Connecticut State Innovation Model (SIM)

Report of the Practice Transformation Taskforce on

Community and Clinical Integration Program Standards

for Advanced Networks and Federally Qualified Health Centers

Community Health Collaboratives

March 2016

Appendix C: Community & Clinical Integration Program – Community Health Collaboratives

COMMUNITY HEALTH COLLABORATIVES

Program Context, Description, and Objective:

Context: One of the core drivers of better healthcare outcomes in Connecticut's SIM Community and Clinical Integration Program initiative is the integration of healthcare delivery with community resources. Such resources are a means to address socio-economic factors that affect the ability to achieve good outcomes. Currently, stakeholders report a lack of integration and coordination across care settings—too few patients are connected to community resources, especially those with complex conditions or who are experiencing equity gaps. Because many community service providers are resource-, capacity-, and geographically-constrained, there is concern that having multiple networks seeking partnerships with community resources using different processes and protocols will lead to complexity and confusion among the clinical and community participants resulting in an adverse impact on consumer health outcomes. The development of community-wide consensus protocols or standards for coordination should improve efficient coordination and more effective support for complex patients and care transitions.

Many SIM states have successfully initiated this integration process by establishing systems of shared governance for community resources (Samuelson, 2015). For the purposes of integrating social support services into clinical care for Connecticut's CCIP initiative, the PTTF has recommended a similar approach of convening community stakeholders to establish local community health collaboratives.

A survey of the existing health and healthcare related collaborative structures will be undertaken so that, where appropriate, our approach can mobilize existing partnerships and resources. For example, there are collaboratives in Connecticut that are comprised of diverse stakeholder groups focused on supporting more effective care transitions and reduced readmissions. Other groups have emerged in response to the hospital's Community Health Needs Assessments and Community Benefit requirements for tax-exempt hospitals.[1] Advanced Networks and FQHCs that are operating in the local community will be strongly encouraged to participate, whether or not they are participating in MQISSP and CCIP.

Collaboration on the coordination of healthcare and community resources may provide the opportunity to establish the foundation for the population health strategies proposed in our model test grant including Prevention Service Centers and Health Enhancement Communities. Accordingly, the process

[1] http://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/Hospitals-and-Community-Benefit-Interim-Report

for developing community health collaboratives may be undertaken in partnership with DPH and in collaboration with state health government stakeholders such as the Departments of Social Services, Mental Health and Addiction Services, Education, and Children and Families; local municipal leadership and health departments; private foundations; and other "Potential Partners" identified for specific focus areas in DPH's SHIP (footnote). The Collaboratives should also include Local Mental Health Authorities, housing and food assistance providers, community pharmacies, and other members of the non-profit and faith communities.

The responsibility for identifying and/or convening the collaboratives may be placed with the vendor responsible for providing technical assistance to participating entities in the CCIP program. The SIM PMO will include the responsibilities as well as the experience and skills required for this role, which might include experience coordinating healthcare, consumer, and community organizations and experience facilitating diverse groups of stakeholders to develop consensus-based solutions. While this convening responsibility may initially reside with the transformation vendor, we envision that the responsibilities to maintain the community health collaboratives will be transitioned to community leaders according to an agreed upon transfer plan.

Description: Establish consensus protocols to better standardize the linkage to and provision of socio-economic services related to the health needs of patients and care transition coordination among community participants. This system of shared decision-making helps further the integration of community services with healthcare services and may prepare communities for the next stage of shared accountability under population health related SIM initiatives. The community consensus guidelines will impact patients with complex conditions and health equity gaps, who are disproportionately in need of better coordination with community resources.

Objective: To improve healthcare outcomes by facilitating efficient coordination between primary care and other healthcare providers with community resources capable of addressing the socio-economic conditions that contribute to poor population health and healthcare outcomes.

