend care team reach
4	**Design Screening and Referral Protocols**	Clearly link these two steps to ensure timely follow-through and improved patient and provider satisfaction

Source: Population Health Advisor research and analysis.

1

Engage leadership by building a compelling business case to garner executive buy-in and needed resources

Health systems play a pivotal role in supporting their communities. However, these efforts are often seen as separate from larger strategic aims. As the industry shifts toward value-based care and holistically addressing consumers' needs, leaders should integrate community partnerships to achieve quality, cost, and experience imperatives.

To do this effectively, leaders must apply the same rigor to community partnerships as other types of affiliation agreements. This includes identifying leaders, setting expectations around commitment of resources, and defining metrics to track and measure partnerships success.

BUILD leaders identified three specific actions for driving success:

- **Establish organizational commitment** including best practice sharing, planning, and shared decision making
- **Provide forums for community involvement** including launching or expanding community advisory groups
- **Define resources for specific projects** including forums for staff to learn about initiatives and community resources

Population Health Management Provides New Incentives for Partnership

Addressing Non-clinical Contributions to Total Cost of Care

Addressing Non-clinical Barriers to Care

25% Missed appointments or rescheduling needs due to transportation problems

$8K Annual per-person health care savings as a result of offering housing and supportive services to high-cost homeless individuals

39% Increased likelihood of a Medicaid-enrolled child visiting an ED more than once in a year if living in un-renovated public housing

Three Goals of Population Health Management Leaders

1 Reducing Unnecessary Utilization

- Non-acute ED visits
- Avoidable readmissions

2 Trading High-Cost Services for Low-Cost Care

- Expanded primary care access
- Medical home enrollment

3 Enhancing Patient Engagement and Care Coordination

- Chronic condition management
- Improved referrals to specialists and PAC

Non-clinical Contributors

- Stable housing
- Healthy food options
- Educational opportunities
- Access to transportation
- Parks and playgrounds

Source: Silver D, et al, "Transportation to clinic," Journal of Immigrant and Minority Health, 14, no. 2 (2012), 350–355; Kersten EE, et al., "San Francisco Children Living in Redeveloped Public Housing Used Acute Services Less than Children in Older Public Housing, Health Affairs, 33, no. 12 (2014), 2230-2237; Corporation for Supportive Housing, "FAQ's About Supportive Housing Research, http://www.csh.org/wp-content/uploads/2011/11/Cost-Effectiveness-FAQ.pdf; Population Health Advisor research and analysis.

Build Lasting Infrastructure to Convene Stakeholders and Review Progress

Heard in the Research: Strategies for Embedding Community Engagement Efforts

Resource Investment

Objective	Recommendation	Action Steps
 **Establish Organizational Commitment**	**Embed values in organizational mission**	❑ Anchor mission at the executive level to embed community engagement across institution ❑ Create incentives to reward mission-oriented activities ❑ Set benchmark standards (e.g., percent of procurement dollars directed toward specific initiative)
 **Provide Forums for Engaging Community**	**Provide technical assistance to partners**	❑ Strengthen partner relationships by facilitating best practice sharing, planning, and decision making ❑ Offer one-on-one support, conduct conference calls and workshops, and hold public hearings when applicable
	Launch or expand a community advisory board	❑ Establish a group comprised of hospital, partner, and community members to ensure responsiveness to consumer and community health needs ❑ Use recommendations to guide strategic direction ❑ Find creative ways to engage this group (e.g., focus groups, pilot testing, community health improvement plan development)
 **Resource Against Defined Goals and Commitments**	**Dedicate staff to lead community partnership efforts**	❑ Focus on building relationships, expertise, and trust to facilitate more rapid decision making ❑ Avoid assigning community partnerships as an extra responsibility for staff with limited time to devote to partnership ❑ Consider having both a clinical staff member and community organization member dedicated to initiatives to ensure both perspectives are represented
	Establish or expand a community center or central partnership office	❑ Provide a visible, accessible location for hospital staff, community members, partners, and others to go for information and to share feedback and ideas ❑ Make community resource guides and other materials available at this location to support referrals to community-based providers

Source: Population Health Advisor research and analysis.

