

Building a Case for Support: Community Development Organizations to Collaborate with Healthcare Organizations

CDOs provide data, person-centered care coordination and enabling services
to Improve SDoH -Community Health Resiliency

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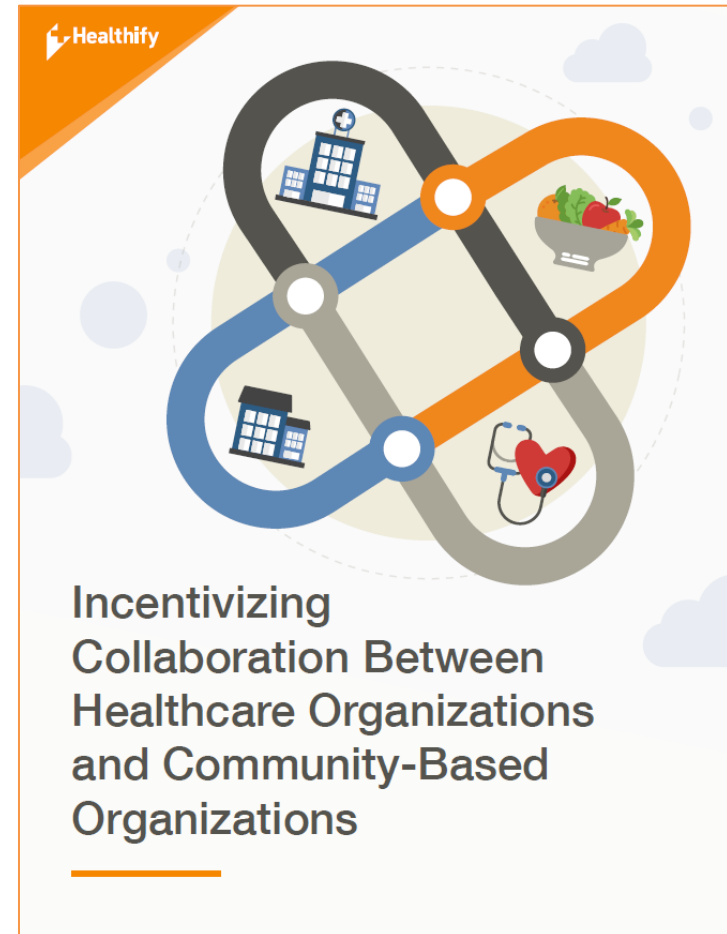
Healthify's white paper provides a great foundation upon which community development organizations (CDOs) can build a case for support for community health workers, social workers and the vast number of community programs and service offerings designed to eliminate and/or improve determinants of health – community health resiliency. The resource provides a high-level overview of existing “value-based purchasing structures” that can be leveraged to incentivize collaboration between CDOs (referred to as community based organizations or CBOs) and Health Care Organizations (HCOs), and also examines the pros and cons of each:

“By establishing partnerships with CBOs, HCOs can create mutually beneficial relationships that reduce the costs associated with care and improve outcomes for patients (residents).”

Community health and well-being is fundamental for person-centered community development organizations, in addition to place-based community economic development, infrastructure, environment and assets. CBOs are uniquely positioned to collect community-level data from the individuals whom they serve on a continuous basis. CBOs are also ideal partners for delivering community specific solutions as well as person-centered care coordination.

Data is Valuable

The case for support for CDOs as enabling service providers to improve health outcomes for residents is contingent on the need to standardize the collection of data that can be linked to electronic health records (HER) and electronic medical records (EMR) systems. CDOs all have some type of intake process: from the sign-in sheet at the door of their office and events to the more elaborate case files used for referrals and direct services. CDOs have worked tirelessly to build trust and respect in the neighborhoods where they serve. That



