American Hospital Association™

Advancing Health in America

BRIDGING THE SECTORS:

A Compendium of Resources

Partnering to Support Individuals with Complex Medical and Social Needs

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Partnering to Support Individuals with Complex Medical and Social Needs

Cross-sector partnerships between health care and community-based organizations are essential for improving and maintaining the health of individuals and families living with complex medical and social needs.

As organizations continue to evolve their efforts to address societal factors that influence the health of individuals and families, leaders and innovators are focusing on building collaborative teams that bring together clinical providers with community-based providers, such as social service and home care agencies, to meet patients' functional, social and behavioral health needs.

Navigating partnerships between hospitals and health systems and community-based organizations can be challenging, as these sectors may have different business and service models, client populations and financial structures.

This compendium highlights resources and toolkits for facilitating cross-sector partnerships, from leading organizations across the country. It was developed by the American Hospital Association with support from the Robert Wood Johnson Foundation and content assistance from the National Center for Complex Health and Social Needs, an initiative of the Camden Coalition of Healthcare Providers.

The **CROSS-SECTOR PARTNERING** section provides resources on the technical how-tos of cross-sector partnering, including in clinical applications and on project administration.

The **SOCIETAL FACTORS** section links to resources about using different types of data on societal factors to describe patient and community populations, and establishing workflows with closed-loop processes.

The **POPULATION HEALTH** section includes resources that define population health and describe strategies to improve the health and well-being of patient and community populations.

In each section, resources are further classified into categories based on the main focus of their content. The list of resources in this compendium is not exhaustive and will be updated periodically as additional tools are identified.

If you would like to submit a technical assistance tool for consideration, please email it to ACHI@aha.org with the subject line "Bridging the Sectors."

Inclusion in this compendium does not necessarily imply endorsement by the AHA, nor should it be construed as advice from the AHA. Rather, these tools and resources are meant to assist hospitals and health systems and their community partners in developing effective partnership strategies.

CROSS-SECTOR PARTNERING

The resources linked in this section are designed to provide insights on the technical aspects, or how-tos, of cross-sector partnering, including in clinical applications and on project administration.

PARTNERING HOW-TOS

Partnership models

- **Integrating to Improve Health: Partnership Models between Community-Based and Health Care Organizations**
  Nonprofit Finance Fund, 2018
  This resource outlines common partnership elements and establishes a framework to describe integration between community-based and health care organizations.
  https://nff.org/fundamental/resources-community-based-organization-and-healthcare-partnerships

Stakeholder engagement

- **Ensuring Access in Vulnerable Communities Community Conversations Toolkit**
  American Hospital Association, 2017
  This toolkit provides ways in which hospitals and health systems can broadly engage their communities using community conversations events, social media and the community health assessment. It also outlines how to focus engagement on specific stakeholders, including patients, boards and clinicians.
  https://www.aha.org/system/files/content/17/community-conversations-toolkit.pdf

- **Community Engagement Toolkit for Rural Hospitals**
  Washington State Hospital Association, 2014
  This toolkit is designed to help administrators leverage their hospital's strengths and resources to engage in a community dialogue about health and form sustainable community partnerships. It includes an assessment to reflect on community engagement activities and determine what's working well and what can be improved.
  https://www.wsha.org/wp-content/uploads/CommEngagementToolkit_1_1.pdf

Building effective partnerships

- **Lessons Learned from Partnerships Between Networks of Community-Based Organizations and Healthcare Organizations**
  Nonprofit Finance Fund, 2021
  This report from the Advancing Resilience and Community Health (ARCH) initiative highlights themes and lessons learned that can inform new approaches to advancing community health. Through ARCH, Nonprofit Finance Fund partnered with three networks — EngageWell IPA, Metropolitan Alliance of Connected Communities, and Thomas Jefferson Area Coalition for the Homeless — to explore what it takes for CBO networks to come together around a shared vision for partnering with health care.
  https://nff.org/report/advancing-resilience-and-community-health

