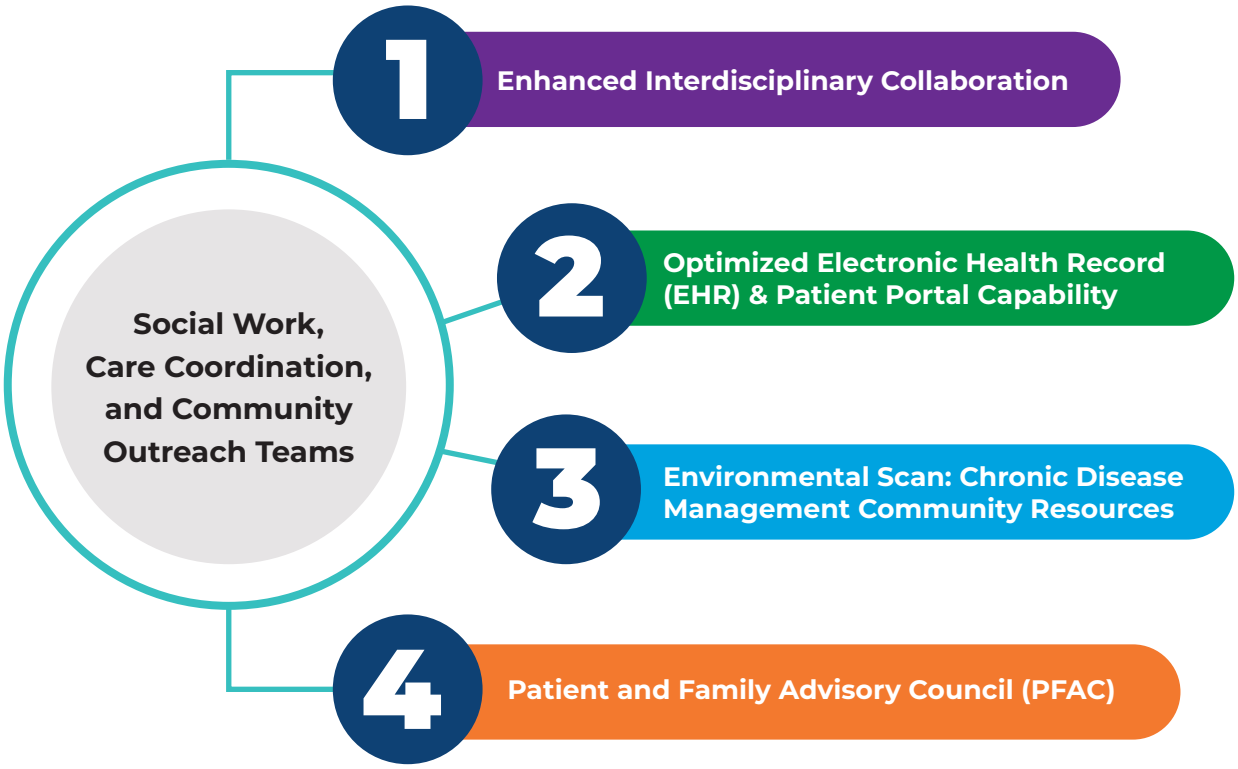
Chronic Disease Management
COMMUNITY NEEDS ASSESSMENT

OVERVIEW
Health care systems are often responsible for improving clinical outcomes, which can be significantly influenced by community factors like access to care, socioeconomic conditions, public health initiatives, access to healthy food, and population demographics. Establishing collaborative partnerships across different sectors is essential to actively improving the health and well-being of the communities that your organization serves.

TIPS
1. Identify the appropriate personnel to assist with assessing available community resources for supporting chronic disease management efforts in your organization.
2. Use the AHS Community Assessment Tool (pages 3-6 of this document) to determine the next steps in forging community partnerships to address service gaps.
3. Identify opportunities to optimize the capabilities of digital health tools, including electronic health records and patient portal systems, to improve communication and care coordination among teams, patients, and their care partners.
4. Engage your organization's Patient and Family Advisory Council (PFAC) to get their perspective on current services, gaps and potential service improvements.

