Better Together: Wellness Through Community Collaboration

Executive Summary

The Connected Community Network (CCN) model is a multi-stakeholder initiative formed to address the social, economic, and environmental determinants of health by leveraging the assets and capacities of community anchor institutions and community-based partners.

The CCN seeks to create health equity in communities through a scalable solution while connecting community resources to underserved populations in need of vital services. The network is designed to be financially sustainable and community-owned and driven.

Journey to Connection

The CCN was borne from dual observations: First, that when patients were linked to and received the social resources they needed, hospital admissions could be reduced and overall health could be improved. Moreover, electronic documentation of this linkage to services further improved a patient's outcomes. The second observation was a lapse in the link between the care patients received within the walls of hospitals and the care they received after returning back to the community and their homes.

Historically patients would receive a slip of paper with a resource and caregivers would never know if the patient received the help they needed. By documenting and tracking the patient's social health journey in addition to their clinical health, the total health of a person was better addressed and gaps in care were better mitigated.

With those two observations serving as the impetus, the CCN began in 2016 in Nevada with referrals to community resources within the hospital, using an existing technology. In late 2017, the CCN began making referrals to a dozen external community organizations in Santa Cruz and saw significant financial return on investment and qualitative benefits of bringing social workers and operators of community programs together to network and understand the resources available and faces behind them.

Now, the CCN model has expanded to include more community-based organizations (CBOs), other stakeholders, and enhanced mechanisms for sustainability to rightly center health in the communities themselves.

How It Works

At the heart of all CCN partnerships are four central tenets: 1) the neutral community convener, 2) a robust 2-1-1 system within the community 3) a collaborative network of CBOs, and 4) a technology platform that allows for effective referrals and coordination of care. These tenets create the most effective CCN, however a community that lacks any component can still operate successfully.

The community convener is integral to the success and impact of the CCN and differentiates the CCN from other similar initiatives. The convener is anchored in the community and a neutral trusted broker,

functioning as the facilitator to bring together local community provider organizations, establish governance, manage network funding, and advocate and align the CCN with local initiatives.

2-1-1 is a three-digit number meant to provide information and referrals to health, human, and social service organizations in multiple languages. 2-1-1 is a confidential resource available every hour of each day wherein callers receive personalized information from a live resource specialist. A robust community 2-1-1 system engaged in the CCN acts as a safety net navigator for the network and strengthens the linkages to support services by creating further access points for those seeking help.

Finally, a shared technology platform allows the community network partners to make referrals and track the outcomes of those referrals more effectively by verifying how and when services are accessed.

With these components, the subsequent community network promotes a no wrong door approach, enabling greater access to and accountability for needed nonclinical services. The CCN also shifts power from sole large systems to community partners through shared governance- the convener hosts an inclusive community advisory group to garner feedback from all community partners engaged in the network, and to steward process improvement, and ensure community data is transparent and available to all CBOs.

In addition, the CCN model includes an innovative "community bank" concept, which ultimately creates a sustainable funding mechanism for public-private partnership. Funding Partners (e.g. any stakeholder with return on investment for this work, including other health systems, payers, government, businesses) will contribute to the community bank for a minimum three years, and share in community infrastructure costs (shared network costs) in three areas on an annual basis: 2-1-1 call center, convener project management and facilitation, and community capacity. The convener is the fiscal agent for the community bank and establishes commitments from funding partners.

While each CCN will look different depending on the composition and needs of that particular community, it is helpful to examine one site to gain a better understanding of the CCN framework and process.

Case Study: San Joaquin County, CA

Background/Overview

San Joaquin County, California is a high-need, low-resourced area economically dependent on agriculture and grappling with significant homelessness issues. The county currently ranks 34th in the state for health outcomes and 40th for health factors among all 58 counties.

Despite these challenges, San Joaquin County is a highly collaborative community, motivated to use existing resources to improve the health and well-being of its residents. Community partners were engaged early during the planning phase to determine willingness for such an initiative. This spirit is ultimately one of the reasons behind the success of the San Joaquin County CCN.

The CCN infrastructure in San Joaquin is built on partnerships, which allows it to be community led and governed. In addition, this partnership base creates multiple access points, allowing the network to reach people where they are.

The San Joaquin County convener is the United Way of San Joaquin (UWSJ). The UWSJ has been an exemplar neutral convener: providing network leadership, supporting governance and decision-making among partners, and leveraging existing community partnerships.

Through this model, the CCN and UWSJ received commitment from 11 funding partners, including Dignity Health St Joseph's Hospital and Medical Center, to pay into the community bank and sustain this work. The funding partners include Adventist Health, Blue Shield of California, Dignity Health, Kaiser Permanente, San Joaquin County Health Care Services – Whole Person Care, San Joaquin County Office of Education, Sutter Health, Abbott Fund, and University of the Pacific. The CCN represented by these health providers, healthcare payers, government agencies, and foundations financially contribute to collectively support an innovative public health infrastructure. The total contributions from these funding partners towards the community bank has totaled more than $200,000 annually. In one case, a funding partner had already selected a different technology for their organization, however seeing the community's desire for a single technology solution and the number of partners engaged committed the organization to side with the community's selection, not their own. The San Joaquin County CCN's funding success coupled with consensus with the community demonstrates the strength of this model towards sustainability and driving engagement while reducing burden to CBOs.

