Health Leads | Network

# NO WRONG DOOR TO ESSENTIAL RESOURCES

How Rogue Community Health and Local Partners Launched A Successful Cross-Sector Hub to Improve Access to Essential Resources


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## ABOUT ROGUE & THE COMMUNITY HUB

Rogue Community Health (Rogue) is a federally qualified health center (FQHC) that serves communities in south-central Oregon across both clinic- and school-based locations.

In partnership with six community-based organizations, Rogue launched its Community Hub ("the Hub") in 2016 to increase cross-sector collaboration in support of community members' access to essential resources and their overall health. Leaders from these organizations set out to address the common challenges that cause burdensome internal inefficiencies — and make it difficult for community members to access the resources they need to be healthy.

## ROGUE COMMUNITY HEALTH AT A GLANCE

**MISSION:** "We improve health, especially for the most vulnerable, in partnership with our community."

- Locations serve south-central Oregon communities ranging from 440 to 81,600 residents
- Run seven school-based health centers
- Provide medical, dental, behavioral health, integrative health, and pharmacy services
- Member Services department created to support transition to Value-Based contracting
- Significant essential needs support provided by 13 community health workers

At the time, community members cited a host of deterrents to accessing needed resources — including overly-complex systems to navigate, difficulty completing applications at multiple organizations, varying eligibility requirements and long waitlists. Individuals and families frequently described not wanting to feel like a burden and often did not pursue referred resources, especially if it cost them significant time and effort. Among the agency providers, there were many duplicative services and competition for grant funds. The organization best suited to provide a high level of service often failed to win a needed grant to expand access, and resource providers were hesitant to partner due to a long history of troubled collaborative efforts.

Through the Hub model, partners sought to eliminate unproductive competition and build toward a future where everyone is supported — especially community members in need. Leaders hoped fewer families would slip through the cracks and more families would access the resources they need, when they need them. They worked to create ongoing opportunities for quality improvement and develop new revenue streams. And they believed local individuals and families would feel a stronger sense of belonging in their communities along the way— as well as deeper connections with the staff who provide these services.

## COMMUNITY HUB PARTNERS

Rogue Community Health
the YMCA
Eagle Point School District 9
Grants Pass School District No. 7
Siskiyou Community Health Center
OnTrack Rogue Valley
Family Nurturing Center
Southern Oregon Goodwill
Southern Oregon Head Start

"Leveraging technology in a closed-loop system of practice to create a sense of belonging amongst our community providers and those we serve." - Community Hub Mission Statement

## GUIDING PRINCIPLES

**The Hub was designed with four guiding principles in mind:**

1. **Accountability:** Partners maintain a shared understanding that, when an individual is referred to a partner organization, they will be served in a timely manner and be treated with dignity and respect. A lack of capacity to accommodate the referral is communicated before it is generated.
2. **Transparency:** Community members are provided options — and are empowered to choose which organization they are referred to, when they are referred and how they want to access the resource.
3. **Shared Language:** Case managers use simple, common language to describe services offered by partner organizations in a confident manner. They understand their own organization's niche and how that may intersect with other services that can benefit the individual or family.
4. **Early Engagement:** Ultimately, partners want to ensure community members do not face a crisis before getting the services they need. Organizations work together to identify essential needs before systems of care are needed.

### JUST ONE OF MANY SUCCESS STORIES

A community health worker (CHW) helped a family quickly find childcare services in their community. Though the family initially indicated they would prefer Head Start, the CHW could see the current waitlist through the Hub's platform — and worked with the YMCA to secure services until Head Start had an opening. The family felt a huge relief, and shared that having so much information readily accessible by their CHW made them feel like they had "VIP status". They felt that everyone involved genuinely cared about helping them thrive.

# COMMUNITY HUB STRUCTURE

### SHARED TECHNOLOGY

With *Lifespan,* Rogue developed a multi-agency, shared, closed-loop software platform for the documentation and tracking of referrals among Hub partners.

### EVOLVING LEADERSHIP

The Hub's current governance structure is made up of leaders from the original partner organizations: Rogue, YMCA, Family Nurturing Center, Head Start and Goodwill.

### SCREENING & NAVIGATION WORKFORCE

All partners screen the community members they serve for essential resource needs. If a need is uncovered, these individuals or families are referred to the Community Hub. Case management staff then connect them to an organization that can provide essential resources they need to be healthy.

Maintaining a trained navigator workforce at each site is critical. Rogue employs CHWs to support their patients in accessing essential resources, including those provided by other Hub partners.

### FUNDING & SUPPORT

Rogue funds the Hub's software platform, with partners contributing staff time and resources to support individuals and families who are referred for navigation to services.