SUMMARY



Approach	Contributions to Patient Experience & Satisfaction	Topic Questions
Enhanced Interdisciplinary Collaboration	• Ensures holistic approach to care. • Enhances coordination across teams. • Improves risk management and avoids service duplication. • Aligns interdisciplinary expertise into personalized treatment efforts.	Consider asking the interdisciplinary team questions about identifying patient needs, supporting care transitions between providers, linking patients to services and resources, and effectively following up on patient outcomes to prevent readmissions. *(Tool questions: 3, 4, 5, 16)*
Optimized Electronic Health Record (EHR) & Patient Portal Capability	• Enhances care planning and communication with other care team members and patients. • Streamlines appointment and medication management. • Facilitates patient education. • Enables "closed loop" electronic referrals. *Defer to organizational EHR vendors, informatics, technology and leadership teams for capability functions.	Which care coordination features are available in the EHR system? For example, are features such as appointment scheduling, direct messaging with internal or external providers, direct messaging with patients, access to patient education materials, and care plan and treatment reminders/alerts enabled? *(Tool questions: 8, 9, 10, 11, 12, 20)*
Environmental Scan: Chronic Disease Management Community Resources	• Identifies resource gaps and advocates for enhancements in the care network to address unmet needs. • Provides effective use of resources and prevents duplicate services. • Enhances care coordination with clinical–community partnerships via streamlined referral systems. • Improves chronic disease clinical outcomes. • Empowers patients, care partners and communities to be active in their care.	Evaluating the organization's familiarity with community resources in the service area is crucial for effectively meeting patient needs. This involves assessing internal and external disease management programs, patient referral systems and follow-up processes. Additionally, consider exploring ways to improve or create a system for monitoring patient enrollment and tracking clinical and behavioral outcomes after participating in programs. *(Tool questions: 17, 18, 19)*
Patient and Family Advisory Council (PFAC)	• Promotes patient-centered care. • Improves communication among patients, families, and providers. • Enhances quality improvement efforts. • Drives efficient strategic planning and policy development. • Builds community trust and engagement.	Consider whether a PFAC and dedicated outreach coordination staff can help the organization improve its ability to develop meaningful connections with the local community. The organization may want to establish or reinforce the PFAC as a valuable link between hospitals and the people they serve. PFACs play a crucial role in gathering valuable insights and feedback from the unique perspectives of patients and their families. By actively involving the council, organizations can gain a deeper understanding of the needs and concerns of those directly impacted by their services, ultimately leading to better engagement and improved patient satisfaction. *(Tool questions: 6, 7)*

Chronic Disease Management Community Needs Assessment

At Alliant Health Solution (AHS), we aim to drive targeted, results-driven quality improvement initiatives with various health care organizations to drive specific and tangible results. Our focus includes hospitals, nursing homes, home health agencies, hospice agencies, physician offices, and community-based organizations.

The AHS Chronic Disease Management (CDM) team developed this needs assessment to enhance community-clinical connections. Your input will provide valuable information to help you tailor CDM programs and provide customized assistance for your region.

Date:		**Point of Contact (POC):**	
Organization:		**POC Phone Number/Ext:**	
State:		**POC Email:**	

About your organization:

1. Select your organization type below:

- ☐ Acute Care Hospital (with In-Patient Psych Unit)
- ☐ Acute Care Hospital (no Psych unit)
- ☐ Inpatient Psychiatric Facility
- ☐ Critical Access Hospital (CAH)
- ☐ Hospital Association
- ☐ Rural Emergency Hospital (REH)
- ☐ Other, please specify:

2. Select the facility type(s) your organization owns/operates from the list below.

- ☐ Skilled Nursing Facility (SNF)
- ☐ Home Health Agency (HHA)
- ☐ Hospice
- ☐ Preferred Provider Network
- ☐ Physician Practice Group
- ☐ Other, please specify:
- ☐ None of the above

3. Does your organization provide cardiac rehabilitation services?

- ☐ Yes
- ☐ No

4. Does your organization own or affiliated with physician/medical practices?

- ☐ Yes
- ☐ No

5. Are the physician/medical practices members of an accountable care organization (ACO)?

- ☐ Yes
- ☐ No

About your organization's patient engagement and satisfaction:

6. Does your hospital have a Patient and Family Advisory Council (PFAC)?

- ☐ Yes
- ☐ No

If yes, how many times a year do they meet? _____

If not, are you interested in free technical assistance on how to start one?