In addition to UWSJ's leadership, the local 2-1-1 San Joaquin (211SJ), operated by the Family Resource and Referral Center, is engaged and operates as a safety net navigator for the network. Moreover, they power the self-referral portals available on the Stockton Strong (the county seat's COVID-19 resource page) and UWSJ websites.

Unite Us is the technology platform selected to enable bidirectional resource referrals for all partners to communicate and coordinate around an individual's needs. This technology provides enhanced coordination towards navigating social needs while streamlining processes for CBOs providing direct services.

Connection in Action

> *"One of the cases that has impacted me the most has been an undocumented family of six. I met one of them before we were using the CCN. The family came to me with a problem and I looked for help through the internet and by phone. The need became more urgent when the pandemic arrived and employment became a problem. The family was months behind in rent payments and struggled with food scarcity. I was able to make a referral which could help them financially. Then I made another referral and we were able to help the family find more help to pay their rent. Thanks to the CCN, families get the help they need within 24 hours. The family is very grateful, especially since they are not English speaking and they are able to get the help they need in their native language."*
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> -Luz Ochoa, Stocktonians Taking Action to Neutralize Drugs (STAND) Trustbuilder, Stockton, California.

Community Alignment

The San Joaquin CCN is also integrated with CommonSpirit's Homeless Health Initiative (HHI), a comprehensive investment program to prevent homelessness and serve the health needs of people experiencing homelessness. As part of HHI, CommonSpirit partnered with Stocktonians Taking Action to Neutralize Drugs (STAND) and California's county-based Whole Person Care program, which supports homeless health interventions, to purchase and build homes in Stockton in order to ensure housing was available for individuals who are enrolled in Whole Person Care.

CommonSpirit is also partnering with the Salvation Army to create the Street Level project in San Joaquin and three other sites in California. Using a successful program in Seattle as a model, case managers meet people where they are living on the street and connect them to community services and agencies and help them transition to stable housing.

CCN and COVID-19

The framework of the San Joaquin County CCN was tested by the COVID-19 pandemic. Social needs for many residents rose dramatically due to COVID-19 and its economic ripple effect. Many CBOs were deeply impacted financially and largely unprepared to operate in the virtual-first world. Some CBOs were forced to close their doors, reduce staff, or limit services in the early phase of shelter-in-place.

The challenges of the pandemic highlighted the significant roles of the CCN convener and 2-1-1. UWSJ responded immediately to create and add a volunteer program to the network to serve short-staffed community-based organizations, while also securing local funding, including a $1 million private donation, to support CBOs through the crisis. In 2020, 211SJ call centers received over 61,000 calls, three times their prior year volume. Calls for food and rental assistance needs were twenty-fold and four-fold higher, respectively, compared to 2019. The CCN model was tested by the pandemic and has withstood the strain. The flexibility of the model, leadership and community engagement, and the strength of the networks to support the CBOs in crisis have proven to be essential.

Growth/Future State

In its first 17 months, the San Joaquin County CCN partnered with 89 community organizations and 131 community programs. Nearly 2,000 network referrals were generated, and more than 1,500 individuals were served. In the first six months of 2021, the San Joaquin County CCN saw a 61 percent increase in referral activity and partner engagement. CommonSpirit Health aims to replicate the success of San Joaquin over our 21 state footprint and establish networks endemic to each community's needs.

The San Joaquin County CCN validates the core premise of the Connected Community Network: Through partnership between local organizations and entities, the needs of the vulnerable and underserved in a community can be better met using a sustainable financial model and an inclusive, community-anchored approach.

CCN Addresses Equity

Health disparities are shaped by determinants of health such as social factors, environmental factors, behaviors, etc, and achieving health equity demands cross-sector engagement. Reaching health equity cannot be done in silo but as a community wide effort. The CCN's foundation is designed for achieving

health equity through its diversity of partners, shared coinvestment, and centering the initiative in the communities themselves. The CCNs tenets apply an equity lens to foster community engagement and ownership, trust, and accountability. Community voice is critical for the network's success and for the iterative learning process for how the CCN is designed and scaled. Community partners are engaged at the initiative's outset; not as an afterthought. A set of principles help guide the development of the network and expectations of all stakeholders involved.

Moreover, with the consent of individuals, the network permits the collection of social data in settings they feel more comfortable disclosing them. This allows measurement of and interventions towards health disparities. Currently, CommonSpirit's CCNs predominantly serve areas with a Community Needs Index (CNI)* score of 5.0 with 27% of individuals identified as Latinx.

In collaboration with our partners, there is an unwavering commitment to transform care to be proactive, holistic, and community-centered. In order to accomplish this, the CCN is one initiative that demonstrates our values of compassion, inclusion, integrity, excellence, and collaboration. We are grateful to our partners across the nation for their wisdom, advocacy, and leadership to build a healthier future for all.

To learn more about the CCN or to how to partner, please contact CCN@commonspirit.org

*The CNI is a zip code-based score that accounts for a community's unmet needs with respect to healthcare, with 1 indicating the lowest need and 5 indicating the highest need.