TBC
Team Based Care

# Clinic-Community Connections

**Meeting patients where they live, work, and socialize by linking them to community-based resources.**

## Key Changes

- **Hire** staff representative of the communities served.
- **Designate** staff to coordinate community linkages.
- **Learn** about community strengths and areas for further support.
- **Develop** relationships and agreements with key community organizations.
- Actively **participate** in community activities that support healthy lifestyles and behaviors.
- Systematically **ask** patients about their social care needs (using the PRAPARE tool, for example).

## Examples

- Identify evidence-based community resources already present (e.g. Living Well with Chronic Disease or Silver Sneakers).
- Practice leaders meet with targeted community agencies to explore linkage opportunities.
- Develop verbal or written agreements that include referral expectations.
- Actively pursue funding &/or partnership opportunities to build needed community resources where there are none.
- Develop workflow to solicit patient needs, link them to resources, and follow up.
- Try a single screening question approach (e.g. asking a single question like "Do you find yourself struggling to make ends meet at the end of each month?").

**Search ImprovingPrimaryCare.org for more resources**

## Primary Care Team Guide Assessment-Related Questions

**The Practice Team**

| | Components | Level D | Level C | Level B | Level A |
|---|---|---|---|---|---|
| 2 | Clinical leaders… | intermittently focus on improving quality. 1☐ 2☐ 3☐ | have developed a vision for quality improvement, but no consistent process for getting there. 4☐ 5☐ 6☐ | are committed to a quality improvement process, and sometimes engage teams in implementation and problem solving. 7☐ 8☐ 9☐ | consistently champion and engage clinical teams in improving patient experience of care and clinical outcomes, and provide time, training, and resources to accomplish the work. 10☐ 11☐ 12☐ |
| 7 | The practice… | does not have an organized approach to identify or meet the training needs for providers and other staff. 1☐ 2☐ 3☐ | routinely assesses training needs and encourages on-the-job training for staff needing it. 4☐ 5☐ 6☐ | routinely assesses training needs, and ensures that staff are appropriately trained for their roles and responsibilities. 7☐ 8☐ 9☐ | routinely assesses training needs, ensures that staff are appropriately trained for their roles and responsibilities, and provides cross training to ensure that patient needs are consistently met. 10☐ 11☐ 12☐ |

**Clinic-Community Connections**

| | Components | Level D | Level C | Level B | Level A |
|---|---|---|---|---|---|
| 27 | Linking patients to supportive community-based resources… | is not done systematically. 1☐ 2☐ 3☐ | is limited to providing patients a list of identified community resources in an accessible format. 4☐ 5☐ 6☐ | is accomplished through a designated staff person or resource responsible for connecting patients with community resources. 7☐ 8☐ 9☐ | is accomplished through active coordination between the health system, community service agencies and patients and accomplished by a designated staff person. 10☐ 11☐ 12☐ |