Identify Metrics to Build the Business Case

Initial Measure Selection Informed by System-Wide Imperatives and Availability of Data

Advice from BUILD Leaders:

- **Define key terms upfront**. For example, there may be multiple concepts of "community" even within a single institution (e.g., metro region, adjacent neighborhoods, specific zip codes)
- **Balance accessibility with meaningfulness of data.** Useful measure sets should capture both community conditions (e.g., whether housing is affordable and people are healthy) and institutional effort (e.g., dollars spent, staff hired)
- **Partner with community groups to collect data.** While hospitals have robust clinical data, other partners have ready access to other helpful data points such as home environment.
- **Include a mix of process and outcome metrics.** Demonstrating outcomes can be slow given the pace of work and long-tail of certain interventions, so ensure metrics provide helpful guideposts for progress in the interim.
- **Aim for "good enough."** There are no perfect metrics or perfect methods for isolating impact in interventions with multiple partners and confounding factors.

Source: Population Health Advisor research and analysis.

Strong Metrics Facilitate ROI Calculations, Transparency, Accountability

Select a Range of Metrics to Capture Both Short- and Long-Term Successes

Metric Pick List: Community Health Initiatives

Competency	Sample Metrics	
Service Volume and Reach	• New users and/or total users of service (e.g., community garden, walking path, playground, supportive housing) • Scale of service (e.g., miles of walking path, number of affordable housing units, number of sites or counties served) • Frequency of service interaction (e.g., number of community gatherings held, monthly encounters per patient)	• Duration of services (average) • Adherence to scheduled patient reassessments/outreach standards • Community referral completion rates • Dollars invested • Staff or volunteer hours committed • Existence of partnership center or community advisory board
Health Access and Awareness	• Percentage of uninsured patients • Percentage of patients with regular PCP • Medical home enrollment rate • CAHPS composite: access to care • Average appointment wait time	• No-show appointments as a percentage of total scheduled appointments or sessions • Awareness of service availability (e.g., walking paths, health fairs) • Percentage of patients “very confident” in accessing or understanding health information
Preventive Care	• Percent of patients not at risk out of those who complete a health assessment for alcohol consumption, exercise, stress management, nutrition, tobacco use	• Completion rates for specialty screenings (e.g., food insecurity, health literacy, depression, alcohol or other substance misuse screening) • Completion rates for preventive services (e.g., immunizations)
Patient Satisfaction and Health Status	• CAHPS composite: satisfaction with care	• Percentage of adults rating their health as “ good” or better
Care Utilization	• Hospital admissions per 1,000 patients • Asthma- or other acute exacerbation-related hospitalization • ED visits per 1,000 patients	• Per-member per-month cost of care • 30-, 60-, and 90-day readmissions rates for medical group patients admitted
Changes in Individual Behavior	• Increases in positive behaviors (e.g., physical activity, school attendance, consumption of fresh fruits and vegetables, savings rate)	• Decreases in negative behaviors or experiences (e.g., adverse childhood experiences, caregiver burden, substance misuse, school mobility of children, tobacco use)
Changes in Population Health/Community Goals	• School readiness • Academic proficiency scores • Graduation rate • Prevalence of specific chronic diseases or conditions (e.g., obesity) • Unemployment rate • Poverty rate; children in poverty • Homelessness rate • Crime rate (e.g., juvenile, violent, property) • Property values	• Voter turnout • Food desert designated areas or grocery stores per zip code • Greenhealth index rating • Sense of community/social connectedness • Feeling of safety • Carbon emissions • STARS index rating • Civic health index rating

Source: Population Health Advisor research and analysis.

Community Advisory Councils Provide Formal Engagement Mechanism

Participants Can Pilot Test Concepts, Provide Feedback on Processes and Written Materials

Case In Brief: Oregon Coordinated Care Organizations (CCOs)

- Local health entities delivering health care and coverage for people eligible for Medicaid
- State contracts with 16 CCOs to provide mental, physical, and dental care under a global budget
- Launched in 2012 and approved through 2017 under 1115 waiver agreement with CMS whereby Oregon must reduce Medicaid cost growth by 2% over agreement period
- CCOs required to engage community members through CACs and governing board to ensure transformation is responsive to local needs
- As of June 2015, ED visits have declined 23 percent since 2011 baseline and the model has yielded improvements in a number of areas of care while continuing to hold down costs

