Connecticut Health FOUNDATION

Changing Systems, Improving Lives.

POLICY *Brief*

UCONN HEALTH
HEALTH DISPARITIES INSTITUTE

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Key Elements for Advancing Clinical-Community Integration

RECOMMENDATIONS FOR EFFECTIVE CLINICAL-COMMUNITY INTEGRATION

1. **Assemble leadership that is inclusive and treats community and clinical representatives equally.**
2. **Focus on all the ways populations become unhealthy and ensure that every individual has opportunities to be as healthy as possible.**
3. **Create ways to rapidly share health information across systems.**
4. **Empower patients to play a bigger role in their care and integrate community health workers into their care teams.**
5. **Reward and hold provider organizations accountable for creating healthy communities.**

WHAT IS CLINICAL-COMMUNITY INTEGRATION?

People of color have a higher burden of disease – a health disparity, or difference in the health status of groups, that is persistent but preventable.

There is increasing recognition that clinical care is necessary but not sufficient to address inequitable and disparate health outcomes. Improving these outcomes requires making connections between traditional clinical practice and the parts of patients' communities that address barriers to good health such as inadequate housing, lack of transportation, and economic hardship. These institutions range from local health departments and social service agencies to schools, community organizations, and churches.

Clinical-community integration programs encourage tailoring clinical services to fit an individual's unique experiences and tackling their unmet social needs.[1] These programs are also designed to create a more seamless care experience by delivering care in the places where individuals live, work, pray, and learn.

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Although clinical-community integration programs vary in design, many emphasize bundling care delivery so that, for example, individuals get primary care and mental health services in one place. Other programs focus on creating tools so that health care providers can assess social needs and easily refer patients to appropriate community services.

Integrating clinical care and communities holds great promise but requires coordination among organizations that are not accustomed to communicating with one another and whose relationships are often marked by long-standing distrust, lack of transparency, and challenges with sharing power and information.

This brief outlines best practices for clinical-community integration programs based on proven or promising models and offers recommendations for how Connecticut organizations can advance this critical work.

WHAT MAKES A CLINICAL-COMMUNITY INTEGRATION PROGRAM EFFECTIVE?

1. Assemble leadership that is inclusive and treats community and clinical representatives equally.

Because clinical-community integration involves organizations from different sectors, the decision-making body that oversees each effort is critical to its success or failure.

Decision-making bodies must have strong leadership and representation from all affected sectors. Payers and consumers are especially important to include as each brings insights about what will help a program succeed. Recognizing historical power imbalances between the participants is also essential. Community systems have not historically had a role in care delivery, even though they play a critical role in ensuring the success of clinical interventions. Decision-making processes must include awareness of this dynamic to ensure buy-in and equitable allocation of resources.

Soliciting community input at all stages of program design and implementation can ensure the program reflects community needs and values and has community support. The method of eliciting input matters. For example, relying exclusively on written or electronic surveys to gather input will exclude community members with lower literacy.

When executed effectively, these leadership and input-gathering strategies enhance coordination among clinical and community providers and can build trust, maximize efficiency, and minimize duplication.

RECOMMENDATION 1 IN ACTION: MINNESOTA'S ACCOUNTABLE CARE MODEL

In Minnesota, two state agencies have taken the lead in fostering a model designed to encourage clinical-community integration, with participation from public and private sector leaders.

As part of the model, the state supports health systems that integrate community health workers, establishing learning communities for them to share information. The model uses storytelling to encourage individuals in targeted communities to share thoughts about challenges and successes in creating healthier communities. Community members submit videotaped stories online for consideration and selected stories are shared throughout Minnesota.

The model also includes accountable communities of health (ACH) that serve specific geographic areas and are collaborations between health care providers, community and social service organizations, and other partners. Each serves diverse populations with a range of approaches to team-based care delivery. Features of the model[2] include:

- ACHs must be community-led, representative of the communities they serve, and made up of a spectrum of providers.
- One organization typically leads an ACH and assumes responsibility for fiscal and resource management.
- ACHs must include an existing accountable care organization – a group of health care providers working together to manage the health of a patient population – and agree to evaluate results.
- The members of each ACH must create a coordinated care-delivery team or community-based system and develop a population health prevention plan.

Although it is too early to evaluate the model's sustained impact, there are early signs of success, including decreases in the use of inpatient and emergency department services and reductions in prescription narcotics claims.[3,4]

2. Focus on all the ways populations become unhealthy and ensure that every individual has opportunities to be as healthy as possible.

Population health approaches are based on an understanding that health outcomes are not solely driven by individual choices,[6] but reflect root causes such as inequities in social conditions, opportunities, and resources.

Successful clinical-community integration programs apply a population health approach that focuses on the whole person. For example, a population health approach would recognize that the exacerbation of asthma symptoms might be tied to poor residential air quality, not necessarily to incorrect inhaler usage. A program that integrates clinical and community-based care would be able to link a patient to services that can address those environmental triggers.

