

# 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. Resources in this compendium are updated frequently to keep content current.

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 **COMMUNITY CARE HUBS** section includes resources which highlight the objectives of community care hubs, provide examples and guide hospitals, health systems and community partners through the collaboration and co-design process.

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](mailto: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

- **Building the Value Case for Complex Care**

*Camden Coalition of Healthcare Providers and the National Center for Complex Health & Social Needs, 2021*

This toolkit is designed to help organizations gain the support of key stakeholders within the organization, as well as outside funders, partners and payers, in making the business or value case for complex care. Content includes how to adjust the value case in times of crisis and ways to champion efforts in various environments.

<https://camdenhealth.org/resources/building-the-value-case-for-complex-care/>

- **Building Effective Health System-Community Partnerships: Lessons from the Field**

*Center for Health Care Strategies, 2021*

This brief shares considerations for health care organizations and government entities working to build effective partnerships with the individuals and communities they serve and better address their health and social needs. It draws from the experiences of two sites: Hennepin Healthcare in Minneapolis and the Los Angeles Department of Health Services Whole-Person Care Program.

<https://www.chcs.org/resource/building-community-partnerships-lessons-from-the-field/>

## 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>

- **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

- **Capturing Patient and Staff Experiences to Assess Complex Care Program Effectiveness** *Center for Health Care Strategies, 2022*  
This brief shares insights from three Advancing Integrated Models pilot sites — Center for the Urban Child and Healthy Family at Boston Medical Center, Hill Country Community Clinic in California, and Denver Health — as part of a Robert Wood Johnson Foundation national initiative. These health care organizations tested a practical set of patient- and staff-reported measures to assess key aspects of complex care delivery.  
<https://www.chcs.org/resource/capturing-patient-and-staff-experiences-of-equity-well-being-and-care-integration-to-assess-complex-care-effectiveness/>
- **One-Stop Shop for Health Care and Community Partnerships** *HealthBegins, 2021*  
This guide offers tools and vetted information on how to initiate, structure and fairly finance partnerships between health care organizations and community-based social service providers. Content is refreshed regularly.  
<https://healthbegins.org/finding-value-faster-a-new-roi-one-stop-shop-for-clinical-community-partnerships/>
- **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/>
- **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>

## CLINICAL APPLICATIONS

### Community-based care coordination

- **Complex Care Startup Toolkit**

*National Center for Complex Health & Social Needs, 2022*

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/>

- **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>

- **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>

## ADMINISTRATIVE RESOURCES

### Business case development

- **Investing in Social Services as a Core Strategy for Health Care Organizations: Developing the Business Case**

*KPMG Government Institute, 2018*

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

- **ROI Calculator for Partnerships to Address the Social Determinants of Health**

*The Commonwealth Fund, 2020*

This tool is designed to assist community-based organizations and their health care partners in exploring, structuring and planning sustainable financial arrangements to fund social services for people with complex needs. Organizations can use the return on investment calculator to compare the financial returns and risks arrangements between cross-sectional partnerships under a selection of payments models.

<https://www.commonwealthfund.org/roi-calculator>

- **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>





## 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, 2023*

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](https://www.aha.org/system/files/2018-01/Applying_Research_Principles_to_the_CHNA_Process.pdf)

### Population health analytics

- **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](https://www.chcs.org/media/RR-Geographic-TA-Tool_081920.pdf)



- **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>

## Person-centered care design

- **Patient and Family Advisory Councils Blueprint**

*American Hospital Association, 2022*

This resource shares learnings and insights from a group of patient and family engagement leaders convened by the AHA. It offers guidance to help organizations build and maintain a high-performing patient and family advisory council, highlighting examples and key takeaways from the COVID-19 pandemic and linking to additional tools.

<https://www.aha.org/patient-and-family-advisory-councils-podcasts-and-blueprint>

- **Lessons on Consumer Engagement from Amplify**

*Camden Coalition of Healthcare Providers, 2022*

This brief shares lessons of authentic consumer partnerships, highlighting opportunities to build trust, involve all relevant players, support community health and well-being, and improve health outcomes. It is designed to help organizations establish mutually beneficial partnerships with community members and individuals with lived experience.

<https://camdenhealth.org/resources/lessons-on-consumer-engagement-from-amplify/>

- **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>

- **Better Care Playbook: Building Shared Outcomes with Community-Based Organizations** *Center for Health Care Strategies, 2019*

The "Playbook" series of resources was developed in partnership with the Camden Coalition of Healthcare Providers to share practical lessons and actionable guides in serving complex populations. This resource provides guidance to help health care organizations and community-based organizations build relationships that draw on each other's strengths, put patients first and support ecosystem development in local communities.

<https://www.bettercareplaybook.org/plays/building-shared-outcomes-community-based-organizations>

- **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>

- **Rural Community Health Toolkit**

*Rural Health Information Hub, 2017–2024*

This toolkit provides rural communities with the information, resources and materials needed to develop a community health program. Each of the toolkit’s six modules contains information that communities can apply to develop a rural health program, regardless of the specific health topic the program addresses.

<https://www.ruralhealthinfo.org/toolkits/rural-toolkit>



## COMMUNITY CARE HUBS

The resources in this section highlight the objectives of community care hubs, provide examples and guide hospitals, health systems and community partners through the collaboration and co-design process.

- **Community Care Hubs: Making Social Care Happen**

*Partnership to Align Social Care, 2022*

This resource provides a high-level overview of community care hubs' background and evolution, with examples from the field. This resource also identifies research that highlights the value proposition for health care organizations working with community care hubs to better align health care and social care systems. <https://www.partnership2asc.org/wp-content/uploads/2022/12/CCH-Primer-Final.pdf>

- **Healthcare Guide to Contracting with CBOs**

*Partnership to Align Social Care, the Aging and Disability Business Institute and the Camden Coalition, 2023*

This toolkit highlights the essential elements of contracting between health care organizations and community partners to address health-related social needs. Featuring leading practices from the field, it was developed with extensive input from community-based organizations, health plans and health systems. <https://www.partnership2asc.org/contracting-toolkit/>

- **Center of Excellence to Align Health and Social Care, US Aging and the Administration for Community Living, Aging and Disability Business Institute, 2023**

This four-webinar series assesses the foundational elements of serving as a community care hub. Geared to community-based organizations that are serving as community care hubs or interested in learning more about the CCH model, these webinars showcase examples from leading CCHs and outline resources available for launching and operating a hub. <https://www.usaging.org/content.asp?admin=Y&contentid=1306>

- **Introduction to Community Care Hubs:** <https://www.viddler.com/v/f613f074>
- **Community Care Hub Functions:** <https://www.viddler.com/v/20c50a5a>
- **CCH Contracting Opportunities:** <https://www.viddler.com/v/b6af01b>
- **Building the Business Case:** <https://www.viddler.com/v/23ff30d6>

- **Working Documents on Community Care Hubs**

*Partnership to Align Social Care, 2022-2023*

These resources provide information on community care hubs including contracting to align health and social care ecosystems and addressing social drivers of health. <https://www.partnership2asc.org/resources/>

- **ACL Technical Assistance Community | No Wrong Door**

*Administration for Community Living*

This website is a collaborative space for the No Wrong Door community — a network to support individuals needing long-term care — and its partners to stay informed, access resources and connect with one another to expand understanding of community care hubs. <https://www.ta-community.com/category/cch-national-learning-community>





# POPULATION HEALTH

These 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 disparities in health outcomes. An overarching goal is for the entire field to have meaningful conversations around these issues. <https://www.aha.org/societalfactors>

- **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>