



# Going Beyond Clinical Walls: Sharing Knowledge and Using Data to Build Common Ground

*This paper is the second in a series of communications and tools inviting clinicians, clinical staff and administrators to connect with community partners and resources for effective problem-solving. This series is designed to help you identify next practical steps to move forward. Other resources in the series can be found at [www.icsi.org/beyondclinicalwalls](http://www.icsi.org/beyondclinicalwalls).*

**Many clinicians today** are looking for ways to more effectively care for patients with complex behavioral, environmental, and other social factors that contribute to illness or hinder wellness. In one example that may resonate, a family practice physician saw a patient with insomnia. By asking whether she felt safe at home, the physician learned that she had three locks on her front door and two locks on her back door. Further discussions revealed that the patient’s experience with community violence and her hypervigilance were contributing to her insomnia. While the clinician believed that mindfulness training could be a valuable therapeutic recommendation, she didn’t have anything immediately available to offer. She wished she had access to a list of community resources at her fingertips, so she could offer the patient additional options.

As this example illustrates, clinicians are often asked to solve problems that are outside their control. If health is inextricably tied to the places where we live, work, play and learn, how can clinicians and public health practitioners reach outside of their walls to share information with each other to address the larger picture? How do we harness the power of shared information to work together to identify needs, set common goals, and forge connections that can help prevent disease before it occurs and improve the health of those who are sick?

Christa Getchell, president of the Park Nicollet Foundation, said that the decision to share data was based on a shared philosophy of “We are better when we are ‘we.’” She also noted the importance of having a burning platform—in this case, gaps in mental health care.

## Sharing Knowledge and Data at the Community/System Level

One common system-level type of information sharing can occur through the community health needs assessment, a requirement of non-profit hospitals\* that helps define the geography they serve, identify top health needs and determine possible interventions.

It is becoming more common for hospitals and their community partners in the same service area to work together on these assessments, avoiding fragmented strategies, duplication of efforts, and unmet needs.

## Information Sharing Uncovers Mental Health Services Gaps

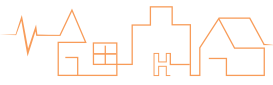
Rather than acting separately on their community health needs assessments, the foundations of two systems in the Minneapolis-St. Paul area—[Park Nicollet Health Services](#) and [Fairview Health Services](#)—decided to share assessment results, realizing there was opportunity to not only save time and expense, but also be more effective in their approach to improving the health of their community. During an informal conversation, the organizations’ leaders discussed the multiple initiatives underway to address mental health needs, and recognized that these uncoordinated efforts would result in overlap and inefficiency. They knew this was a top community need for both systems, and agreed that working together they could be more effective.

To begin their collaboration, the foundations convened a group that included community stakeholders and learned that the [Greater Twin Cities United Way](#) was examining the relationship between geography, income and health in order to best meet the community’s social and health services needs. When United Way leaders heard that the community health needs assessments had identified mental health as a key community issue, they agreed with the foundations’ leaders to share their respective information to better understand the situation and explore possible solutions together.

The hospitals worked through required procedures to share their de-identified aggregated admission data with United Way, which showed where admitted patients lived. Greater Twin Cities United Way provided a list of mental health and social services programs in the region drawn from its 211 database.

By combining these data, they created overlay maps of acute care, mental health and social services facilities within these areas. The maps revealed ‘mental health care service gaps’—areas lacking mental health services—in the second and third ring suburbs of Minneapolis. The data also validated the belief that there is a shortage of psychiatrists and psychologists in the identified areas.

\*The Affordable Care Act requires that non-profit hospitals complete community health needs assessments.



### Next Steps: Tackling the Issue Together

The parties are now working to address gaps in care and better target their resources, and the health care systems are more aware of the mental health and social services available to their patients.

Mia Hoagberg, interim president of the Fairview Foundation, said Fairview was already aware of the general health care needs in a suburb close to one of its hospitals, but had not focused as much on mental health. After sharing the mapping data with senior leaders in charge of mental health services, “the combined data helped us assess how mental health care will fit into our 2015 plans and where we want to focus resources,” she said.

The information convinced Park Nicollet to plan its next community clinic in one of the identified suburbs. “Sharing data really helped us to get to that point,” Getchell noted.

