

CONNECTICUT  
HEALTHCARE  
INNOVATION PLAN



# Practice and Transformation

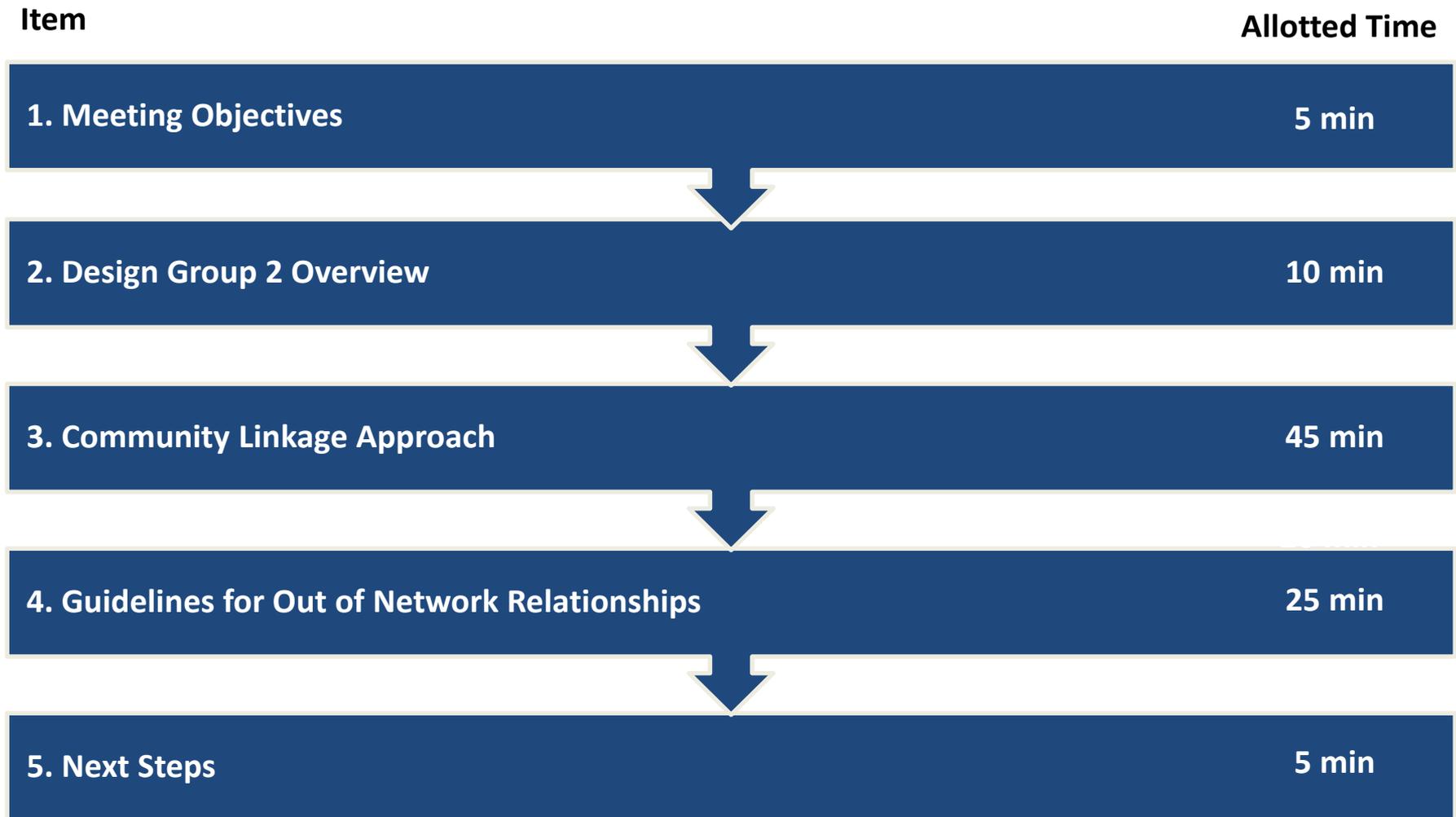
## Taskforce: CCIP

Design Group 2, Session 2:  
Community Integration

August 6<sup>th</sup>, 2015

# Meeting Agenda

Item	Allotted Time
1. Meeting Objectives	5 min
2. Design Group 2 Overview	10 min
3. Community Linkage Approach	45 min
4. Guidelines for Out of Network Relationships	25 min
5. Next Steps	5 min