- **The Partnership for Public Health**
  American Hospital Association, 2020
  This webpage offers a suite of tools and resources that showcase leading strategies for active collaboration across the public health field. These resources were developed by engaging health care leaders across the U.S. as part of the Partnership for Public Health project, a joint effort between the Center for State, Tribal, Local and Territorial Support (CSTLTS) within the Centers for Disease Control and Prevention, American Hospital Association and the National Association of County and City Health Officials.
  https://www.aha.org/center/community-health-well-being/partnership-public-health

- **Partnering to Catalyze Comprehensive Community Wellness: An Actionable Framework for Health Care and Public Health Collaboration**
  Public Health Leadership Forum and Health Care Transformation Task Force, 2018
  This report provides a framework to facilitate collaborative working relationships between the public health and health care sectors. The framework includes tactics and actionable strategies to support several elements of collaboration: governance structure, financing plan, cross-sector prevention models, data-sharing strategy, and performance measurement and evaluation.
  https://hcttf.org/wp-content/uploads/2018/06/Comprehensive-Community-Wellness-Report.pdf

- **A Playbook for Fostering Hospital-Community Partnerships to Build a Culture of Health**
  American Hospital Association, 2017
  This playbook offers effective methods, tools and strategies for creating new partnerships and sustaining successful existing ones. The playbook incorporates lessons learned from the Learning in Collaborative Communities cohort, 10 communities across the U.S. with strong, successful hospital-community partnerships.
  https://www.aha.org/ahahret-guides/2017-07-27-playbook-fostering-hospital-community-partnerships-build-culture-health

- **Practical Playbook: Building a Partnership**
  de Beaumont Foundation, Duke Family Medicine & Community Health and Centers for Disease Control and Prevention, 2017
  This resource provides a step-by-step process for organizing and preparing, planning and prioritizing, implementing, monitoring and evaluating, and sustaining a primary care and public health partnership project.
  https://www.practicalplaybook.org/section/building-partnership

- **Partnership Assessment Tool for Health**
  Nonprofit Finance Fund, 2017
  Designed for community-based organizations and health care organizations already engaged in partnership, the Partnership Assessment Tool for Health, or PATH, provides a format to understand progress toward benchmarks characteristic of effective partnerships, identify areas for further development and guide strategic conversation. The tool is designed to help partnering organizations work together more effectively and maximize their impact.
  https://nff.org/fundamental/partnership-assessment-tool-health

Organizational readiness for partnership

- **Readiness Assessment Tool**
  Aging and Disability Business Institute, 2020
  This tool guides a community-based organization through the process of successfully preparing for, securing and maintaining partnerships with the health care sector, by assessing the organization's current readiness and also providing a framework and resources for navigating the process successfully. (Must log in or create an account for free access to this tool.)
  https://www.aginganddisabilitybusinessinstitute.org/assessment-tools/

- **Value Proposition Tool: Articulating Value Within Community-Based and Health Care Organization Partnerships**
  Nonprofit Finance Fund, 2018
  This tool is designed to assist partners in articulating their value within an emerging or existing partnership through a series of reflection questions and considerations.
  https://nff.org/fundamental/resources-community-based-organization-and-healthcare-partnerships

- **Nonprofit Readiness for Health Partnership**
  Nonprofit Finance Fund, 2018
  This tool assesses a community-based organization's readiness to engage in partnership with health care organizations to deliver outcomes related to social determinants of health. It helps organizations review key capacities likely required for successful outcomes-oriented partnerships, to identify the organization's strengths and weaknesses and to determine what capacity building and investment the organization may require before engaging in outcomes-oriented partnership arrangements. The tool is designed for self-assessment and internal use and not intended to evaluate potential partners.
  https://nff.org/fundamental/nonprofit-readiness-health-partnership

- **Hospital Guide to Reducing Medicaid Readmissions Toolbox**
  Agency for Healthcare Research and Quality, 2017
  This package of tools accompanies the Hospital Guide to Reducing Medicaid Readmissions, which offers in-depth information about the unique factors driving Medicaid readmissions and a step-by step process for designing a locally relevant portfolio of strategies and collaborating with cross-setting partners to reduce Medicaid readmissions. Some of the tools are adaptations of best-practice approaches to make them more relevant to the Medicaid population; other tools are newly developed.
  https://www.ahrq.gov/sites/default/files/publications/files/medreadmissions.pdf

