# Going Beyond Clinical Walls:
# Building Community Relationships
## Real-Life Examples

ICSI Institute for Clinical Systems Improvement

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**Clinicians and clinical staff** can build community relationships to increase resources available for patients and families. Potential relationships include: public health organizations, social services organizations, behavioral health services, health advocacy organizations, educational institutions, faith-based organizations and others, depending on local context.

The following examples illustrate a range of options, including resources that are currently available or can be developed for patients and communities to address complex clinical problems. Of course, this is just a sampling of both the types of organizations and possibilities. Select one or more to develop for your clinic, hospital and/or community for better health and health care.

| Problem or Opportunity | Examples of Resources Widely Available |
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| **Decreasing Unnecessary Use of the Emergency Department**<br>Connecting with United Way or similar community resources | A woman entered North Carolina's Moses Cone Hospital emergency department (ED) 130 times in one year. She had diabetes and was insulin-dependent, but did not have a refrigerator to store her medicine. She did have a cell phone and a charger, so her primary physician was 911. Health professionals worked with community agencies through United Way to identify supports, including a prescription drug assistance program and a refrigerator. Subsequently, she has not been to the ED a single time this year.<br>United Way: www.211.org<br>Many apps/products are being developed to connect clinicians and patients/families to community resources. Some are in beta testing, and some require purchase of the product. Examples include Healthify (www.healthify.us), 1 Degree (www.1deg.org), Purple Binder (purplebinder.com) and Aunt Bertha (www.auntbertha.org). |
| **Increasing Child Literacy**<br>Connecting with community resources for reading | Four children under the age of six visited the HealthPartners Riverside Clinic in Minneapolis, Minn. with their caregiver, a great aunt. Their pediatrician said, "The kids are very active, which makes the clinic visit very chaotic. When I gave each child a book, they became excited and quickly settled down to look at the new book. It turned a difficult clinic visit into a wonderful one, with the opportunity to share with their guardian the obvious benefit of books for learning and entertaining the children. This family does not have the resources to buy books on their own and I look forward to giving them more when they come in." The clinic worked with the local chapter of "Reach Out and Read," a nonprofit organization that promotes early literacy in pediatric exam rooms. Each child is given a book to take home as part of well-child visits.<br>Reach Out and Read: http://www.reachoutandread.org/resource-center/medical-providers/start-a-program |
| **Increasing the Ability to Live Independently**<br>Connecting with Adult Day Services and the YMCA | An older man had a history of chronic heart failure, diabetes, depression, early stage dementia, hypertension and COPD, and had been hospitalized three times earlier in the year. He began attending a Minnesota Adult Day Services center two days per week, where he receives health monitoring, socializes and eats a nutritious meal; he faithfully exercises two times a week at the YMCA. He's had no hospitalizations since his enrollment in Adult Day Services. With increased strength and balance, he has put his cane away.<br>National Adult Day Services Association: www.nadsa.org |