Oregon's CCO Model Engages Community At All Levels

Coordinated Care Organization

Network of providers, health plans, and other entities that have taken on financial risk and agreed to work together in their local communities to deliver health care services to Medicaid beneficiaries

Governing Board

- Provide overall guidance and decision-making authority for the CCO
- Establish standards for publicizing the activities of the CCO and CAC

Community Advisory Council (CAC)

- Identify and advocate for preventive care practices
- Oversee community health assessment and adoption of a community health improvement plan

Clinical Advisory Panel (CAP)

- Establish an approach to assure best clinical practices throughout the CCO
- Engage providers to build networks that enhance the Triple Aim

Stakeholders Participating in CCO Board, Councils, and Panels

Providers | Beneficiaries | Hospitals | Local Government | Community Groups

Source: Oregon Health Authority, "Centers for Medicare & Medicaid Services Amended Waiver List and Expenditure Authority". July 2012, www.oregon.gov/oha; Population Health Advisor research and analysis.

2

Prioritize initial focus by determining what services or programs to start with, recognizing process will be iterative

The first challenge is narrowing down the list of potential focus areas. The wide range of social determinants of health—economic stability, physical environment, education, food, social context—lead to either decision paralysis or an overwhelming number of initiatives that stretch resources too thinly, resulting in limited impact.

Instead, leaders in this space work with their community and use their own data to prioritize a subset of initiatives. Across BUILD participants, food and nutrition emerged as the most common area of partnership. Forty-one percent of BUILD communities are designing innovative programs that link residents to food pharmacies, fruit and vegetable prescription programs, cooking demonstrations, nutrition education courses, and an expanded network of food suppliers to expand access to healthy options.

To prioritize efforts in your own community, BUILD leaders recommend organizations:

- **Utilize a mix of qualitative and quantitative data**
- **Be transparent about how decisions will be made,** especially when priorities may differ across stakeholders
- **Define terms** to avoid assumptions and misunderstandings
- **Prevent perfect from being the enemy of good**

Many Options for Prioritizing Partnership Efforts

Initial Focus May Be Dictated By Resource Availability and Presence of a Champion

Heard in the Research: Where Provider Organizations Are Concentrating Initial Efforts

Topic	Sampling of Interventions	BUILD Projects Focusing Here
Neighborhood and Environment 	• **Repurposing vacant parcels** as community greenspace and gardens (Baystate Health System, Sisters of Providence Health System) • Investing in **urban infrastructure improvements** (Providence Health & Services) • Clustering education, recreation, conservation, and green infrastructure around a **community gathering place** (St. John Providence Health System)	35%
Housing 	• **Pinpointing distressed buildings for repairs** and improvements to reduce asthma-related hospital visits (Montefiore Medical Center; Mercy Medical Center and UnityPoint Health) • Providing **prevention-based housing maintenance** to reduce health hazards in the home (The MetroHealth System) • **Increasing number of affordable housing sites** and reducing number of residents who have to move due to rising rents (Sutter Health)	18%
Crime and Violence 	• Providing **case management** to pregnant women and teaching literacy and **responsible parenting techniques** that offer alternatives to physical discipline (Maryland Medical Center) • Identifying and addressing root causes of crime-driven health outcomes (Jackson Health Systems)	18%

Additional areas heard in research: workforce development and training, culture-based economic development, life skills training

Source: Population Health Advisor research and analysis.

Food and Nutrition Often at the Heart of Initial Partnership Efforts

Obesity, Food Insecurity, and Chronic Conditions Are Inextricably Linked

41%

BUILD Health Challenge projects focused on food and nutrition

2.9X

Increased likelihood of poor overall health status if a member of a food-insecure household

$50

Medicaid savings for every $1 spent on Meals on Wheels

Three Common Types of Provider-Led Food Insecurity Partnerships

	Connection to Federal and State Benefits	Increased Access to Healthy Foods	Nutrition Education and Food Literacy
Goal	Empower and support patients eligible for existing services	Provide supplemental assistance to patients and families who are food insecure and/or living in a food desert	Offer wrap-around support services that build healthy life skills and habits that acknowledge environmental limitations (e.g., limited access to produce)
Primary Offerings	• SNAP enrollment assistance program • On-campus WIC Office	• Emergency food • On-site food pantry • Discounted produce partnership • Free meal program	• Nutrition/cooking classes • Budget-friendly, healthy recipes • Grocery store tours
Additional Services	• School meal program enrollment • Senior meal program enrollment	• Hospital-owned grocery store • Store discounts and vouchers	• Community garden • School food service enhancement support