# 1. Meeting Objectives

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1. Review design group two objectives
2. Establish point of view on approach for community linkages: shared governance vs network specific governance
3. Receive feedback on specificity of guidelines around clinical linkages outside the network

## 2. Design Group Two Overview

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Design group two is tasked with providing input on the development of recommendations on how the CCIP programs should develop relationships with community partners

# 2. Design Group Two Overview: Discussions To Date

1

**Relationship Requirements:**

Requirements for relationships between networks and community organizations – the governance structure for these relationships, the type of agreement pursued between the two organizations (i.e.; handshake, charter, MOU), and roles and responsibilities for each organization

2

**Value Proposition:**

What is the benefit for organizations outside of the network to integrate their services into the network? While the network may benefit through shared savings, what is the incentive for the organizations outside the network?

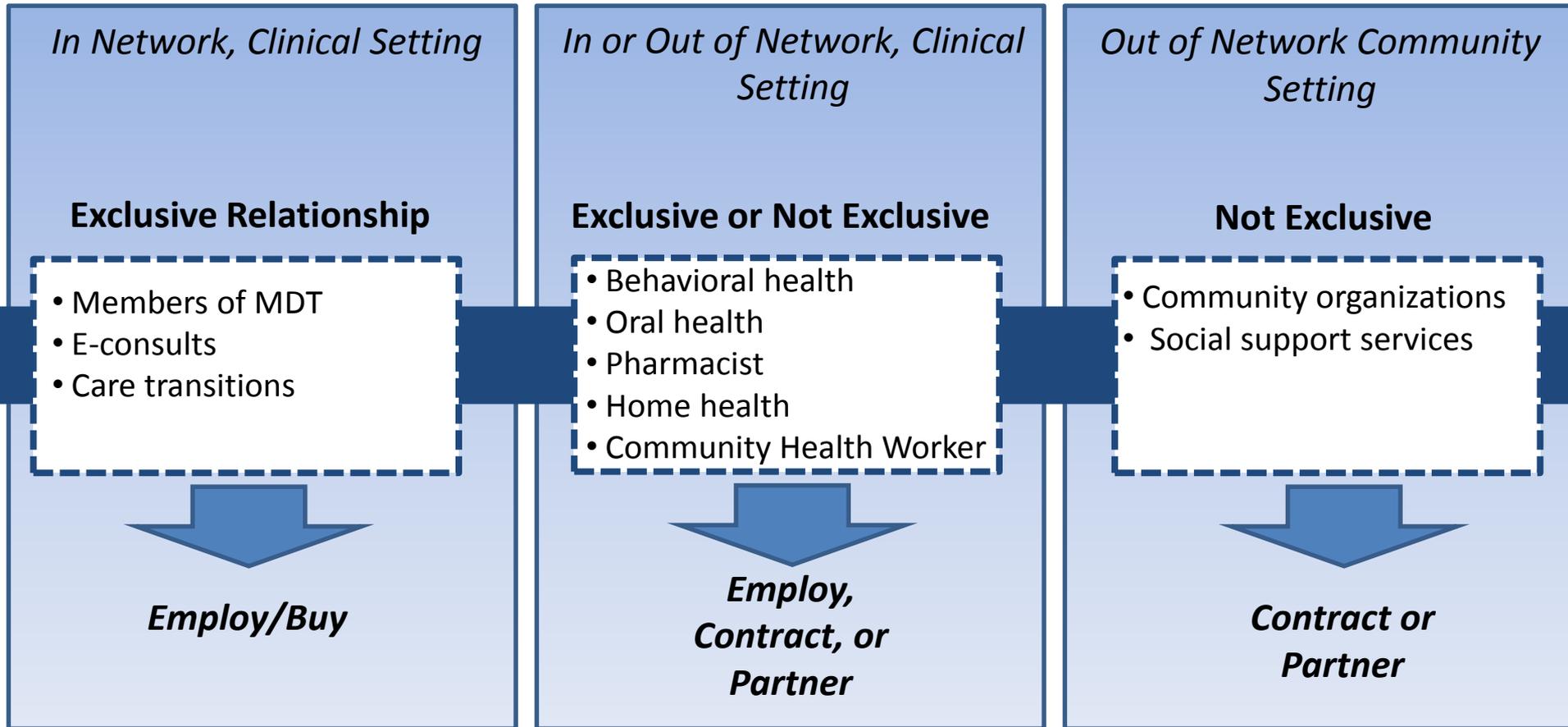
3

**Common/Crucial Linkages:**

Complex: Housing, Food, Vocational  
Equity: Food/Nutrition, Economic, Housing  
Behavioral Health: Behavioral Health Providers

# 3. Community Linkages: Approach

As we continue to discuss the recommendations around agreement types and governance of clinical-community linkages, we should consider how the community based nature of these services will influence the type of governance that is pursued.