Both foundations and Greater Twin Cities United Way are using the information to help determine where to focus their grant efforts. “Mental health services fall into our ‘safety net’ category,”

*“Sharing learned knowledge is step one in improving efficiency and patient care.”*

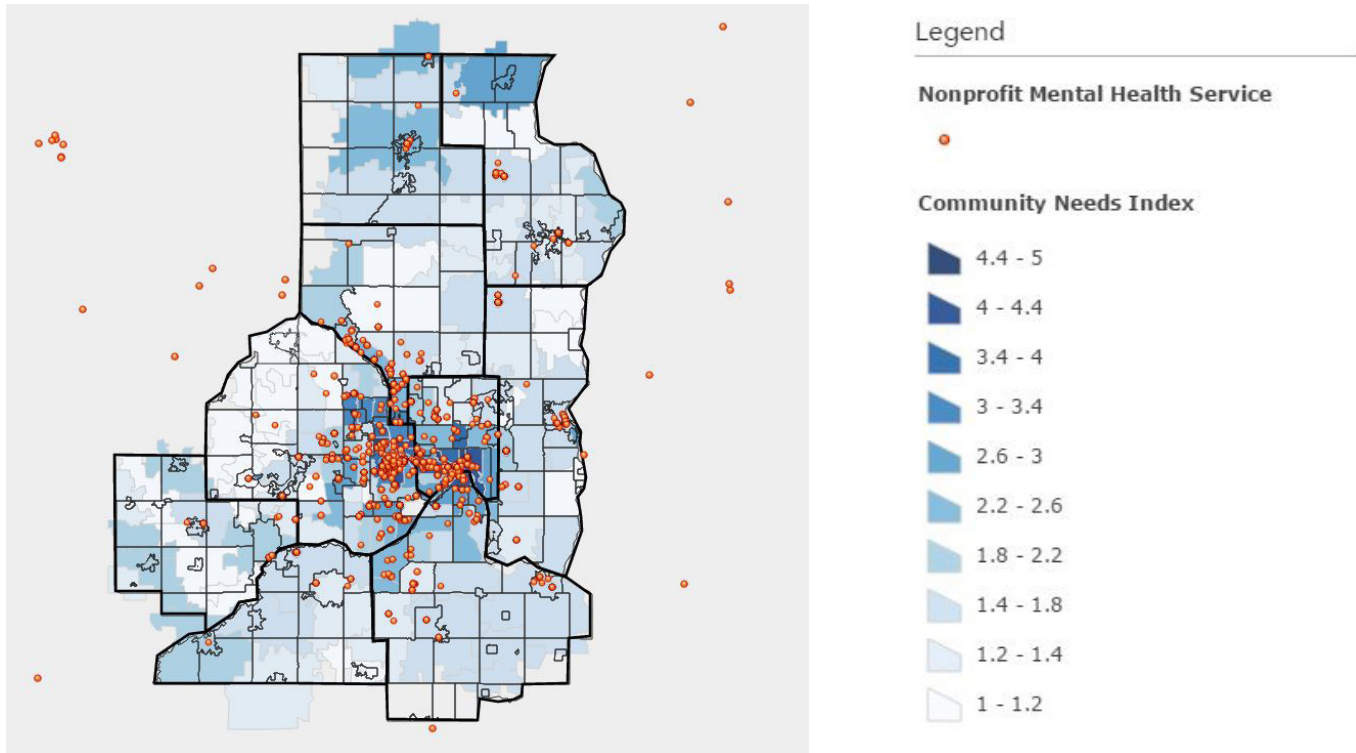
**Rita Cortese, MD**, Park Nicollet family medicine physician and medical director for school-based clinics

said Alana Wright, director of Greater Twin Cities United Way’s Empowering Healthy Lives area. “In our next grant round, we’ll definitely be considering these areas of greatest need.”

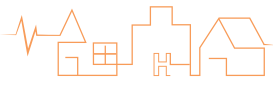
The group also learned that the issue is not just insufficient mental health resources, but a lack of knowledge about available resources to not only treat mental illness but also address its contributing factors. They are exploring how to make the United Way’s 211 database and other community resources available virtually so that all area non-profits can more easily access them to support mental health-related needs. The health care systems are also considering adding similar resource lists to their electronic health records (EHRs) in several pilot clinics.