Source: Brown, JL et al, "The Economic Cost of Domestic Hunger," Sodexo Foundation, http://www.sodexofoundation.org/newsletter/pdf/economic_cost_of_domestic_hunger.pdf; Center for Effective Government, Washington, D.C.; Chen MA, et al, "The Role of Hospitals in Improving Non-Medical Determinants of Community Population Health," Division of Health Policy and Economics, Weill Cornell Medical College, http://nyshealthfoundation.org/uploads/resources/community-population-health-report-april-2016.pdf; Population Health Advisor research and analysis.

Use Readily Available Data to Guide Selection Process

Don’t Let Imperfect Information Inhibit Progress

Existing Data Enables Immediate Prioritization

		Data Location	*Advantage Gained*
Quantitative	**Clinical Data**	• Electronic Medical Record • Lab systems • E-prescribing system • Patient portal	Highlights common conditions experienced by community
Quantitative	**Billing History**	• Electronic Medical Record • Financial/accounting systems	Contains data on avoidable utilization, areas for improvement
Quantitative	**Demographic Information**	• Electronic Medical Record • Patient portal • Registration system • Scheduling system • Community Health Needs Assessment	Provides additional context to guide prioritization and selection of target populations
Qualitative	**Community Interests**	• Community Health Needs Assessment • Community-led meetings • Frontline staff feedback, particularly from community-based providers (e.g., EMTs) • Staff or board meetings	Provides perspective on the issues that are important to a community and surfaces champions

Heard in BUILD Interviews

- Utilize a mix of both qualitative and quantitative data when possible to find the sweet spot between financial opportunity and community interests
- Acknowledge that community priorities may differ from hospital priorities and be transparent about how decisions will be made
- Listen and respond to non-clinical challenges, misunderstandings, and issues that may not be related to a specific project but connected to building a lasting relationship
- Remember that there is no wrong place to start, since all efforts will be valuable

Source: Population Health Advisor research and analysis.

Hospital-Based Food Pantries Offer Supplemental Food Assistance

Framing Hunger as a Health Issue Minimizes Stigma and Increases Access

Tactics Used to Increase Patient Comfort in Accessing Boston Medical Center's Preventive Food Pantry

Identified Barriers to Adherence	*Solutions Implemented to Boost Utilization*
Visibility: Patients may be embarrassed about accessing a food pantry or being seen carrying food out of the pantry because of perceived stigma	**Location**: Food pantry is placed in an out-of-the-way location on the hospital's fourth floor to keep patient interactions private
	Carrying containers: Staff encourage patients to use luggage, backpacks, purses, or duffel bags to discreetly carry food; pantry keeps donated bags on hand
Language and cultural barriers: Patients may not feel comfortable expressing their preferences or concerns in English	**Language services**: Hospital's translation service is located adjacent to the food pantry, facilitating communication between pantry staff and users

Program Design Goals

- Minimize or eliminate perceived stigma
- Increase patient comfort level
- Boost referral adherence and utilization of food pantry

Case in Brief: Boston Medical Center

- Private, not-for-profit 496 bed safety net academic medical center in Boston, Massachusetts
- Nutritionists at Boston Medical Center's Growth Clinic encouraged clinicians to proactively identify and address food insecurity, prompting Boston Medical Center to open a food pantry on its campus to meet demand for services
- The food pantry addresses condition-specific and general food insecurity needs for low-income patients referred by a clinician. Patients can access the pantry Monday-Friday from 10am-4pm, twice per month and receive three to four days worth of food for their household at each visit
- Stigma was identified as a common barrier to initial utilization, so staff identified specific drivers and now ensure patients have translation services available and discreet ways of picking up food (e.g., in suitcases or inconspicuous bags, having a family member pick up food for them)
- The pantry serves 80-100 people per day and approximately 7,000 people per month

Sources: Population Health Advisor research and analysis.