What type of relationship should be pursued?

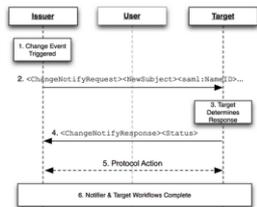
# 3. Community Linkages: Approach

Community facing services (e.g.; social services) will likely not be owned by the network and in many geographic areas there will be multiple networks but only one provider per needed social service.

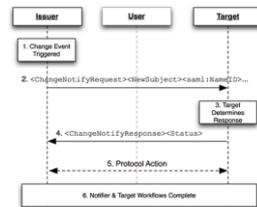


# 3. Community Linkages: Approach

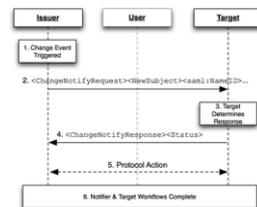
Having networks develop unique protocols and processes to interact with community resources that have to be shared, may present unintended barriers to community and clinical integration.



Protocol A



Protocol B



Protocol C



Local Community Organizations/  
Social Services

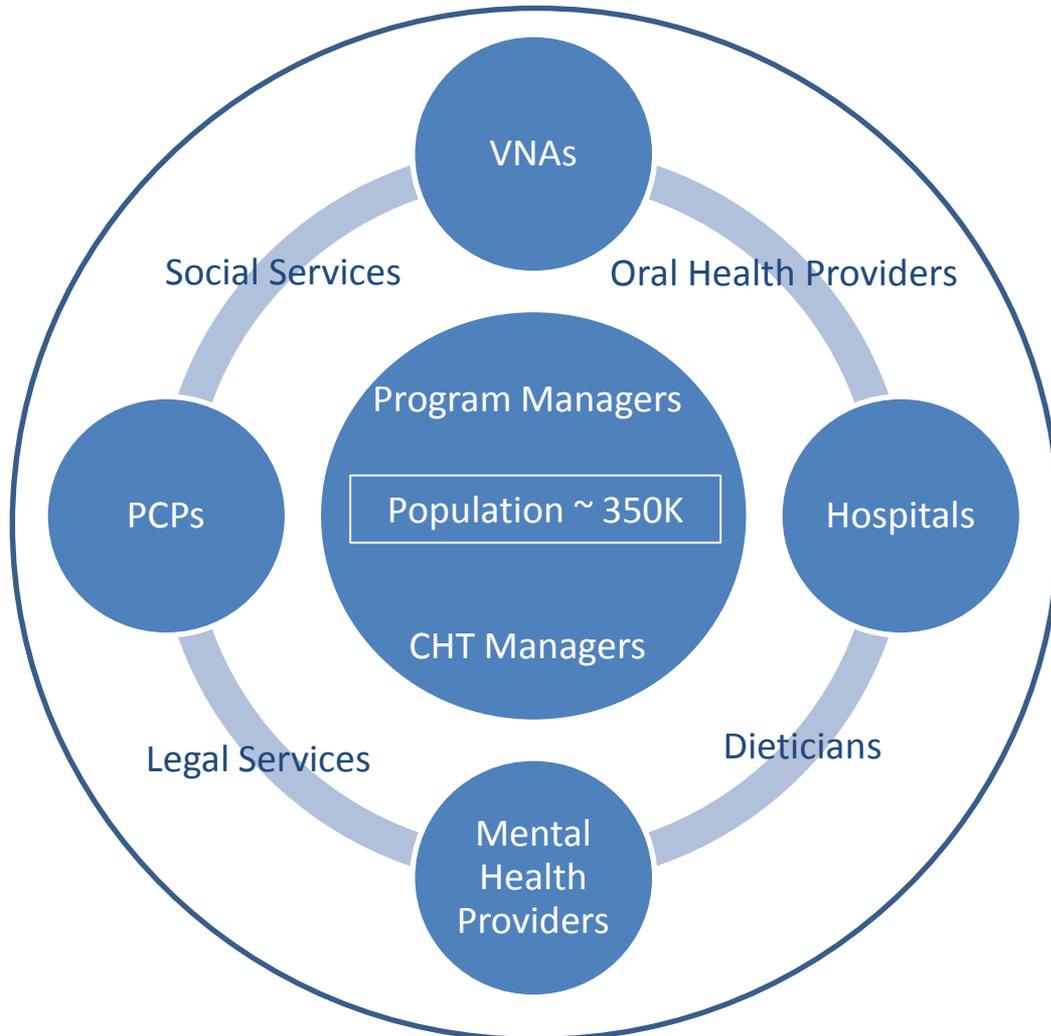
## Potential Barriers

- Inefficiencies: community organization will have to manage to multiple protocols and processes
- Technology: independent development of relationships may lead to use of multiple technological solutions for communication [**Design Group 3 to discuss benefit of a standardized solution**]
- Network Bias: community organizations may work more closely with one organization over another if processes and protocols are easier to follow leading to potential equity and access issues for patients

# 3. Community Linkages: Approach

Other states have integrated community resources into clinical care by using geographically shared governance model to manage the clinical-community relationships.

## Vermont Local Geographic Approach



## Program Development:

- State funded Program Managers to support development of core Community Health Teams (CHTs)