- **Conditions for a Healthy System of Health**
  ReThink Health, Fannie E. Rippel Foundation, 2015
  This assessment captures 11 key conditions that together build momentum toward a transformed regional system of health over time. Organizations can use this tool to understand those 11 key conditions, assess their efforts on each condition and identify areas of strength, improvement and opportunity.
  https://www.rethinkhealth.org/wp-content/uploads/2015/08/developmental-assessment-803.pdf

CLINICAL APPLICATIONS

Community-based care coordination

- **Complex Care Startup Toolkit**
  National Center for Complex Health & Social Needs, 2021
  The Complex Care Startup Toolkit is a practical collection of guides, templates and other tools for new and developing complex care programs, regardless of setting, population or geography. With examples from programs and organizations across the U.S., the toolkit covers program design, program operations, data and process improvement, team and leadership development, community mapping and collaboration, and communication.
  https://www.nationalcomplex.care/research-policy/complex-care-startup-toolkit/

- **Addressing Social Needs Through Integrated Healthcare and Social Care in Texas: Case Studies, Key Issues, and Recommendations to Advance Practice**
  Texas Health Improvement Network, 2020
  The Texas Health Improvement Network conducted a 15-month project to explore the current practice of health care and social care integration in Texas and identify key issues impacting adoption and sustainability. This report provides background information, recommendations and six case studies, providing a qualitative snapshot of health care and social care integration activities in Texas.
  https://www.utsystem.edu/sites/default/files/sites/texas-health-journal/THIN_Healthcare%2BSocial-Care-October2020.pdf

- **Community-Based Care Coordination – A Comprehensive Development Toolkit**
  Stratis Health, 2020
  This resource provides a variety of tools for use at different stages in the development of a community-based care coordination program, including how to begin a program. Tools focus on people, functions, policy and processes to achieve success in the community-based care coordination environment.
  https://stratishealth.org/toolkit/care-coordination-toolkit/

- **Care Coordination Toolkit**
  Centers for Medicare & Medicaid Services, 2019
  This toolkit highlights innovative care coordination strategies that Medicare accountable care organizations use to collaborate with beneficiaries, clinicians and post-acute care partners to ensure high-quality, effective care is provided at the right time and in the right setting.
  https://innovation.cms.gov/files/x/aco-carecoordination-toolkit.pdf

Clinical-community linkage relationship

- **Addressing Patients' Social Needs to Help Reduce Health Inequity During the COVID-19 Pandemic**
  American Hospital Association, 2021
  This resource examines the impact of the social determinants of health on patients and communities as they battle the COVID-19 outbreak and provides ideas and case examples to help hospitals and health systems address patients' ongoing social needs.
  https://www.aha.org/resources/2020-04-24-awareness-social-needs-can-help-address-health-inequity-during-covid-19

- **Integrating Services for Community Health: A Community-Clinical Linkages Toolkit for Local WIC Agencies**
  Society for Public Health Education and National WIC Association, 2017
  This toolkit was specifically created for local women, infants and children (WIC) agencies working to create partnerships between community organizations and clinical settings. This resource also has useful information for health care professionals, health education specialists, social workers, hospital benefit managers, and administrators working in clinics, community-based organizations or public health agencies.
  https://www.sophe.org/wp-content/uploads/2017/07/National-WIC-Association_final2.pdf

- **Community-Clinical Linkages for the Prevention and Control of Chronic Diseases**
  Centers for Disease Control and Prevention, 2016
  This guide outlines key strategies for public health practitioners implementing community-clinical linkages that focus on adults age 18 and older, with the rationale, key considerations and potential action steps for each particular strategy. It also includes resources for public health practitioners to use when implementing a strategy and shares examples of community-clinical linkages.
  https://www.cdc.gov/dhdsp/pubs/docs/ccl-practitioners-guide.pdf

- **Clinical-Community Relationships Evaluation Roadmap**
  Agency for Healthcare Research and Quality, 2013
  This roadmap is designed for future research and evaluation of effective clinical-community resource relationships and will be of use to funders, researchers and program evaluators interested in primary care. The resource's investigators pose priority questions and recommendations for advancing research and developing clinical-community resource measures, based on an environmental scan of measures, a targeted literature review of research, an assessment of evidence gaps, and input from an expert panel.
  https://www.ahrq.gov/prevention/resources/chronic-care/clinical-community-relationships-eval-roadmap/index.html