3

Build or strengthen partner relationships by leveraging unique strengths of community organizations to extend care team reach

With a prioritized list of opportunities, the next step is assembling the right group of stakeholders. The BUILD Health Challenge illustrates the tremendous range of organizations with shared objectives for community health.

However, shared goals do not ensure a seamless working relationship. Formalizing partnerships with these groups extends reach while building on the skillsets, relationships, data, or tools each partner brings to the table.

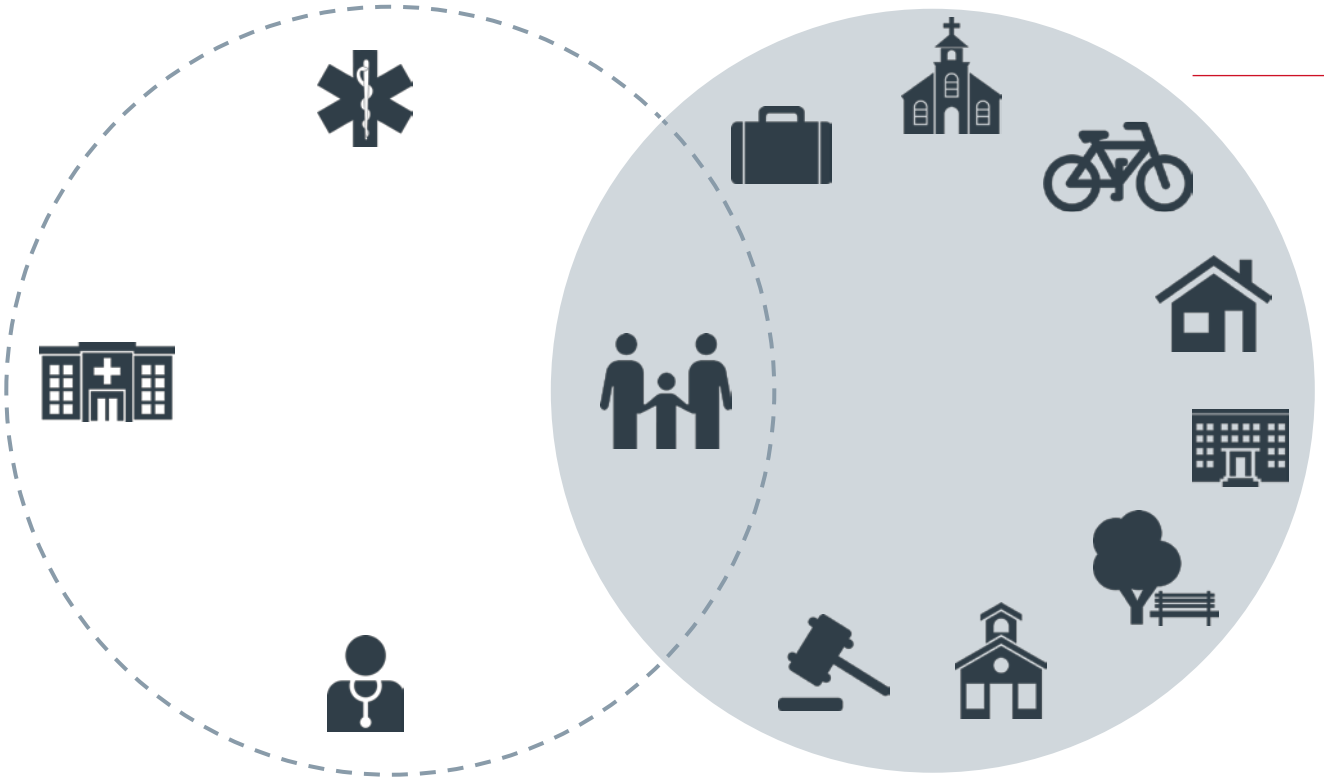
Building effective partnerships starts with these key steps identified by BUILD leaders:

- **Build trust with your community** by sending hospital leaders to community meetings, learning from community partners, and integrating existing partnership structures
- **Create positive working relationships with public health and community-based organizations** by identifying the strengths of each partner, avoiding duplication of effort, and outlining processes for information sharing and decision making
- **Surface community priorities** , noting areas of alignment or areas where prioritization differs