- Community Health Teams were tasked with designing all features of the program as a shared resource to meet local needs, not just the social services
- CHT managers were responsible for designing practice-level clinical and community-level procedures and protocols

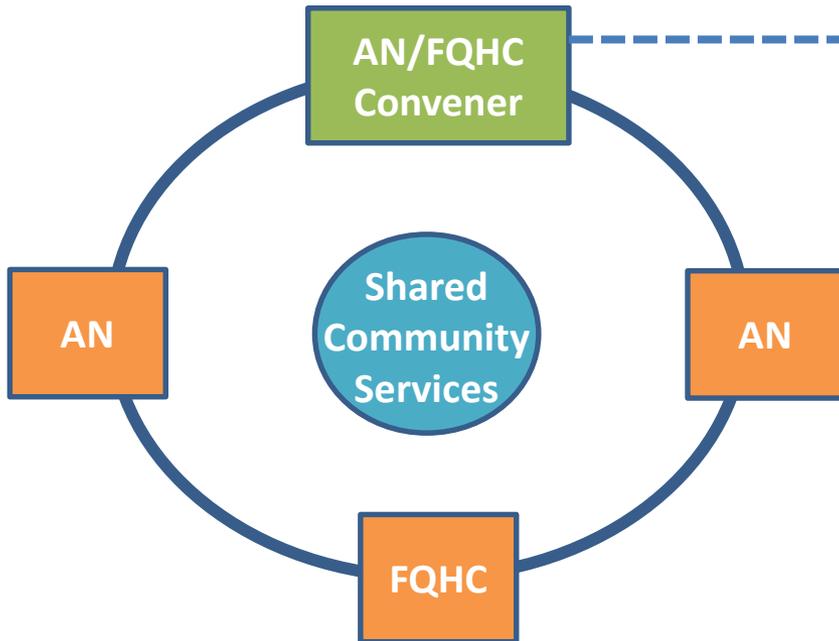
## Governance:

- The entity in charge of hiring and convening stakeholders for shared governance manages CHT dollars (usually hospital, sometimes FQHC)
  - The convening organization
- Convening entity in partnership with the community develops governance of their local programs with general guidance from the state
  - HIT and certain other statewide policies are enforced

# 3. Community Linkages: Approach

Unlike Vermont, the geographic overlap of networks in Connecticut would require that one network be designated as a convener to develop shared governance of clinical-community relationships in the various service areas.

## Connecticut Service Areas



*Illustrative*

## Leadership Team

Develops leadership team (governance) for shared services that **has partners and representation across the continuum of health, community-based care, organizations that address social determinants of health, and consumer/patient** representation.

*What services should be considered shared resources?*

Housing

Food

Income

Transportation

Utilities

*CT 2-1-1 provides information about many community/social services focused on supporting emergent needs, on-going needs, and providing education/guidance*