## THE HUB'S SHARED TECH PLATFORM

The Hub was developed with a private vendor and is available for use in other communities. The system features several functions that support successful referrals through the sharing of key information across agencies:

- **Shared contact information** on individuals in the Hub system to support successful hand-offs between agencies, as well as the ability of case managers to follow up. This is particularly helpful as contact information can change frequently among community members served.
- To avoid issues with data privacy (HIPAA, FERPA, and 42 CFR Part 2), **only basic demographic, contact information and data on essential resource needs is shared**. Medical and diagnostic information is not shared across Hub partners. If an individual is in need of complex care management, Rogue provides those services in-house or through its electronic health record — as do other partners with their core programs and services. All individuals using Hub services must sign a consent form to have their demographic, contact and social needs information shared across agencies.
- *Lifespan* allows for **documentation of an individual's goal, in their own words**, for the referral, based on an identified resource need. For example, if an individual is in need of employment support, they can be more specific about the type of job, industry or hours they're looking for. This puts the individual at the center of all activities, and ensures agencies have the detail and nuance needed to provide the right type of assistance.
- Tracking each individual's status helps case managers understand what level of engagement they'll need to provide to support individuals through the referral process. This also provides a level of **accountability among partners, as well as transparency in following up on referrals** to make sure services are completed and closed.
- Partners use a "capacity button" to **update fellow case managers on their current ability to accept referrals**. This allows individuals/families to choose resources based on how long it may take the providing organization to accept the referral. It also more evenly distributes referrals across agencies in the Hub, preventing any one service from becoming overloaded.
- The software allows for the generation of **reports on the volume of individuals, needs, referrals and successful connections**. Data has been used to identify opportunities to improve Hub operations and for funding applications.

> "It's about the collaboration behind the tool, not the tool itself."
>
> – Ryan Bair, Rogue CHC

## OPPORTUNITIES FOR COLLABORATION AT MULTIPLE LEVELS

**Central to the success of the Community Hub is strong collaboration across multiple touchpoints at each agency. Collaboration is modeled at the executive level and is adopted by directors, managers and front-line staff.**

### EXECUTIVES

The CEOs of the Hub's participating organizations have a strong relationship, and met for about two years before the program was officially developed. Early on, they set the tone that the Hub would be focused on meeting the needs of the individuals and families they all serve — not what each organization can get out of the partnership. They adopted a team mentality to think through how the organizations could work together to provide the best possible services to people in their community. The CEOs meet monthly to discuss opportunities to improve and grow their collaboration.

## OPPORTUNITIES FOR COLLABORATION AT MULTIPLE LEVELS (CONT.)

### PROGRAM DIRECTORS & MANAGERS

Program director- and manager-level staff from each agency meet regularly to work out the operational details for the Hub — identifying improvements to the software to support warm hand-offs, **developing shared forms and training opportunities for front-line staff**, and reviewing Hub program data. Most recently, this group started to define the business case for the Hub itself, as well as each organization's own business case for participating.

Culturally, it has been important for the directors to orient their own staff around seeing this as a trans-organizational system, which is very different from the siloed manner in which they were used to working. This is an ongoing process, but the directors have established several opportunities for case management staff to learn about the services at each agency — and develop a shared language when talking about addressing essential needs and the social determinants of health.

### FRONT-LINE STAFF

#### Shared Language

Adopting shared language helps to ensure that families receive the same level of service at each point of entry. The collaborative training model supports development of this shared language. Case managers are introduced to the same terms and concepts, and any acronyms are defined (although discouraged from being used) or replaced by simple, universally-understood terms.

Through this process, case managers build their own capacity to speak confidently with individuals and families about how other services available in the Hub may benefit them. For example, a CHW from Rogue is able to speak specifically and simply with patients about how the family and child services available at partner organizations may improve their overall health and wellness goals.

#### Individual / Family Awareness

To further support a shared language for the Hub, directors from the six original Hub partners co-created talking points for case managers to help build trust and understanding with patients who might be nervous about using a closed-loop referral. They recognized this was a new way of working for their staff, and also a unique experience for the people they serve.

For these individuals and families to truly be at the center — and drive their own choices about their resource needs — they would also need to become educated about what the Hub is, how it works, and how it can benefit them.

#### Collaborative Training

All case managers from participating agencies are trained together on trauma-informed care, implicit bias, customer service, crisis de-escalation, health and system literacy, and how to use *Lifespan*. This collaborative training model builds camaraderie among the case management staff and a deeper understanding of what each does at their respective organizations.