- **Clinical-Community Relationships Measures Atlas**
  Agency for Healthcare Research and Quality, 2013
  This resource provides a list of existing measures for assessing the structures, processes and outcomes associated with clinical-community relationships for delivering clinical preventive services. The measures are organized according to a framework that includes the relationships between clinicians, patients and community resources.
  https://www.ahrq.gov/prevention/resources/chronic-care/clinical-community-relationships-measures-atlas/index.html

- **Potential Measures for Clinical-Community Relationships**
  Agency for Healthcare Research and Quality, 2013
  This supplement to the Clinical Community Relationships Measures Atlas suggests 52 potential measures that could be developed to fill the gaps in existing measurements. It also proposes a core set of 13 measures culled from the existing measures in the atlas and the 52 potential measures that represent the essential aspects of clinical community relationships for prevention. These measures are suggested for further testing and development with the ultimate aim of increasing the delivery of appropriate clinical preventive services.
  https://www.ahrq.gov/prevention/resources/chronic-care/ccrm-atlas-suppl/index.html

ADMINISTRATIVE RESOURCES

Business case development

- **Investing in Social Services as a Core Strategy for Health Care Organizations: Developing the Business Case**
  KPMG Government Institute, 2019
  This guidebook is geared toward all payer and provider organizations that currently bear some form of risk for managing total costs of care for a distinct population. Though focused mainly on organizations that are responsible for managing high-need, high-cost populations, this guide offers steps and practical approaches for any organization (payer or provider) that either currently bears risk or is in the process of moving to risk-based remuneration models for a covered population.
  https://institutes.kpmg.us/content/dam/institutes/en/government/pdfs/2018/investing-social-services.pdf

- **Community Paramedicine Business Case Assessment Tool**
  Center for Health Care Strategies, 2016
  This tool forecasts costs and savings under different implementation and expansion scenarios, and identifies cost and savings drivers — such as patient volume, health service costs and operating costs — and how these drivers affect financial performance.
  https://www.chcs.org/resource/community-paramedicine-business-case-assessment-tool/

Financial

- **Health Care and Community-Based Organization Partnership: What Does It Cost?**
  Nonprofit Finance Fund, 2018
  This resource guides partnerships in estimating costs to help align goals, prioritize decisions, communicate with stakeholders and advocate for funding.
  https://nff.org/fundamental/resources-community-based-organization-and-healthcare-partnerships

Agreements (legal, shared services)

- **Collaboration Toolkit: Creating an MOU**
  Colorado Nonprofit Association, 2013
  This toolkit explains what a memorandum of understanding is, what it should include and the process for creating or revising an MOU, and provides additional resources and references.
  https://anschutzfamilyfoundation.org/wp-content/uploads/2016/04/MOU-toolkit-MAIN.pdf

Project planning

- **Guide: Developing a Population Health Project Plan**
  Health and Community Services Workforce Council and CheckUP Australia, 2013
  This resource provides step-by-step guidelines and information to support comprehensive planning, development and implementation of population health initiatives and programs.
  https://www.checkup.org.au/icms_docs/182812_8_GUIDE_Developing_a_Population_Health_Project_Plan.pdf

SOCIETAL FACTORS

The resources in this section are designed to provide an understanding of how to use different types of data on social factors to describe patient and community populations, and how to establish workflows with closed-loop processes.

Community health (needs) assessment

- **Community Health Assessment Toolkit**
  American Hospital Association, 2017
  This toolkit offers a nine-step pathway for conducting a community health assessment and developing implementation strategies.
  https://www.healthycommunities.org/resources/community-health-assessment-toolkit

- **Applying Research Principles to the Community Health Needs Assessment Process**
  American Hospital Association, 2016
  This guide identifies tools and research principles to support community health needs assessments, describes patient- and community-centered practices to integrate into data collection during the CHNA process, and provides direction for identifying evidence-based resources to inform CHNA implementation strategies.
  https://www.aha.org/system/files/2018-01/Applying_Research_Principles_to_the_CHNA_Process.pdf