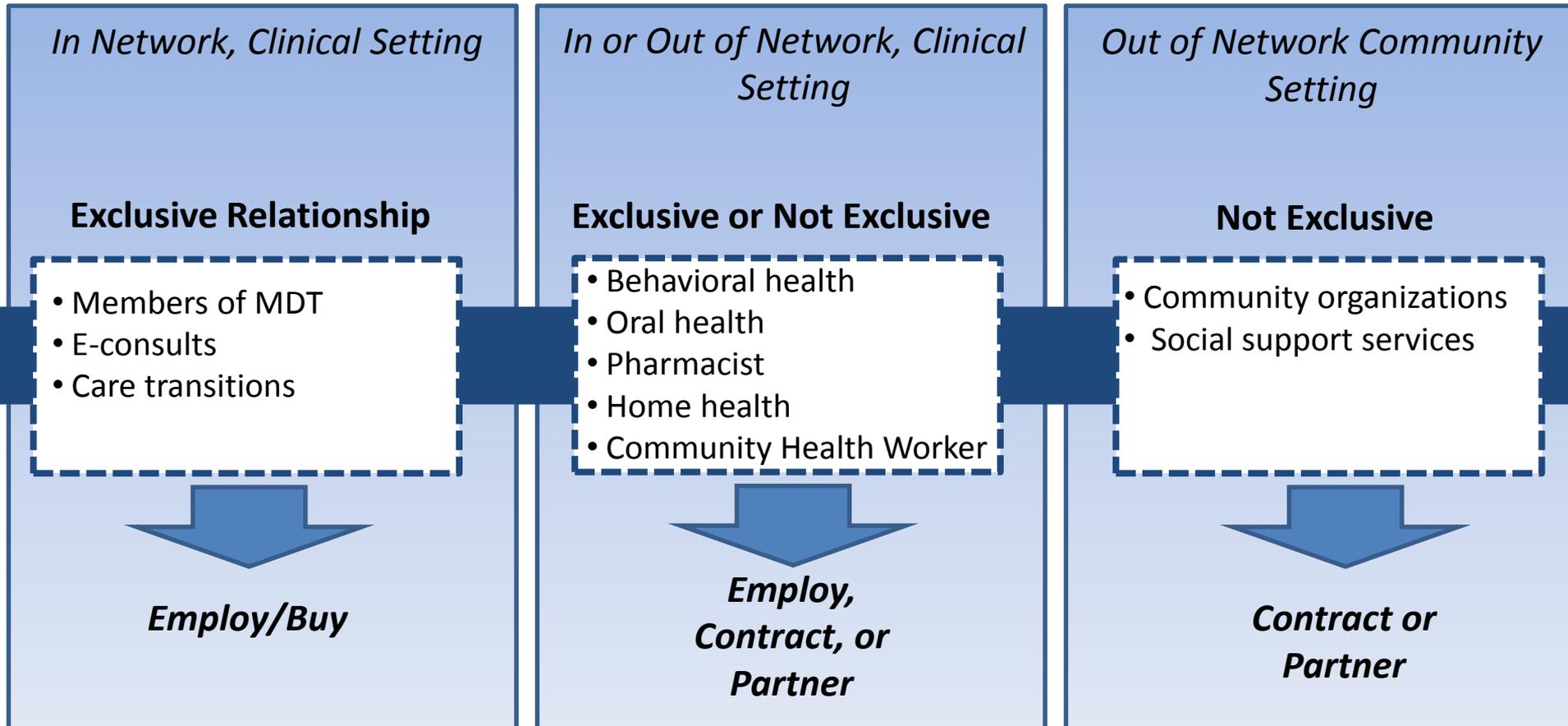
# 3. Community Linkages: Approach

## Discussion Questions:

- 1) Is standardization of protocols and processes for interacting with community resources needed?
- 2) Should standardization be achieved through shared governance?
- 3) Should there be a designated lead convener?
  - If there is only one CCIP recipient in the service area should they be the convener?
  - If there are multiple CCIP recipients in the service area, should networks compete to be the lead convener? Should they be co-conveners?
- 4) Should the lead convener receive funding to execute? If there are co-conveners how would funding be distributed?