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|  <br>**Improving Home Environment for Children**<br>Connecting with local public health and/or other healthy homes programs | A regular check-up at an Ohio clinic determined a young child had an elevated lead level. The nurse practitioner called the Cuyahoga County Board of Health, and a lead case manager contacted the family to initiate a lead questionnaire and referral for a home assessment. Through the local Healthy Homes program, the case manager was able to provide lead education and discuss available resources, including remediation grants, HealthyStart/Healthy Families, and a free HEPA vacuum cleaner loan program. An environmental specialist with the department also worked with the family to assess risk for other hazards and follow up with the property owner to ensure the remediation was completed in a lead-safe manner.<br>http://www.ccbh.net/healthy-homes<br>Contact your local health department for resources available in your area or National Center for Healthy Housing (www.nchh.org). |
|  <br>**Preventing Diabetes**<br>Connecting with a faith community to involve patients in healthy lifestyle programs | A faith community nurse at Woodbury Baptist Church in Minnesota facilitates a diabetes prevention program in partnership with HealthEast Care System. Participants have lost a total of 460 pounds and are still losing weight. Some have been able to discontinue their high blood pressure medication, and many have lowered their HA1c levels. The class is beginning to influence the social functions of the church community. Healthy snacks are served, and individuals are trying to adopt a healthy lifestyle.<br>This program is also offered at YMCAs in 41 states.<br>http://www.ymca.net/diabetes-prevention |
|  <br>**Increasing Social and Physical Activity for Better Health**<br>Connecting with activity programs such as Silver Sneakers | An older woman with Parkinson's disease was experiencing more mobility issues, and her situation was affecting her marriage. She enrolled in Silver Sneakers through UCare health plan in Minnesota and became involved in physical and social activities. When her primary care physician saw her at her next visit, he hardly recognized her. She was more physically fit, her mood was markedly better, and her relationship with her husband was improved. She attributed her improvement to being involved in Silver Sneakers.<br>Many health plans offer this program at no additional cost to their members (http://www.silversneakers.com/tools/health-plan-locator). Other community physical activity programs can be found at local community activity centers, YMCAs, YWCAs and other organizations. |
|  <br>**Increasing Support for Families with Seniors**<br>Connecting with Area Agencies on Aging | The family of an older man with complex medical problems was having a hard time supporting his needs. They needed in-home nursing and had questions about assisted living and insurance coverage. The patient's care coordinator at North Memorial Clinic referred them to the Senior Linkage Line® sponsored by Area Agencies on Aging in Minnesota. Usually the contact ends there, and the clinic does not know if any action was taken. But through a pilot program, the information specialist at Senior Linkage Line connected back to the clinic care coordinator with next steps. In this case, a home care consultation was arranged and the patient's family was provided information on Medicare Part A and nursing support.<br>There are 618 Area Agencies on Aging across the nation in every state and 246 Title VI Native American aging programs. To find the agency in your area, go to http://www.n4a.org. To find specific resource information, go to www.eldercare.gov. |

| Problem or Opportunity | Examples for Potential Local Replication |
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|  <br>**Addressing Social Needs for Better Medical Outcomes**<br>Connecting with new workforce approaches | A middle-aged Latino man with multiple sclerosis and uncontrolled diabetes was hospitalized several times over a few months. A few days after he was discharged from the most recent trip to the emergency room, he visited a new doctor at a primary care clinic of Massachusetts General Hospital. Through an interpreter, he explained that he was out of insulin for his diabetes and his symptoms of multiple sclerosis were worsening. When he did have appointments, he had inconsistent transportation service with inadequate interpretation and follow-up. The doctor referred him to Health Leads. By the end of the day, the patient had a new transportation company, appointments with his other providers, and several vouchers for his medication, and was on his way to better outpatient treatment.<br><br>Health Leads recruits and trains college students to work side-by-side with patients to connect them with the basic resources they need to be healthy.<br><br>https://healthleadsusa.org |
|  <br>**Addressing Social Needs for Better Medical Outcomes**<br>Connecting with educational institutions for training opportunities | A man with uncontrolled depression and diabetes, new to the Austin–Mayo Clinic Health System, was enrolled in a specialized care coordination program. The patient did not have a telephone, making care coordination difficult. However, the clinic had added social worker interns from a local college to the care team, and an intern connected the patient to an agency that provided him with a used cell phone for better communication. The interns also connected patients to additional community resources for basic needs such as transportation, housing and food. In addition, they helped staff learn about available resources.<br><br>Contact the social work department of an educational institution near you about field placements. |
|  <br>**Addressing Social Needs for Better Medical Outcomes**<br>Connecting with community health workers | A young Latino boy with asthma was not getting better despite seeing a physician and getting prescriptions. Through a partnership with community health workers, clinicians at Nemours Children's Health System in Delaware introduced the patient and his mom to a community health worker who subsequently visited their home. The community health worker discovered that prescriptions were not filled, and the father was not convinced of the diagnosis. Because of these interactions, the family had prescriptions filled and used appropriately, and the patient had fewer exacerbations of his asthma.<br><br>Community health workers provide culturally competent outreach, education, care coordination, information and referral, and advocacy.<br><br>http://www.cdc.gov/dhdsp/pubs/docs/chw_evidence_assessment_report.pdf |
|  <br>**Improving Medical Care and Support By Addressing Legal Concerns**<br>Connecting with legal resources | A 35-year career nursing home worker retired because of osteoporosis, arthritis, high blood pressure, carpal tunnel syndrome and a hand injury. She was denied Social Security disability benefits, and when a fire destroyed her home, she stayed with friends and in shelters for two years. Her doctor at a community health center in Iowa referred her to a medical-legal partnership attorney from Iowa Legal Aid. The attorney obtained medical documentation of the patient's disability and filed an appeal. Within two weeks, the patient started receiving $800 a month in disability pay, and a back benefit of $18,000. The attorney also enrolled the patient in Medicaid so she had coverage going forward, and the health center was reimbursed $7,000 for previously uncompensated care.<br><br>Medical-legal partnerships have been established in more than 200 health care organizations in the majority of states.<br><br>http://medical-legalpartnership.org/partnerships/#/states=45 |