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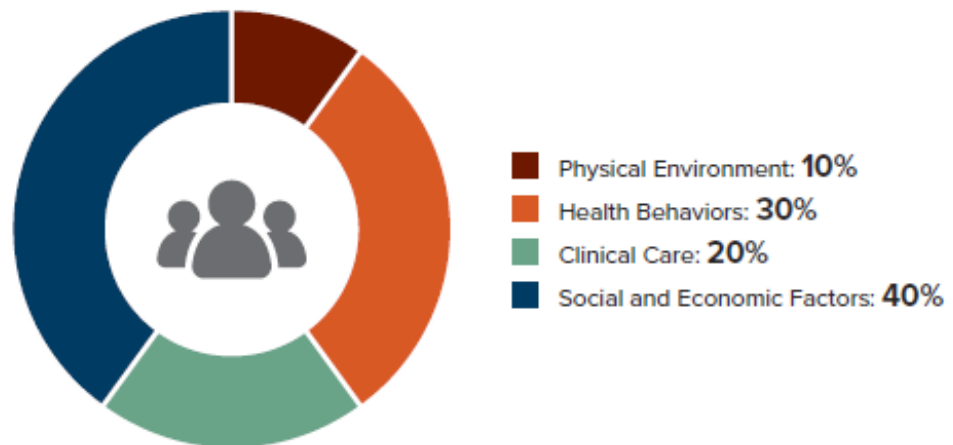
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trust has earned them the right to personal information as confidants and advocates for residents. Information that is most valuable to health care organizations in achieving their goal of improved health outcomes, and the increasing pressures to do more with less from evolving “value-based purchasing” structures.

Step 1 | PRAPARE

CDOs can use PRAPARE (Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences) to standardize the personal characteristics, family and home, money and resources and social and emotional health data typically collected from residents. PRAPARE is a national effort to help health centers and other providers collect and apply the data they need to better understand their patients’ social determinants of health, transform care to meet the needs of their patients, and ultimately improve health and reduce costs. PRAPARE is a standardized patient risk assessment tool, and a process and collection of resources to identify and act on the social determinants of health. You may ask why would CDOs want to use a health assessment tool? The answer lies in understanding what impacts health. Social and economic factors and physical environment represents 50% of what impacts health. And, I dare say nearly 90% of what CDOs do is social, economic and physical environment improvements.

FIGURE 1.1. Social, Economic, and Environmental Factors Play a Large Role in Impacting Health Outcomes



CHAPTER 1: Understand the PRAPARE Project

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The PRAPARE Implementation and Action Toolkit states that “documenting patient complexity using PRAPARE as well as the services and partnerships your organization provides to mitigate the social determinant risks can build the evidence base needed to advocate for sustainable payment systems to support holistic care that goes beyond the medical model, and to advocate for policies that support upstream community change.”

The simple tool can help standardize data collected by CDOs, and empower them to work in concert with health care organizations to improve health outcomes for residents. In partnership, CDOs and HCOs can go deeper into data collection to expand the breadth of data collected to provide even more granular insights into barriers to health equity.

The PRAPARE tool is both evidence-based and stakeholder driven. It was informed by research

on social determinant of health domains that predict poor outcomes and high cost, the experience of existing social risk assessments, and the advice and feedback from key stakeholders including patients, providers, clinical leadership, non-clinical staff and payers. It aligns with national initiatives prioritizing the social determinants of health (e.g., Institute of Medicine’s recommendations, Healthy People 2020 goals), measures proposed under the next stage of Meaningful Use, clinical coding under ICD-10 Z codes, and health centers’ current federal reporting requirements (i.e., Uniform Data System).