# RESULTS TO DATE

## MORE SUCCESSFUL RESOURCE CONNECTIONS

While the Hub is still in its early stages, the participating organizations are already seeing benefits from adoption of the model. Notably, **82 percent of individuals served by the Hub have completed their appointment at the referred organization.** Rogue attributes this to the behavioral activation approach that the Hub creates on a large scale. By establishing a system where individuals, families and service providers all feel a greater sense of belonging, community members are better equipped to access the resources they need to be healthy.

## INCREASED STAFF EFFICIENCY & MORE TIME FOR FAMILIES

The collaborative structure within the Hub has also increased efficiency among agency staff. For example, **case managers have been able to save, on average, about four hours a day on tracking down and following up on referrals.** The information sharing structure allows them to access referral status information in real time, which frees up time to spend with individuals and families. This adds values to the case management process with efficient and cost-effective communication supporting teams

Notably, case managers are not being asked to increase their caseloads to fill the difference. Leadership felt that ensuring that the families served are getting the case management support they need to meet their goals was the priority.

## EARLIER INTERVENTIONS

The Hub is designed to serve a "rising risk" population — and has made it easier for community members to access CHWs before they are in crisis and more complex systems of care are needed. Access to CHWs was previously limited only to Medicaid beneficiaries, but through the community partnerships within the Hub, any individual can get direct referral and access to CHWs. Rogue has found that this **helps to reduce the number of missed appointments**, as CHWs are often able to address barriers to attendance before a patient's initial appointment. Rogue believes that health outcomes will continue to improve over time if Hub partners are able to successfully intervene earlier to support individuals and families.

## STRONG REFERRAL PATHWAYS LEAD TO NEW BUSINESS

For Rogue, the Hub structure has created strong referral pathways to their clinics, resulting in **many new patients and a compelling individual business case** for participating in and supporting the Hub. The additional patient volume will be helpful both in the current fee-for-service payment system and as Oregon Medicaid continues its transition to advanced payment models that have a larger focus on population management.

These new patients come mainly from referrals from Hub partners, as they encounter community members who are not connected to primary care. However, the **organizations in the Hub are also partnering in other ways that drive referrals and enrollment in each others' services**. For example, new access points have been created for community members that were not previously available. Head Start has invited Rogue to provide registration for school on Rogue's website — and Rogue is embedding CHWs at School-Based Health Centers to help families access resources, including primary care. In short, the collaborative approach has led to better access to services for families and more business for Hub partners.

# RESULTS TO DATE

## BETTER COMMUNITY-LEVEL DATA ON PREVALENCE OF ESSENTIAL RESOURCE NEEDS

Though many stakeholders now hear more about non-medical social needs and the social determinants of health — and see prepared data from community health needs assessments — they rarely, if ever, get to see implementation data that speaks to the real prevalence of unmet resource needs within their community. The Hub allows for the collection and reporting of such data. Currently, the monthly essential needs screening data has shown that 22-27 percent of the population served has an unmet need, and within the Hub, 25 percent of families have more than one unmet need. These **statistics would have been impossible to capture previously with resource providers working in silos** collecting different data points on only the community members each organization serves.

The Hub's structure allows for the **collection of community-level essential needs data among people that live in the region.** Hub partners use common terms and process measures to track resource needs across the continuum of services and capture a more accurate representation of unmet resource needs among community members. The ability to report these numbers is certainly valuable, and demonstrating tangible impact in addressing these needs generates excitement.

## WHY IT WORKS

**When asked what makes the Hub so successful, Rogue points to its guiding principles — Serve Vulnerable Communities, Create a Centralized Network and Help Small Businesses — along with four key factors:**

### 1 A Community-Owned Resource

Rogue has worked hard to ensure that the Hub is owned by the community. It's proprietary software platform has been shared openly, and the organization is adamant about not being seen as the "leader" of the Hub. Rogue recognizes that there is a history of mistrust of the healthcare sector among its community partners, as health systems have often focused mainly on community efforts that benefit themselves in some way. Rogue wants to avoid that approach and instead be seen as a collaborative partner — and a backbone administrator (not owner) of the Hub database. They are currently developing a shared governance agreement around the use of Hub data that is amenable to all partners involved.

### 2 Familiarity with Partner Services & Delivery Models

Hub partners have taken significant steps to understand each others' services and delivery models, which has been critical for identifying common ground and approaches that work for everyone. For example, as Rogue started to explore how to build the business case for the Hub model, they reached out to each partner organization to understand their revenue sources, the measures they tracked and how they assess value. This process helped to identify where measures overlap among partner organizations and which data elements needed to be built into their data management system.

