CHANGE IDEA: Identify community partners for care coordination and linkage through community asset mapping.

STEP 1: GET READY (TASKS)

A. Convene a health center planning team, including health care providers, family members, care coordinators, social workers, and administrative staff. See this sample invitation for a letter or email. It may be helpful to note that this is a multi-step process that may take several months.
B. Explore existing community assets (e.g., 311 lines, Family Resource Centers, Help Me Grow) as opportunities to strengthen gap areas.
C. Select 1-3 initial goals for enhancing care coordination through community asset mapping (e.g., improve access to health services, reduce roadblocks to behavioral health care).
D. Use data to identify high-need areas that require additional resources (e.g., mental health services, substance use treatment, nutrition programs).
E. Select a Geographic Information System (GIS) community asset mapping tool, such as QGIS, that will allow easy access, updating, and sharing among care coordinators and patients.
F. Assign roles and responsibilities to manage the asset mapping process and ensure data accuracy.
G. Provide training on the asset mapping tool.

STEP 2: PLAN AND PRACTICE

Use Geographic Information System (GIS) mapping to identify community partners.

A. **Identify Relevant Data Sources:** Collect up-to-date data on local services related to mental health, early intervention, housing, nutrition, and transportation. Include recent needs assessments or landscape analyses if available.
B. **Dialogue With Key Partners:** Meet with key partners to understand services, referral processes, and communication standards to optimize possible "warm handoffs" and reduce missed referrals and follow-up.
C. **Map Resources:** Use GIS to create a map that includes the following services:
    - Mental health (e.g., counseling, therapy centers, home-based infant mental health)
    - Early intervention (e.g., developmental screening programs, early childhood education programs)
    - Housing assistance (e.g., public housing, housing vouchers, shelters)
D. **GIS Mapping:** Enter the collected data into the GIS and create separate layers for each service type. Geocode each resource to its geographic location for easy reference.

E. **Pilot Test:** Test the GIS mapping with a small group of families over a short period of time to evaluate the process of connecting families to community resources.

Evaluation:

- **Data Review:** Evaluate the accuracy of the GIS map by comparing it with existing resource directories. Check for missing services or outdated information.
- **Feedback Collection:** Gather feedback from care coordinators, families, and community partners on usability and effectiveness.
- **Measure Success:** Use key performance indicators to measure:
  - ✓ Number of families connected to services
  - ✓ Referral timeliness and accuracy
  - ✓ Family satisfaction
  - ✓ Stakeholder feedback on GIS usability

Key Questions:

- Were families able to identify available services easily?
- Did the GIS mapping tool accurately reflect available resources?
- Did the tool streamline the referral process?
- Were there any significant gaps in services?
- What language issues arose?

STEP 3: REVIEW AND REFINE

A. **Evaluate the mapping tool's effectiveness:** Assess how well the community asset map supports care coordination by monitoring patient satisfaction, timely access, and health outcome improvements.
B. **Gather feedback:** Collect input from care coordinators, families, and staff. Identify areas for improvement, such as missing resources or gaps in the referral process.
C. **Adjust workflows and tools:** Based on the feedback, refine workflows and update the community resource map to include additional assets or remove outdated information.

STEP 4: EXPAND

A. **Expand asset mapping to all care coordinators:** Once the mapping tool is refined, expand its use to all care coordinators at the health center. Ensure that every care coordinator is trained and has access to the map.
B. **Integrate asset mapping into patient intake:** Incorporate questions about needs (e.g., housing, nutrition, transportation) into the patient intake process to ensure care coordinators are aware of these factors from the beginning.
C. **Develop partnerships with community organizations:** Foster relationships with local organizations and service providers to keep the map current and ensure patients are referred to appropriate resources.

STEP 5: SUSTAIN

A. **Embed the process into daily operations:** Integrate the asset mapping process into standard operating procedures so care coordination remains a routine.
B. **Monitor long-term outcomes:** Track long-term outcomes for referred patients, including improvements in health and access to care.

C. **Share success stories:** Share patient stories with staff and community partners to reinforce the impact of the asset mapping process and build momentum.
D. **Continuously monitor the effectiveness:** Regularly review the impact of asset mapping on care coordination, focusing on patient access to resources, satisfaction, and health outcomes.
E. **Make improvements to the map:** Continue adding new community resources and remove outdated ones to keep the map current and user-friendly.
F. **Gather ongoing feedback:** Solicit regular feedback from care coordinators and patients about how the community asset map is functioning to further refine the process.