- ☐ Yes
- ☐ No

7. Does your hospital have a community outreach coordinator or liaison?

- ☐ Yes
- ☐ No

About your electronic health record (EHR) system(s):

8. What EHR system(s) are being used? _____

9. Where are they being used? Check all that apply:

- ☐ System-wide
- ☐ Inpatient only
- ☐ Emergency department
- ☐ Laboratory
- ☐ Other, please specify: _____

10. If you have a patient portal, what information is accessible to patients? Check all that apply:

- ☐ Appointment notes/discharge summary
- ☐ Laboratory/test results
- ☐ Imaging results
- ☐ Medication scripts
- ☐ Referrals
- ☐ Other, please specify: _____

11. If you have a patient portal, how does it enable bidirectional communication between patients, providers and/or administrative staff?

- ☐ Direct messaging (text or mobile application)
- ☐ Email
- ☐ Robocalling
- ☐ Other, please specify: _____

12. Does the patient portal enable coordination for the following activities or services? Select all that apply.

- ☐ Appointment scheduling
- ☐ Prescription requests
- ☐ Provider referrals
- ☐ External education or self-management referrals
- ☐ Treatment tracking/care plan progress

About your readmissions team:

13. Do you have an internal readmissions team?

- ☐ Yes. Go to question 14.
- ☐ No. Skip to the next section.

14. What cross-functional team departments are represented in the readmissions team? Select all that apply.

- ☐ Ambulatory Care
- ☐ Case Management
- ☐ Emergency Department
- ☐ Hospitalists
- ☐ Infection Control
- ☐ Nurse Managers/ Chief Nursing Officer
- ☐ Pharmacy
- ☐ Population Health
- ☐ Quality Department
- ☐ Social Work
- ☐ N/A
- ☐ Other. Please specify: _____

About addressing readmissions with post-acute providers:

15. Does your organization regularly meet with community post-acute providers to review hospital readmission issues?

- ☐ Yes
- ☐ No

If yes, does this also include post-acute providers outside of your network/preferred provider network?

- ☐ Yes
- ☐ No

16. Who is already at the table? Select all that apply.

- ☐ Cardiac Rehab
- ☐ Community-Based Organizations
- ☐ Dialysis Centers
- ☐ Home Health Agencies
- ☐ Hospice
- ☐ Long-Term Care/Short-Term Rehab
- ☐ Other Hospitals
- ☐ Physician Practices
- ☐ Pulmonary Rehab
- ☐ Other, please specify: _____

17. Has your organization completed an environmental scan of available community resources within the zip codes of your service area?

- ☐ Yes
- ☐ No

18. Select the disease management programs/services you offer or patients are referred to. Share the name of the organizations you partner with for each applicable service.

- ☐ Chronic Disease Self-Management Program (CDSMP) _____
- ☐ Chronic Kidney Disease Education _____
- ☐ Chronic Pain Self-Management Program (CPSMP) _____
- ☐ Crisis Management Education _____
- ☐ Diabetes Self-Management Program (DSMP) _____
- ☐ Dialysis Preparation _____
- ☐ Medicare Diabetes Prevention Program (MDPP) _____
- ☐ National Diabetes Prevention Program (NDPP) _____
- ☐ Nutrition Education/Medical Nutrition Therapy _____
- ☐ Self-Measured Blood Pressure (SMBP) _____
- ☐ Sepsis _____
- ☐ Stress Management Education _____
- ☐ Substance Use Disorders Treatment _____
- ☐ Weight Management _____
- ☐ Other, please specify: _____
- ☐ None

19. Which community programs do you refer to or recommend to patients?

- ☐ Congregate Meals
- ☐ Cooking Classes/Nutrition Education
- ☐ Farmer's Market/ Food Cooperative
- ☐ Fitness & Recreation Classes
- ☐ Food Assistance Programs (e.g., food pantry)
- ☐ Food Shopping Guidance (e.g., supermarket nutrition class)
- ☐ General Health Awareness and Education
- ☐ Manipulative/Body-Based Therapies (e.g., massage)
- ☐ Meal Delivery Service (e.g., Meals on Wheels)
- ☐ Medically Tailored Meals
- ☐ Mind-body Therapies (Tai Chi, meditation, imagery, etc.)
- ☐ Other, please specify: _____
- ☐ None

20. If your organization has an electronic referral system for programs listed in questions 18 or 19, describe the referral and follow-up process to improve patient participation.

- ☐ Please describe:

- ☐ Not applicable. Our organization does not have an electronic referral system for external referrals.

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