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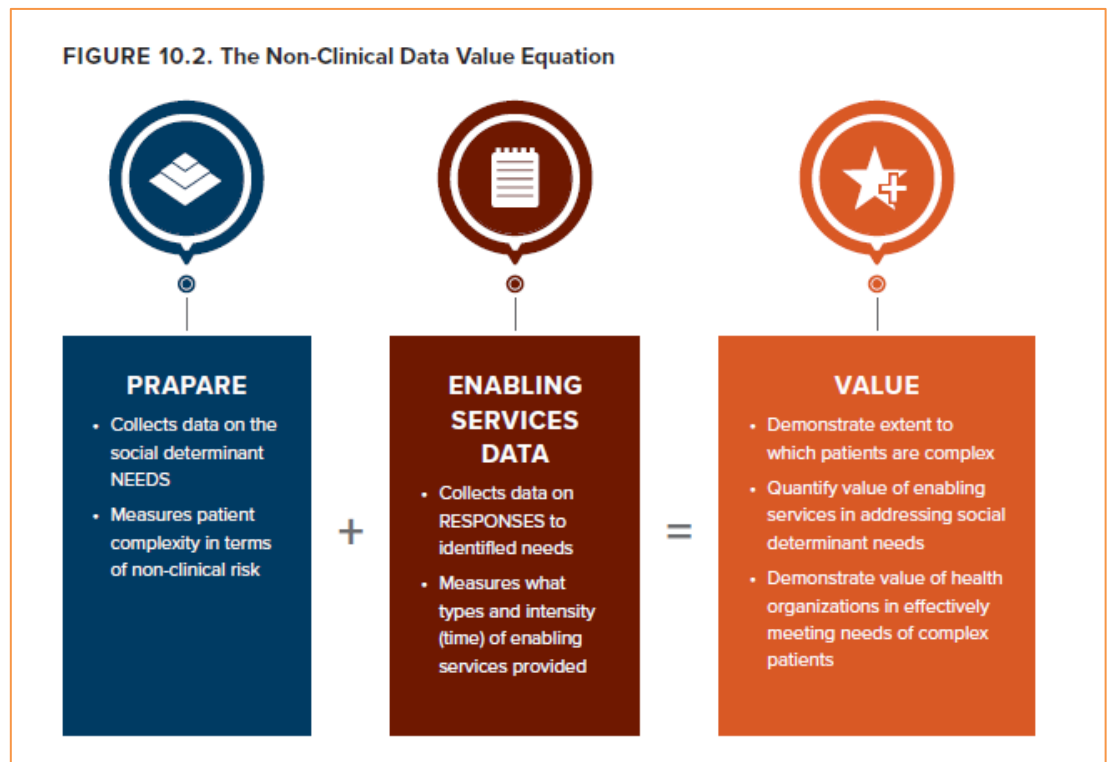
Step 2 | Enabling Service Tracking

The PRAPARE toolkit notes that it is important to track enabling services to better understand the value of interventions to address patient risks. Research demonstrates that enabling services lead to positive impacts on outcomes, costs, access, and patient satisfaction. By documenting enabling services, community development organizations can determine which programs and programs (interventions) are most effective at addressing particular risks for particular populations which can inform clinical operations as well as lead to resource allocations from health organizations in their quest to improve patient care.

CDOs can demonstrate its value by sharing data that demonstrates the extent to which patients (residents) are complex. But, that is not the only value CDOs have to offer.

CDOs now have a means to quantify the value of providing services that address social determinant needs. This is where “value-based purchasing” partnerships can be formed for a win-win outcome:

- CDOs generate earned income to sustain resident services.
- HCOs effectively meet needs of complex patients to improve health outcomes and save costs.
- Residents/Patients are healthier, and so are communities.



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Enabling Services Data Collection Implementation Companion



The *Enabling Services Data Collection Implementation Packet* serves as a guide for tracking enabling services using AAPCHO's standardized template. Enabling services are defined as non-clinical services that are specifically linked to a medical encounter or the provision of medical services for a patient at a health center. They are aimed at "enabling" patients to use appropriate medical services available at a health center to improve health care access and outcomes. To enable standardized data collection, simplify coding and aggregate data for national evaluation and advocacy purposes, the following 15 major categories are used. Additional enabling services can be added to the protocol under the "Other" category.



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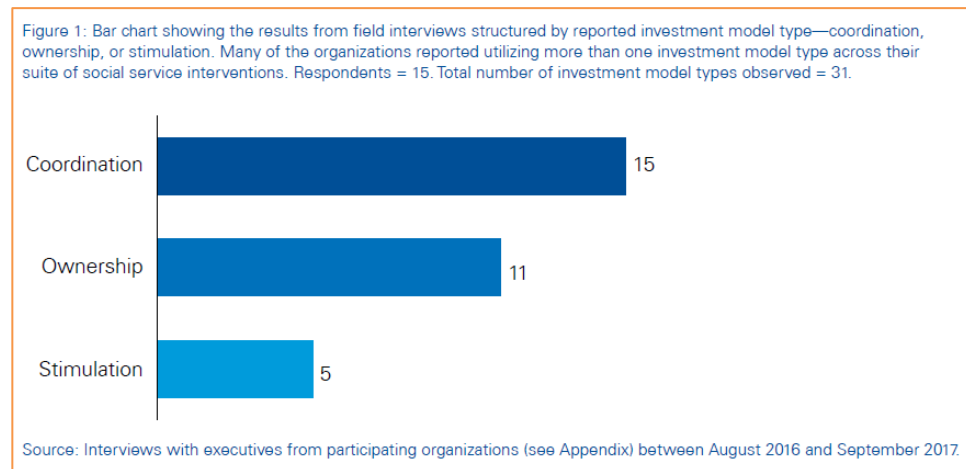
AAPCHO’s Enabling Services Accountability Project (ESAP) demonstrated the feasibility of collecting standardized enabling services data in the Electronic Health Record (EHR) and highlighted the impact of these services on health care access and outcomes. Overall, the project illustrated the role enabling services play in increasing access and quality of health care for medically underserved communities, providing *compelling data* to adequately compensate health centers for delivering these essential and non-clinical services. I believe PRAPAE and Enabling Services tracking provide a framework to standardize data collection for the community development sector.