## Data Mapping Reveals Services Gap

This graphic depicts the Community Needs Index map compiled by zip code for the nine-county Twin Cities metro area, overlaid with available mental health services. This is one of several overlay maps created by the Greater Twin Cities United Way using data supplied by the foundations of Fairview Health Services and Park Nicollet Health Services, along with programs and services from its 211 database. The Community Needs Index is a standardized index of community health needs that combines variables such as access to care, local economic trends, poverty, and insurance.



Data Source: Dignity Health and Truven Health Analytics



## Conclusion

This is just one system-level example of sharing knowledge and using data involving mental health services. What challenges facing your community and patients would benefit from such collaboration? Who might help you in sharing information, data and resources to more effectively address the complex behavioral, environmental, and other social factors that impact health? Your local public health departments and community-focused organizations such as United Way are always good places to start. See *Resources* for other ideas.

# Resources

## Clinician Tools

[Going Beyond Clinical Walls: Building Community Relationships Real-Life Examples](#) provides a list of examples illustrating how clinicians and clinical staff can build community relationships in myriad ways.

## Collaboration in Community Health Needs Assessment

- [http://www.mha.org/documents/chna\\_guide.pdf](http://www.mha.org/documents/chna_guide.pdf)

**Community Health Improvement Partnership** is one successful model in which organizations in a community are working together on health needs assessments, including representatives from health plans, hospitals, community health and social service organizations, schools, higher education and public health departments.

- <http://www.hennepin.us/your-government/projects-initiatives/community-health-initiatives>
- <http://www.healthiertogetherstcroix.org/the-plan/history/>
- <http://www.polkcountyhealthdept.org/>

**The Centers for Disease Control and Prevention** (CDC) has resources available for implementing the Community Health Needs Assessment.

- <http://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/tools/change/pdf/changeactionguide.pdf>

## Data/Mapping/Simulation Model

The **County Health Rankings** measure vital health factors and provide a revealing snapshot of how health is influenced by where we live, learn, work and play. The Roadmaps Action Center offers guidance to help improve health in your community.

*How can you start or further conversation(s) about such opportunities? When and how can you involve possible community partners? Find additional resources at [www.icsi.org/beyondclinicalwalls](http://www.icsi.org/beyondclinicalwalls).*

## 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](http://www.icsi.org). Follow ICSI on Twitter [@icsiorg](https://twitter.com/icsiorg).

## The Case for Collaboration

The collaboration between the health care foundations and Greater Twin Cities United Way demonstrates the potential benefits of clinicians and communities sharing knowledge and data, including:

- Create opportunities for new or increased investment of resources
- Validate common knowledge, but with greater clarity
- Help with prioritization to determine which efforts will have the most impact
- Uncover inequalities and identify opportunities for action
- Review usage data to evaluate the effectiveness of activities and programs
- Identify gaps in data that could be addressed through collective efforts

Portland, Oregon's **Regional Equity Atlas** project includes a mapping tool to assess how well different populations in the Portland-Vancouver metro region can access key resources to meet basic needs and advance their health and wellbeing.

**Community Commons** is an interactive mapping, networking, and learning utility for the broad-based healthy, sustainable, and livable communities movement. Registered users have free access to contextualized mapping, reporting, data visualization, sharing and more.

The **ReThink Health Model** is a sophisticated, empirically-based, analytical computer tool that simulates the behavior of a regional health system and can be customized to reflect differences in regional health systems.

## Health Statistics Data

- <http://epi.grants.cancer.gov/registries.html>
- <http://www.cdc.gov/nchs/>

## National Organizational Collaborations

**Stakeholder Health** is a voluntary movement of people within hospital health systems who see the opportunity to address the underlying causes of poor health in their communities by strategically shifting existing resources and partnering with diverse stakeholders.

**Network for Regional Healthcare Improvement** (NRHI) is a national organization representing over 30 member Regional Health Improvement Collaboratives working to transform the health care delivery system and achieve the Triple Aim by collaborating with physicians and other providers, provider organizations, commercial and government payers, employers, consumers, and other health care-related organizations.

## About the Robert Wood Johnson Foundation

For more than 40 years the Robert Wood Johnson Foundation has worked to improve the health and health care of all Americans. We are striving to build a national Culture of Health that will enable all Americans to live longer, healthier lives now and for generations to come. For more information, visit [www.rwjf.org](http://www.rwjf.org). Follow the Foundation on Twitter at [www.rwjf.org/twitter](https://twitter.com/rwjf) or on Facebook at [www.rwjf.org/facebook](https://www.rwjf.org/facebook).