Broad Range of Partners To Choose From

Clinical-Community Linkages Improve Access to Funding and Services

Sphere of Patient Activity and Interactions



COMMON COMMUNITY PARTNERS

- Public health departments
- County mental health agencies
- School districts and universities
- Faith-based organizations
- YMCA/YWCA
- Service leagues (e.g., Lions, Rotary)
- Environmental organizations
- Local agencies (e.g., Area Agencies on Aging, housing and city planning departments)
- Non-profit service providers (e.g., Meals on Wheels, food banks)
- Local businesses (e.g., bodegas, barber shops)
- Public safety providers (e.g., police, EMS)
- Private firms (e.g., real estate and architecture firms)

BUILD Health Challenge Partnership Scale

3	8	$149K
Primary partners per project (including hospital)	Average total number of partners involved per project	Average hospital match per implementation site

Source: Population Health Advisor research and analysis.

Successful Collaboration Hinges on Trust, Use of Existing Infrastructure

Allow Sufficient Time to Build Strong Relationships

Three Steps for Effective Partner Collaboration

Build trust with your community

- Send hospital representation to community meetings
- Initially focus on listening and learning from the community
- Respect and utilize existing power and communication structures

Create positive working relationships with partners

- Identify the unique strengths of partners to scale and prevent duplication of effort
- Determine how group will share information and make decisions

Surface community priorities

- Acknowledge that community priorities may be different or in a different order than hospital's priorities
- Find ways of extracting the community's thoughts on primary concerns and proposed solutions

Source: Population Health Advisor research and analysis.

Stakeholders Bring Unique Perspective and Specialized Expertise

Ensure Balance of Interests are Represented

Advice from BUILD Leaders:

- **Commit to showing up**. Hospitals and health systems can differentiate themselves by showing up and signaling interest, awareness, and investment.
- **Be willing to spend time in "inaction" mode.** Presenting data on challenges or plans without first soliciting input can inhibit long-term buy-in. BUILD leaders suggest spending up to a year just listening and building connections in order to facilitate speedier implementation down the line.
- **Use existing lines of communication to spread messages by word of mouth**. Certain individuals will naturally emerge as respected advisors during meetings, so partnering with them to serve as spokespeople and communication liaisons can improve reach and effectiveness of messaging.
- **Find common ground.** Each major stakeholder group has a very distinct culture, language, skillset, and process for managing projects, data, money, and communication. Community health needs assessments are a common lever for bringing disparate groups together and recognizing the unique strengths each party has to offer.
- **Balance inclusion with agility**. Differences in culture and pace of work can inhibit decision making, so consider engaging a broad group for strategy and a smaller group for operational execution.
- **Make decisions with a long-range view.** Meetings and conversations may surface non-clinical challenges, misunderstandings, and issues that may not be directly related to a specific project but connected to building a long-term relationship (e.g., serving Halal food in the hospital).
- **Guide the community to their own solutions.** Even if the hospital has a plan it's interested in proceeding with, take the time to understand community interests and responses to data presented so that the ultimate plan comes from them.

Critical Strengths of Various Stakeholder Groups

Trauma, EMS, field-based providers

– Have firsthand context around community challenges

– Understand clinical working relationships

Public health departments

– Trained to prepare community health needs assessments

– Have specialized expertise and resources related to health promotion and prevention

Hospitals

– Have access to large data sets and the expertise to analyze

– Likely to have existing templates, fact lists, and translation services that can be shared with others

Community-based organizations

– Have an ear to the ground

– Excel at community engagement

– Often have expertise in a particular social determinant

Source: Population Health Advisor research and analysis.

4

Design screening and referral protocols to clearly link these two steps and ensure timely follow-through and improved patient and provider satisfaction

With partnerships in place, the critical next step is hardwiring the process for collaboration. Specifically, health system leaders should determine how information will flow between partners to identify patients, recommend services, and follow up. Developing this process ensures partners can deliver on cost, quality, or experience goals.

Existing hospital and clinic screening and stratification efforts help identify patients groups most likely to benefit from access to new resources. Alerting care teams to these resources can also kick-start the process of identifying the best way to handoff patients and information between partners. Collecting feedback from teams and making improvements to the process ensure that initial gains can be maintained and serve as an effective way to communicate success stories to larger stakeholder groups.