Step 3 | Case for Support Framework

The person-centered data that CDOs collect is valuable for HCOs to address medial utilization, costs and health outcomes, especially in vulnerable high-need, high-cost populations. CDOs also provide person-centered care coordination and enabling services to improve SDoH. CDOs employ community health workers and social workers, and offer a vast number of community programs and services designed to eliminate and/or improve determinants of health.

[KPMG](#) observed that investments by payor and provider organizations were modest in scale and temporary, and often funded through time-limited grants or launched pilots without a long-term strategy. KPMG’s work led to the development of a guide for building a case for incorporating social services into health care business models. While the guide was intended for payer, provider and even employer organizations, I believe it provides CDOs a framework to build a case for incorporating community development organizations into health care business models based on a hybrid approach as a long-term data-driven strategy.

In 2017, KPMG discovered that SDoH investment strategies were typically a hybrid of **coordination** (collaboration) with a third party nonprofit organizations (NPOs) and CBOs; **stimulation** using temporary funds or grants to help third-party NPOs and CBOs; and **ownership** investments paid directly to third parties either by reimbursing out of pocket for services or by incorporating the service into its own organization as illustrated below in its Figure 1.



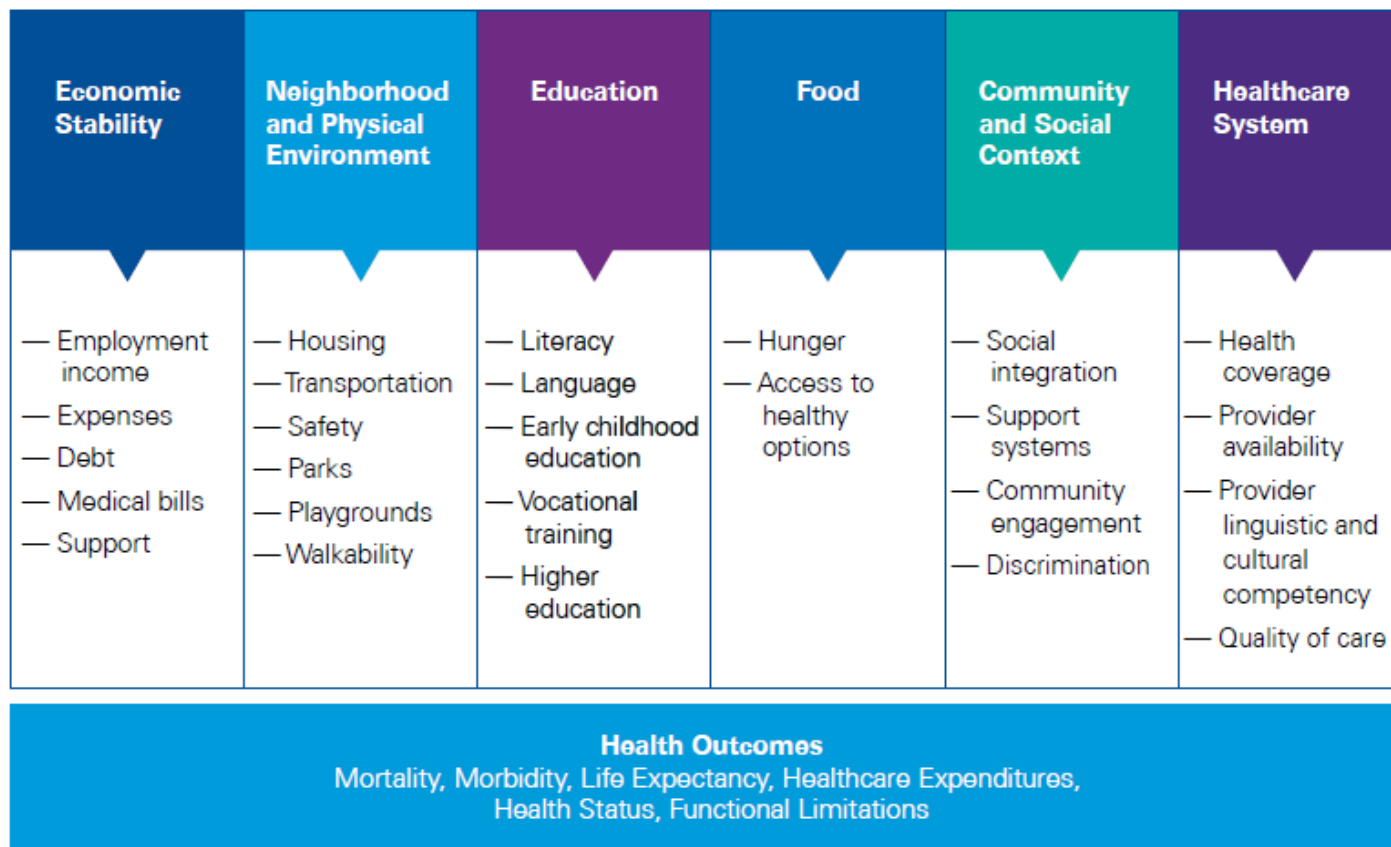
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A hybrid investment approach provides a framework for a “value-based purchasing” model for CDOs and HCOs to not only address, but improve social determinants of health. The KPMG guide used the Heiman and Artiga model to classify and categorize SDoH, which is closely aligned with others like HealthyPeople.gov and Robert Wood Johnson Foundation, as a common definition for CDOs & HCOs:

Figure 2: Categories of Social Determinants of Health as depicted in the Heiman and Artiga model from the Kaiser Family Foundation (KFF). The Heiman and Artiga model allocates social determinants of health into six different categories.



Source: H.J. Heiman and S. Artiga, “Beyond Healthcare: The Role of Social Determinants in Promoting Health and Health Equity.” Kaiser Family Foundation: Washington, DC, 2015.

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The six categories of SDoH clearly illustrate that CDOs and HCOs share in the work of improving health outcomes. However, I suggest that the Health Outcomes should be much broader than mortality, morbidity, life expectancy, healthcare expenditures, health status, and functional limitations. These outcomes only speak to “good health and well-being” outcomes rather than the depth, breadth and cross-spectrum outcomes for all of the determinants. I offer the United Nation’s Sustainable Development Goals as a “shared blueprint for peace and prosperity for people and the planet, now and into the future” as the desired outcomes for long-term sustainable community health resiliency partnership:



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Organizing for Collective Impact

A [2017 survey report](#) by [Deloitte Center for Health Solutions](#) states that 88% of hospitals were screening for social needs, but as Healthify points out screening alone will not improve health outcomes. The transformation to the health plan of tomorrow is just a stepping stone on the journey to the future of health according Deloitte. Innovation tends to occur in seven-year cycles. At the end of three innovation cycles, existing business models will have changed dramatically. And, Deloitte predicts that the second wave of innovation cycle for health care plans is new market players. Nontraditional players will begin disrupting the health plan market with **data-driven, consumer-centric offerings** that challenge undifferentiated plans. Deloitte states that health care plans are evolving and by the third innovation cycle...

Moving toward the future of health

At the end of three innovation cycles, market leaders' focus will revolve around three fundamental roles:

Click below to explore.

The infographic features a central circular graphic with a glowing heart and data points. Below it are three teal boxes, each with a white plus sign icon:

- Well-being and care delivery
- Care enablement
- Data and platform

A quote from a 2019 article, [Forces of Change, The Future of Health](#), seems to suggest an even wider health equity gap for underserved communities and vulnerable populations: "By 2040 (and perhaps beginning significantly before), streams of health data—together with data from a variety of other relevant sources—will merge to create a multifaceted and highly personalized picture of every consumer's

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well-being. Today, wearable devices that track our steps, sleep patterns, and even heart rate have been integrated into our lives in ways we couldn't have imagined just a few years ago. We expect this trend to accelerate. The next generation of sensors, for example, will move us from wearable devices to invisible, always-on sensors that are embedded in the devices that surround us." In light of the devastating impacts of COVID-19 on communities of color, this picture of the future does not include communities served by CDOs, without taking collective actions NOW! I'm proposing CDOs begin with steps 1 and 2 outlined earlier – PRAPARE & Enabling Services data is fundamental to form a value-based purchasing collective for CDOs and HCOs work together to close the health equity gap and strengthen community health resiliency.