Population health analytics

- **Population Health Toolkit**
  National Rural Health Resource Center, 2019
  In cooperation with the Federal Office of Rural Health Policy, this toolkit provides visualizations of data from multiple sources that answer questions that rural hospitals and communities have about the health of their communities. Users can explore their data further by downloading the information to create their own analysis and graphs.
  https://www.ruralcenter.org/population-health-toolkit

- **Geographic Data Sources for Assessing Health-Related Social Risk Factors**
  Center for Health Care Strategies, 2020
  This resource summarizes publicly available data sources that can be used to further understand community-level, health-related social risk factors to better understand needs of potential high-risk populations. It was produced as part of a national initiative that brings together leading innovators in improving care for low-income individuals with complex medical and social needs.
  https://www.chcs.org/media/RR-Geographic-TA-Tool_081920.pdf

Person-centered care design

- **Change Package: Person-Centered Engagement at the Organizational Level**
  Community Catalyst/Center for Consumer Engagement in Health Innovation, 2020
  This toolkit is for leaders and staff at organizations across the health care spectrum — hospitals, large medical practices, health clinics, health plans, accountable care organizations and more — to aid in developing meaningful person-centered engagement structures at the organizational level. It incorporates lessons from three case studies and includes tools and strategies for planning, implementing and scaling person-centered engagement structures.
  https://www.healthinnovation.org/change-package/introduction/about

- **Screening for Social Needs: Guiding Care Teams to Engage Patients**
  American Hospital Association, 2019
  This tool from the AHA's Value Initiative is designed to help hospitals and health systems facilitate sensitive conversations with patients about nonmedical needs that may be a barrier to good health. It includes strategic considerations for implementing a screening program, tips for tailoring screenings to hospitals' unique communities, case examples and a list of national organizations that can help connect patients with local resources.
  https://www.aha.org/toolkitsmethodology/2019-06-05-screening-social-needs-guiding-care-teams-engage-patients

- **Engaging Patients and Community Members in Trauma-Informed Care Implementation Planning**
  Center for Health Care Strategies, 2019
  This fact sheet outlines considerations to guide health care organizations in meaningfully engaging patients and community members in designing and implementing a trauma-informed approach to care.
  https://www.traumainformedcare.chcs.org/resource/engaging-patients-and-community-members-in-trauma-informed-care-implementation-planning/

- **High-Need, High-Cost Patient Personas**
  The Commonwealth Fund, 2019
  This toolkit includes a series of "personas" for different types of individuals with complex health and social needs, as well as their caregivers. The personas — which include people who are older than 65 with functional limitations, those who have an advancing illness, those who have three or more chronic conditions, and others — help depict the experiences, motivations and goals of a group of patients, as well as the barriers they face.
  https://www.commonwealthfund.org/trending/high-need-high-cost-patient-personas

POPULATION HEALTH

Theses population health resources define population health and describe strategies to improve the health and well-being of patient and community populations.

- **Societal Factors that Influence Health: A Framework for Hospitals**
  American Hospital Association, 2020
  This framework is designed to guide hospitals' strategies to address the social needs of their patients, social determinants of health in their communities and the systemic causes that lead to health inequities. An overarching goal is for the entire field to have meaningful conversations around these issues.
  https://www.aha.org/societalfactors

- **Pathways to Population Health: An Invitation to Health Care Change Agents**
  American Hospital Association, Institute for Healthcare Improvement and project partners, 2019
  This guide brings together various Pathways to Population Health tools and resources in a practical and actionable way to help health care professionals and organizations accelerate progress toward the goals of population health, well-being and equity.
  https://www.aha.org/system/files/media/file/2020/09/Pathways-to-Population-Health-Framework.pdf

- **Improving Population Health: A Guide for Critical Access Hospitals**
  National Rural Health Resource Center, 2014
  This tool provides guidance for rural hospital leaders to incorporate population health principles and programs into strategic planning and operations. A systems-based framework is used to identify critical success factors for successfully managing this transition. Tools, resources, suggested readings, case studies and additional materials on how to integrate population health as culture change also are included.
  https://www.ruralcenter.org/resource-library/improving-population-health-a-guide-for-cahs