BUILD leaders emphasized the need to:

- **Integrate non-clinical data into care planning conversations** by framing social risks as clinical risks, which can ease discomfort while also enabling valuable care plan customizations
- **Define data collection mechanisms and limitations upfront** to address access to information, interoperability, and privacy concerns
- **Assign clear ownership for resource connection processes** to ensure individuals know how to refer and request resources

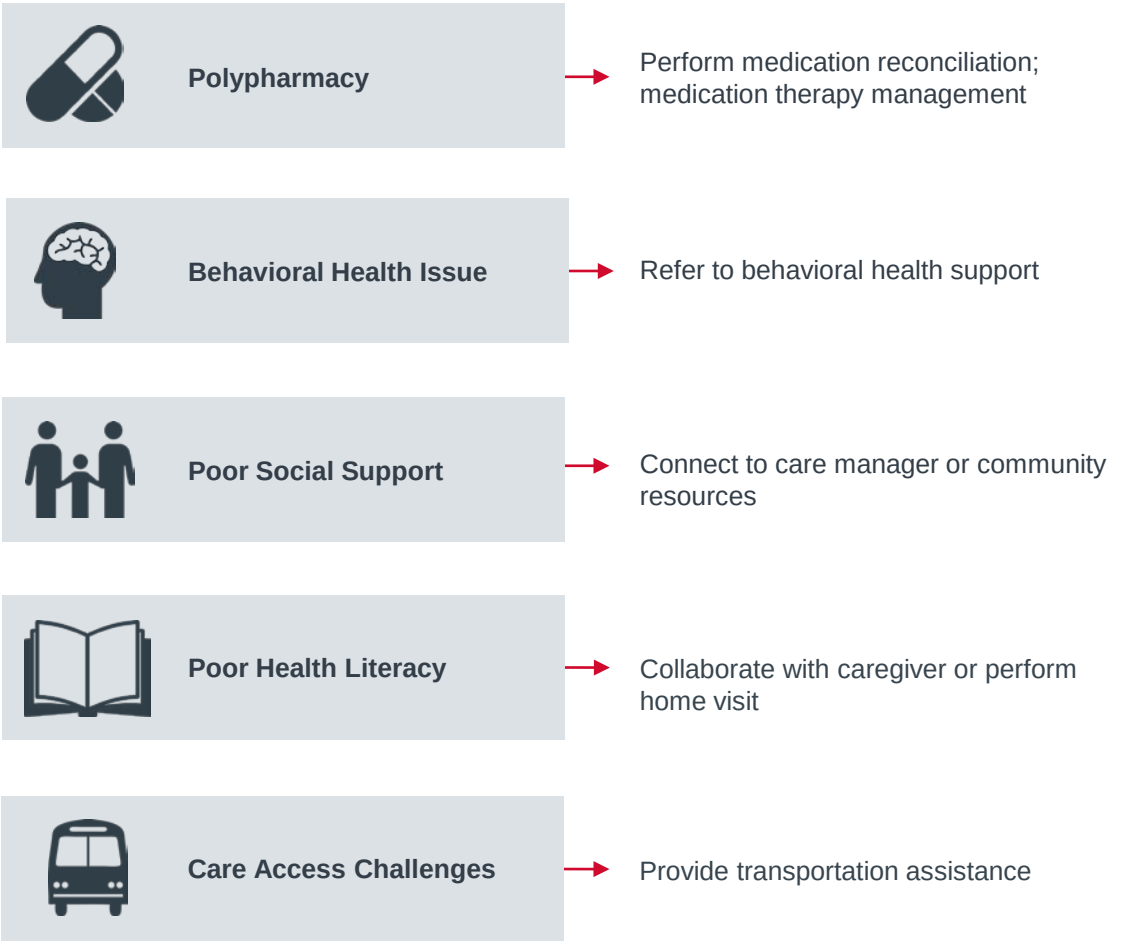
Non-clinical Data Essential to Effective Care Planning