1. Standardize Data Collection

Now is the time for CDOs to form a strong sector collaborative and leverage tools like Salesforce to begin collecting PRAPARE and Enabling Services data. Salesforce provides a platform for CDOs to manage various aspects of their business such as donor management, grant management as well as resident/constituent management. Collecting data is the initial step, to attract all stakeholders to the table for the next step, which is the first step of the collective impact model for change.

2. Design a Common Agenda

That means coming together with not only HCOs, but philanthropy, government, corporations and residents to collectively define the problem and create a shared vision to solve it, knowing that one-size does not fit all neighborhoods. Here again, I would suggest looking at step 3 outlined above -- building a case for support framework.

3. Identify Shared Measurements

That means agreeing to track progress in the same way, which allows for continuous improvement. Here again is why step 1 is critical. The health and enabling services data is a means to link CDO and HCO data. The collective can then determine what other data is needed to find a point of agreement on metrics to move forward.

4. Implement Reinforcing Activities

That means coordinating collective efforts to maximize the end result. This is the point of tension, and having stakeholders with decision making power at the table is critical.

5. Have Continuous Communications

That means building trust and relationships among all participants.

6. Support a Strong Backbone

That means having a team dedicated to orchestrating the work of the group.

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Conclusion

Community health and well-being is fundamental for person-centered community development organizations, in addition to place-based community economic development, infrastructure, environment and assets. CBOs are uniquely positioned to collect community-level data from the individuals whom they serve on a continuous basis. CBOs are also ideal partners for delivering community specific solutions as well as person-centered care coordination. Community development organizations (CDOs) are place-based CBOs that can collectively build a case for support for value-based purchasing structures to incentivize collaboration between CDOs and HCOs for community development-based health workers, social workers and the vast number of our community programs and service offerings designed to eliminate and/or improve determinants of health – strengthen community health resiliency – health equity.

Works Cited

- Incentivizing Collaboration Between Healthcare Organizations and Community-Based Organizations*, **Healthify**, 2019. Retrieved from https://get.healthify.us/white-paper-payment-model-partnerships-hco-cbo?utm_source=website&utm_medium=blog&utm_campaign=white-paper-financing-partnerships&utm_content=cta-button&hsCtaTracking=8a30fee3-dd70-49c9-8633-6c53e92004e2%7C8fe47063-bcea-4961-9c72-bd2c19c88bf0
- PRAPARE: Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences Implementation and Action Toolkit*, March 2019, Association of Asian Pacific Community Health Organizations (**AAPCHO**), the National Association of Community Health Centers (**NACHC**), and the Oregon Primary Care Association (**OPCA**) May 2019. Retrieved from <https://www.nachc.org/research-and-data/prapare/toolkit/>
- Enabling Services Data Collection Implementation Companion*, Association of Asian Pacific Community Health Organizations (**AAPCHO**), 2019. Retrieved from https://www.aapcho.org/resources_db/enabling-services-data-collection-implementation-packet/
- Investing in social services as a core strategy for healthcare organizations: Developing the business case*, **KPMG**, 2017. Retrieved from https://drive.google.com/file/d/1SMt_qnjOESUI07jOftgLAGkCjy21LcLw/view
- Sustainable Development Goals*, **World Health Organization**. Retrieved from: https://www.who.int/health-topics/sustainable-development-goals#tab=tab_1
- Deloitte 2017 survey of US health system CEOs: Moving forward in an uncertain environment*, **Deloitte Center for Health Solutions**. 2017. Retrieved from: <https://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-lshc-deloitte-2017-survey-of-us-health-system-ceos.pdf>
- Forces of Change: The future of health*, Batra N., Betts, D., Davis, S. Deloitte Insights, April 30, 2019. Retrieved from: <https://www2.deloitte.com/us/en/insights/industry/health-care/forces-of-change-health-care.html>