High-Level Shared Community Health Board Collaborative Development Process:

1. **Planning Strategy**
2. **Identify and convene stakeholders impacted by the Community Health Collaborative model in defined area(s)**
3. **Develop standardized protocols and processes for network linkages to shared services**
4. **Implement long-term assessment and improvement process**

Detailed Community Health Board Collaborative Design Standards for Technical Assistance Vendor:

1. **Planning Strategy**

   The transformation vendor develops a planning strategy that ensures the Community Health Collaborative process is unbiased, inclusive of relevant stakeholders, and person-centered in its vision and goals. Strategy includes the following:

   i. Conflict of interest policies
   ii. Plans and timelines for regular meetings including for the transfer of convening responsibilities to a local board
   iii. Goals and objectives

2. **Identify and convene stakeholders impacted by Community Health Collaborative model in defined service area(s)**
   a. The vendor convenes healthcare and community stakeholders who are representative of the designated service area. Representative stakeholders at a minimum include:
      i. Social services providers reflective of the socio-economic and health needs of the patient populations being served, informed by the root cause analyses conducted for health care disparities and complex patients[2]
      ii. Local government agencies with health focused missions (e.g.; local health department, municipal leadership)
      iii. Healthcare providers from across the continuum of care (i.e., hospitals, LTSS, primary care practices, VNA/home health, FQHCs, specialists, behavioral health and dental providers, pharmacists, etc.)
      iv. United Way (2-1-1)[3]
      v. Consumers representative of the service area familiar with the target social, environmental and healthcare needs
   b. The Community Health Collaborative will also work with state health government stakeholders, including the Department of Public Health and the SIM Project Management Office, and other state entities.
   c. The vendor establishes a schedule for meetings that are open to the public

3. **Develop standardized protocols and processes for network linkages to shared services**
   a. The Community Health Collaborative defines shared services and community linkages according to the local needs of the networks[4] and takes into consideration state population health needs, goals and strategies.
   b. The Community Health Collaborative identifies operational areas appropriate for standardization working with networks to identify local needs[5]
   c. The Community Health Collaborative develops protocols and processes that reflect the needs, resources, and capabilities of the local community in delivering integrated, person-centered care as follows:[6]

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[2] Relevant socio-economic domains include, but are not limited to housing, nutrition, employment/vocational assistance, education, transportation, and legal assistance

[3] United Way representation will be required to participate due to the central role they play statewide to catalogue social service resources and access to data on the community's needs through the 2-1-1 program

[4] Shared services and community linkages include services where multiple networks call on a limited community resource.

[5] The Community Health Collaborative may assist networks with their needs assessments and help to aggregate data and analysis within available resources.

[6] Protocols to be standardized will be dependent on service area and community but may include: public awareness, education, and communication of the availability of community services; clinical processes for

i. Solicits input from patients and consumers to ensure the needs of the community are reflected[7]
ii. Considers the capacity and capabilities of the healthcare and social service providers in the community[8]
iii. Builds upon existing community health initiatives, partnerships and resources.

d. The Community Health Collaborative develops an implementation plan and process for proposed standardized processes and protocols across the networks and community partners

4. **Implement long-term assessment and improvement process -**
   a. The Community Health Collaborative transitions convening responsibilities to a board of local stakeholders pursuant to agreed-upon plan
   b. The transition plan and goals & objectives take into consideration, to the extent practicable, the SIM Population Health Plan including recommendations Health Enhancement Communities and Prevention Service Centers.
   c. The Community Health Collaborative holds regular meetings and forums to collect concerns and feedback on potential improvements
   d. Within available resources, the Community Health Collaborative incorporates a data collection and analytics function to determine the impact of these new protocols
      Analytics will compare health outcomes and utilization compared to a relevant baseline or comparison group in coordination with the SIM PMO
   e. The Community Health Collaborative will update and modify these protocols over time given the results of the analytics and the feedback from collaborative participants.

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connecting individuals to community services (e.g. standardized transition checklist); and management of referrals and systems for verifying follow-up appointments.

[7] This includes ensuring that communications around processes for accessing needed services are culturally and linguistically appropriate.

[8] Because technology systems, methods of communication, and capacity to handle increased administrative tasks will vary across Connecticut, the community collaborative must strive to develop processes and protocols that reflect the capabilities of all participating community and healthcare providers in order to ensure the feasibility of the proposed standardized processes.