# 4. Non-Exclusive Clinical Linkages

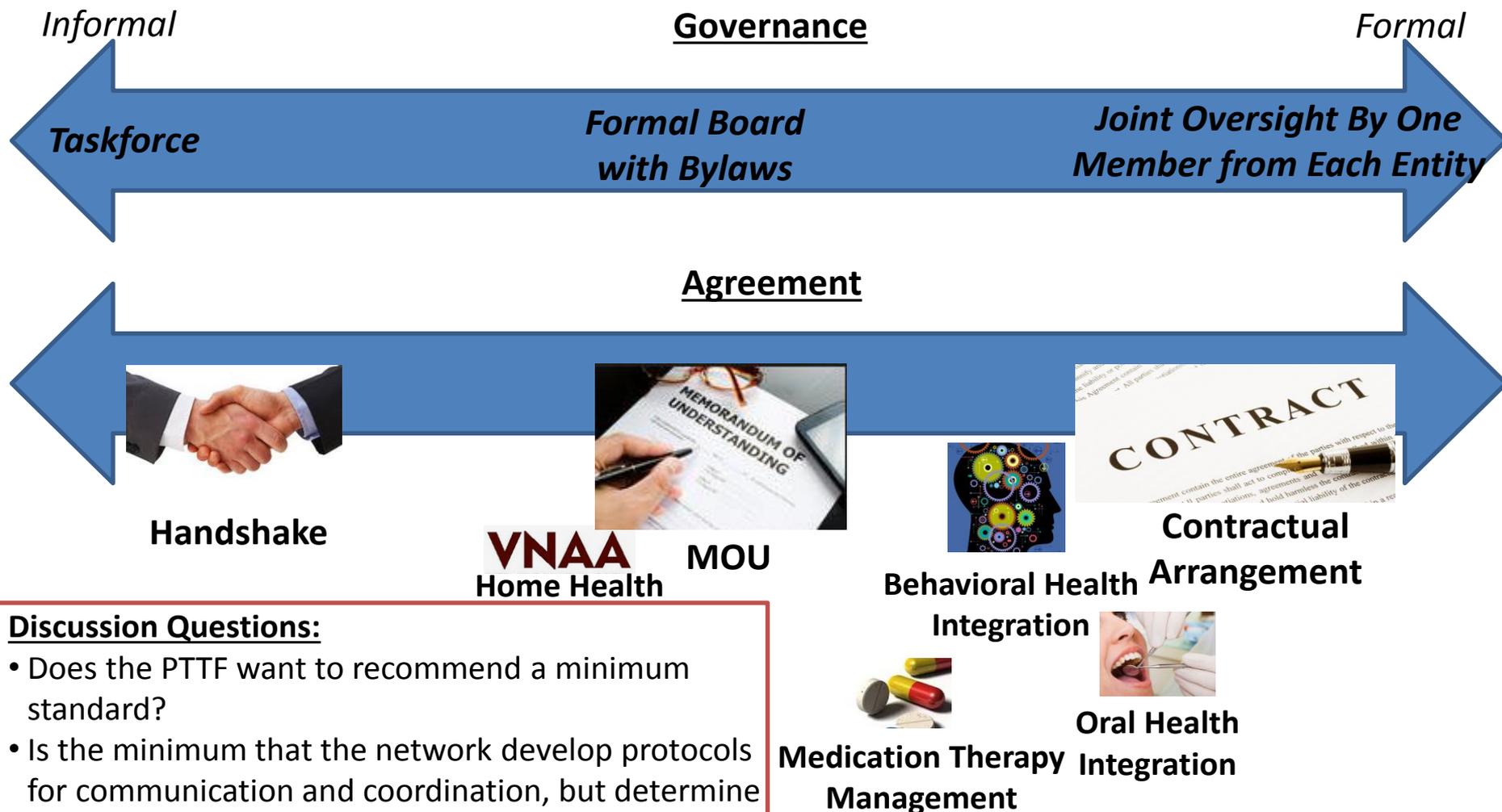
In addition to developing recommendations around clinical-community linkages, the PTF should also consider recommendations for non-exclusive clinical relationships (e.g.; behavioral health or oral health)



If these are developed as non-exclusive relationships, what should they look like?

# 4. Non-Exclusive Clinical Linkages

The agreement and governance chosen may vary depending on what service is being provided and how it influences the potential value of the relationship.



**Discussion Questions:**

- Does the PTF want to recommend a minimum standard?
- Is the minimum that the network develop protocols for communication and coordination, but determine relationship that is most suitable for them?

# 4. Standards For All Linkages

Regardless of the governance models pursued, at a minimum entities will be required to determine which approach they want to take in order to share patient information.

## Release of Information

- Most basic way to receive consent
- Patient signs and allows release of information to designated organizations
- Administratively the most cumbersome

## Business Associates Agreement

- Contract between organizations who want to share protected patient information
- Does not require that the patient sign a statement to specifically allow for their health information to be shared with specific organizations

## Consent Registry

- Most advanced form of patient consent
- Patient can control real-time what information they will allow access to and to whom
- Potential to allow for more efficient sharing of information and likely removes need for BAA or release of information, but requires technological infrastructure that does not exist today (SIM funded option)

# 5. Next Steps

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- Draft initial set of guidelines for the design group to review and provide feedback on
- Share guidelines with broader PTTF at next meeting