Currently, the Hub is focused on tracking volume and the prevalence of resource needs — data that is valuable to all partners. Outcome measures of interest are still tracked within each organization, but the partners would like to better understand the intersectionality between different outcomes. For example, is there a correlation between the diabetics measure HbA1c control and a feeling of belonging? How does the level of patient activation impact the outcomes of interest for each partner?

### 3 A Unique, Shared Mission & Vision

Hub partners have made a point of honoring each others' goals and reporting requirements, but also make it clear how each organization can contribute to common goals. Hub leaders have developed a unique and shared mission and vision for the collaborative that all parties agree to support. In addition, all expectations for participation in the Hub are clearly described in the Memorandum of Understanding (MOU) that organizations must sign in order to join. The expectations include time, resource-sharing, accountability and transparency commitments. This MOU also describes how the partnership is about being a "giving organization" — both in how each approaches its own service delivery and work with Hub partners — to ultimately support the community.

### 4 A Relaxed Approach to Recruitment

For the Hub to work as intended — and for partners to feel true ownership — all participants must agree to the level of engagement and information sharing described in the MOU. This makes it critical for each organization to be ready and motivated to participate. Rather than trying to convince new organizations to join, Rogue takes an open and welcoming approach to grow the Hub's network. For example, an organization that recently joined the Hub had been burned by past efforts to partner on service coordination. Rogue met briefly with the organization's leadership to describe the collaborative effort and left additional information about the Hub. After taking some time to review the materials, this formerly hesitant organization decided to join. It was likely the "no-pressure" approach to recruitment — and perhaps a bit of fear of being left out of something other agencies are joining — that convinced this organization to commit to the collaborative.

## REMAINING CHALLENGES & OPPORTUNITIES

To support access to sustainable and adequate funding to meet service demand, **the Hub continues to develop its collective business case by determining the prevalence of resource needs**, by type, among community members — and the costs of service delivery for each participating organization. Data collected so far on the prevalence of needs among inidividuals and families, as well as their willingness to access services, has been a major step forward in this effort. It offers a glimpse into the value that effective collaboration across agencies can provide for communities and their potential to improve health and wellness.

**Measuring outcomes and evaluating the Hub's impact is still in its early stages.** The intersectionality between health and essential resource needs is not well understood. And significant disparities remain in health and other wellness indicators across populations that are driven by systemic inequities. Hub partners are exploring how they can help reduce these disparities in outcomes at the community level. Notably, the Hub is working to integrate equitable approaches into their work, including support of case management staff in approaching direct services with an equity lens.

**As the number of organizations within the Hub grows, they continue to manage multiple points of data entry and the need for better interoperability across organizations.** It has been a challenge for case management staff to document information both in the *Lifespan* and in their own systems, but moving to one system would then require navigating additional, complex data sharing and privacy issues. Hub leaders are exploring what the right balance is — and what processes will provide the most benefit to the community.

**Feedback from front-line staff has helped to identify opportunities to improve the Hub's services.** For example, Rogue's CHWs have successfully referred patients to several resource providers that are not currently in the Hub. Rogue is reaching out to these organizations to engage them as Hub partners.

To continue to improve and grow the Hub, Rogue and its partners recruit community organizations to join the Hub and explore how to use the software in a variety of settings and situations. For example, Rogue is **exploring how the software can support larger organizations to create "mini-Hubs" to more efficiently direct referrals to specific departments** that address a particular resource need. This model could be beneficial for the Department of Health and Human Services and local school districts, where the ability to direct a referral to the right person in the right department is critical to successful resource connection for a family.

**Finally, the Hub is considering various funding options to sustain the collaborative over time.** Oregon's Coordinated Care Organizations (CCOs), private medical practices and other local partners may be possible funding sources, as this model supports the CCO goals of better service coordination for Medicaid beneficiaries to improve health outcomes and reduce costs. The Hub is also exploring federal grants for social impact collaborations, Health Resources and Services Administration (HRSA) funding options, and potentially some targeted funding to support health and housing initiatives and Medical-Legal Partnerships within the Hub.

### ABOUT THE NETWORK

The Health Leads Network is a community of healthcare practitioners and caregivers who are taking action to address essential needs within our organizations. Network members work in a wide range of health system roles and settings — but share a commitment both to drive improvement initiatives on the ground, and to advance health equity in their communities.

The Network was created to bring action-oriented practitioners together to collaborate, share and learn from each other. We translate critical front-line experience into tangible tools, guidance and learning opportunities — all designed to support members in advancing the integration of essential needs into community-led health initiatives.

Learn more at healthleadsusa.org/network — or email network@healthleadsusa.org for additional information.