Patient Needs Dictate Intervention Type and Sequencing

Heard in the Research

- **Incorporate non-clinical risk factors in risk assessment tools.** Assessing both clinical and non-clinical risk factors simultaneously helps reframe social issues as health issues while also helping providers customize interventions.
- **Balance predictive value and accessibility of data.** A best practice risk assessment tool strikes a balance between being highly predictive of readmissions or poor health outcomes and not overly burdensome for staff to perform.
- **Use hypotheses of risk to inform data collection methods.** Some projects use zip code analysis, while others use face-to-face assessments either in the health care setting or out in the community.
- **Gather data from partners to fill gaps in hospital data sets.** Clinical and community partners often have access to psychosocial and non-clinical data that would otherwise be time-consuming to collect. When determining what to share, consider accessibility, willingness to share, patient privacy, and value of data. Interoperability and privacy concerns may complicate data sharing, so define limitations upfront.

Risks Mapped to Sample Interventions



Source: Population Health Advisor interviews and analysis.

Health Systems Responding By Bolstering Community Partnerships

Broad Range of Strategies Being Deployed to Extend Wraparound Support

Investment Required

Develop Community Resource Guides

- Community resource guides assist in identifying community organizations for assistance
- Universal referral forms improve exchange of patient information

Leverage Volunteers and External Resources

- Volunteers support either within the organization or in the community to connect patients to community resources
- Community members can be leveraged for health screenings or health education and coaching

Employ Community Resource Specialists

- Community Resource Specialist handles non-clinical patient issues that interfere with clinical outcomes
- Forges relationships with local organizations and fields patient requests

Source: Population Health Advisor research and analysis.

Multilevel Team Allows Coverage of Clinical, Non-clinical Patient Needs

Interconnected Providers Offer Comprehensive Coverage

Community Resource Specialist

Patient Social Assistance

- Transportation arrangement
- Appointment reminders
- Community health resources
- Caregiver assistance
- Socialization groups
- Friendly phone calls to isolated patients

Resource Coordinator

- Compiles repository of community resources
- Forges relationships with local organizations
- Fields direct patient requests

Non-clinical Home Services

- Durable medical equipment ordering
- Medical device replacement
- Home care services
- Meals on Wheels

Case in Brief: MassGeneral Care Management Program

- 900-bed academic medical center in Boston, Massachusetts
- Part of the six-year CMS Medicare Care Management for High Cost Beneficiaries Demonstration
- Multidisciplinary team including primary care physician, nurse care manager, social worker, pharmacist, medical director, and community resource specialist provide comprehensive clinical care, non-clinical support to high-risk, co-morbid Medicare patients
- Program achieved a seven percent net savings in care costs in the first three years for the top 2,500 highest-cost Medicare fee-for-service patients; reduced emergency department visits by 35 percent and hospitalizations by 20 percent

Source: Population Health Advisor research and analysis.

Related Population Health Resources from the Advisory Board

Tactics to Reduce Avoidable ED Utilization

Best practices for reducing avoidable emergency department utilization with a focus on increasing access, inflecting behavior change through education, and developing cross-continuum support for complex patients.

Incorporating Non-clinical Risk Factors for Ongoing Management

Evaluation of the use of non-clinical risk factors to improve risk stratification and ongoing patient management. Insights provide guidance for identifying non-clinical risk factors, collecting metrics, and using to inform the care planning process.

Provider-Led Strategies for Addressing Food Insecurity

New research on implementing programs to address food insecurity, including case profiles that highlight a broad range of services as well as action steps for improving food security in your community.

Where Do You Fall on the Path to Value-Based Care?

We generally find that health systems fall on a spectrum in terms of how advanced they are on the path to population health management. Learn about the most common population health profiles and see how your organization stacks up.

Building a Super Utilizer Program and Leveraging CPRM to Support

Webconference on industry-proven best practices for building a super utilizer program with detail on how to leverage CPRM data and identify the right patient groups to support.

Crimson Care Management Case Study Library

Compilation of our most successful member case studies across the Crimson Care Management cohort. Learn how others are leveraging their applications to develop and execute customized care programs, strengthen communication, improve outcomes, and reduce care costs.

Offerings Span the Care Continuum

Primary Care Innovation

Telemedicine and Remote Monitoring

Patient Engagement

Emergency Department Avoidance

PAC Partnership Network Performance

Source: Population Health Advisor research and analysis.

Advisory Board

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