

COMMUNITY CONSENSUS & LINKAGES PROCESS AND GUIDELINES

Developed under guidance from the Practice Transformation Task Force as part of the Connecticut State Innovation Model Initiative

Program Context, Description, and Objective:

Context: One of the core drivers of success in Connecticut's SIM Community and Clinical Integration Program initiative involves the integration of healthcare delivery with community resources capable of addressing the socio-economic determinants of poor health outcomes. Currently, due to the lack of integration and coordination across care settings, too few patients are connected to those resources, especially those with complex conditions and experiencing equity gaps. Because many of these important community service providers are resource-, capacity-, and geographically-constrained, there is concern that having multiple sets of disparate networks seeking partnerships from across Connecticut for their own patients with their proprietary processes and protocols will place unmanageable burdens on these community resources, which are by definition intended to serve the entire community. In this case, rather than require providers to build their own social service capabilities, which would be both outside of the scope of their core competencies and an inefficient use of resources, 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 PTF has recommended a similar approach of convening community stakeholders to establish local Community Health Board Collaboratives. This convening responsibility will be included in the RFP for the transformation vendor responsible for providing technical assistance to participants in the CCIP program. The SIM PMO will include the responsibilities as well as the experience and skills required for this role, which will include experience dealing with healthcare, consumer, and community organizations and experience facilitating diverse groups of stakeholders to develop consensus-based processes and protocols. While this convening responsibility will initially remain with the transformation vendor due to the time and resource requirements to launch the effort, the responsibilities to maintain the Community Health Board Collaboratives will be transitioned to community leaders according to an agreed upon transfer plan.

Description: The Community Consensus & Linkages guidelines will establish a process for communities to streamline the linkage to and provision of important socio-economic services related to the health needs of patients. This system of shared decision-making helps further the integration of community services with healthcare services and may prepare communities for the next generation 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 social service providers.

Objective: To facilitate the connection of patients with socio-economic conditions contributing to poor health outcomes with community resources capable of addressing those needs in a coordinated way with the primary care provider and/or care team and in a way that is most efficient for the primary care team and community services providers.

High-Level Shared Community Health Board Collaborative Development Process:

1. Transformation vendor responsibilities
2. Identify and convene stakeholders impacted by the Health Board 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:

Standards

1. Transformation vendor expectations -

- The transformation vendor develops policies to ensure the Health Board Collaborative process is unbiased, inclusive of relevant stakeholders, and person-centered in its vision and goals. Outline includes the following:
 - Conflict of interest policies
 - Code of ethics for participation
 - Plans and timelines for regular meetings including for the transfer of convening responsibilities to a local board
 - Goals and objectives

2. Identify and convene stakeholders impacted by Health Board Collaborative model in defined service area(s) -

- The vendor convenes social service, healthcare, and community stakeholders who are representative of the service area for which the Health Board Collaborative oversees. Representative stakeholders at a minimum include:
 - 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 patients¹
 - Local government agencies with health focused missions (e.g.; public health, municipal leadership)
 - 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.)
 - United Way (2-1-1)²
 - Consumers representative of the service area familiar with the target social, environmental and healthcare needs
- 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

- The Health Board Collaborative defines shared services and community linkages according to the local needs of the networks³
- The Health Board Collaborative, with facilitation by the vendor, identifies operational areas appropriate for standardization working with networks to identify local needs⁴

¹ Relevant socio-economic domains include, but are not limited to housing, nutrition, employment/vocational assistance, education, transportation, and legal assistance

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

³ Shared services and community linkages include services where multiple networks call on a limited resource in the community with separate processes and protocols. This may include hospitals serving multiple networks.

⁴ The Community Health Board Collaborative can assist networks with their needs assessments as needed and help to aggregate data and analysis.

- The Health Board Collaborative develops protocols and processes that reflect the needs, resources, and capabilities of the local community in delivering integrated, person-centered care to individuals as follows:⁵
 - Solicits input from patients and consumers to ensure the needs of the community are reflected⁶
 - Considers the capacity and capabilities of the healthcare and social service providers in the community⁷
- The Health Board 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 -

- The Health Board Collaborative transitions convening responsibilities to a board of local stakeholders pursuant to agreed-upon plan
- The Health Board Collaborative holds regular meetings and forums to collect concerns and feedback on potential improvements
- The Health Board 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 coordinating with the SIM PMO
- The Health Board Collaborative will update and modify these protocols over time given the results of the analytics and the feedback from collaborative participants

⁵ 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 connecting individuals to community services (e.g. standardized transition checklist); management of referrals and systems for verifying follow-up appointments; and transitions of care and discharge planning from healthcare providers such as hospitals who will be working with more than one network. All protocols should be in accordance with best industry practices.

⁶ This includes ensuring that communications around processes for accessing needed services are culturally and linguistically appropriate.

⁷ 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 reality of all participating community and healthcare providers in a way that does not place unmanageable burdens on organizations.