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|  <br>**Increasing Physical Activity in Children**<br>Connecting with local recreational organizations | In Seattle, Washington, the mother of a 9-year-old girl credits the Everyone Swims program with boosting her daughter's confidence and love of swimming. Everyone Swims is a collaboration between Seattle Children's Hospital, Public Health Seattle, King County and 14 clinics and recreation swimming partners. Providers routinely screen and refer patients for swimming lessons, the same way they would refer a child to a health care specialist. While the partnership looks different in various clinics, the Harborview Children's Clinic advocated to add a question on swimming ability to the electronic medical record system. Audits have shown a significant increase in the percent of children who are screened for swimming ability.<br>http://www.seattlechildrens.org/classes-community/community-programs/drowning-prevention/policy<br>Contact your local parks and recreation facilities for opportunities in your area. |
|  <br>**Improving the Design of Communities**<br>Collaborations for policy development for healthy living | A number of years ago, two family practice physicians at Entira Family Clinics noticed that in their rapidly growing hometown of Woodbury, Minnesota, there were few places with open and accessible athletic activities, especially for children. They contributed their leadership to the efforts of local city officials and athletic associations to develop and pass a referendum that ultimately funded a sports center with many fields for baseball, softball, soccer and football; an ice rink; a dome for seniors and other walkers; and later funding for neighborhood parks and trails. The physicians and their patients benefited from a community designed for an active lifestyle.<br>www.activelivingbydesign.org |
|  <br>**Connecting with Public Health – A Playbook** | There are many examples of public health developing relationships and working with primary care. A recently organized compendium and "playbook" can be found at https://practicalplaybook.org. You can search by state and by topic. |

Building community relationships requires many essential elements, including such things as shared language, understanding and trust. For those new to building community partnerships, the following reference from the Institute for Educational Leadership, while written for developing relationships with faith communities, offers insights for developing new relationships: http://www.iel.org/ pubs/sittap/toolkit_06.pdf. Additionally, Connecting with Public Health – A Playbook offers useful tools and resources for connecting with public health.

*Companion pieces to this table of examples include a paper, a conversation guide, and a video, found at www.icsi.org/beyondclinicalwalls.*

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### About the Institute for Clinical Systems Improvement

The Institute for Clinical Systems Improvement (ICSI) is a non-profit collaboration of medical groups, hospitals, non-profit health plans, purchasers and consumers with a mission to accelerate improvement in the value of health care delivered to the populations we serve. For more information visit www.icsi.org. Follow ICSI on Twitter @icsiorg.

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