Although many health care providers acknowledge the role of social factors in overall health, many lack formal knowledge and training on how to incorporate those factors into care plans. Clinicians who deliver care within an organization with deep ties to community supports will likely be more comfortable asking patients about social needs and better able to refer them to appropriate services.

RECOMMENDATION 2 IN ACTION: WASHINGTON'S PLAN FOR IMPROVING POPULATION HEALTH

The Healthier Washington initiative is led by three state agencies that partner with insurers, hospitals, doctors, local governments, foundations, and community leaders. Washington's plan for improving population health focuses on health equity, prevention, and social determinants of health such as housing, education, and employment. The plan provides a collection of resources for population health assessment, community engagement, setting goals, conducting evaluations, and communicating results to community members and other stakeholders. Additional population health priorities are set for specific geographic regions. These accountable communities of health are charged with conducting regional needs assessments and designing regional health improvement plans. Leaders meet regularly to make needed course corrections to their plans.

Health equity means that everyone has a fair and just opportunity to be as healthy as possible.[5]

3. Create ways to rapidly share health information across systems.

One of the greatest barriers to clinical-community integration is inadequate communication between systems and a limited ability to exchange patient information. For example, school systems rarely communicate with health care providers, even though they may have useful information about children and families. A school nurse might know that a child has frequent asthma attacks or that a student's family struggles with food insecurity. Efforts to integrate clinical care and communities can be successful only if organizations and the providers in them have access to uniform data about each patient's health and social needs.

The widespread use of electronic health records offers the potential for creating "flags" to alert providers about social service needs or reminders to screen for social issues. This kind of data exchange is essential to streamlining referrals, especially for community and social services. However, there is resistance to sharing data because of concerns about potential risks if sensitive data is misused. In addition, organizations sometimes want to maintain control over information. Working collaboratively to set ground rules about data collection, sharing, and use can minimize these barriers. Working to build trust among partners will likely do even more to remove sharp elbows around the table.

RECOMMENDATION 3 IN ACTION: HUNGER SCREENING IN COLORADO

Kaiser Permanente of Colorado collaborates with Hunger Free Colorado, an outreach and advocacy organization, to administer comprehensive hunger screening during routine clinical visits. Screening results are entered into electronic medical records. Patients who screen positive are referred to a community specialist who connects them with community services such as the Supplemental Nutrition Assistance Program. Referrals to such services have increased significantly and Colorado's rates of food insecurity are among the lowest in the country.[7]

4. Empower patients to play a bigger role in their care and integrate community health workers into their care teams.

Traditional health care delivery places all the authority over clinical decisions in the hands of providers. Programs are likely to achieve better outcomes if they invite patients to weigh in on care plans and offer concrete suggestions to improve how providers talk to patients about patient choices. Effective clinical-community integration programs use community health workers to educate and empower patients, remind them about follow-up appointments and medication schedules, and help them navigate complex systems.

RECOMMENDATION 4 IN ACTION: EMPOWERING PATIENTS THROUGH RELATIONSHIPS

The Camden Coalition of Healthcare Providers in New Jersey empowers patients and communities to take control of their health.[8] The coalition's COACH model is designed for patients with complex health and social needs, and relies on a care team that includes nurses, community health workers, and social workers who meet weekly with patients. A hallmark of this model is building relationships between patients and care team members that are secure, genuine, and continuous.[9] To this end, care team members call patients between visits, take time to listen and explain care plans, and keep their word. An authentic, healing patient-provider relationship can build the patient's trust in the health care system or rebuild it if it has been broken. These kinds of relationships can also lead to more collaborative treatment planning and increase the likelihood that care plans are tailored to each individual. Strong relationships might even encourage patients to communicate more openly with providers about non-clinical barriers to sustained healthy behavior change. The COACH model is decreasing costs of care, emergency department visits, and hospital admissions.[10]

5. Reward and hold provider organizations accountable for creating healthy communities.

Implementing and sustaining clinical-community integration programs will require changing how health services are financed. There is growing momentum toward paying providers based on the quality of care rather than the number of patients. These kinds of payment and financing models could incentivize providers to look beyond the clinic to work more closely with supports in patients' communities.

RECOMMENDATION 5 IN ACTION: VERMONT'S BLUEPRINT FOR HEALTH

The Vermont Blueprint for Health, launched in 2003, is led by officials in state government, health care, housing, social services, and the private and nonprofit sectors. Vermont's advanced primary care model integrates patient-centered medical homes and community health teams, which provide comprehensive support such as tracking patient appointments, helping individuals find child care or transportation, and filling out insurance forms. Vermont is applying this approach to an initiative providing opioid addiction treatment, support, and services at home.

In Vermont, health care provider groups are working together as accountable care organizations (ACOs) that share the accountability for health care costs and quality. ACOs are enabled by payment models that create more alignment across Medicaid, Medicare, and commercial insurers. This alignment means that providers' payment is partially based on the value of the care they deliver, rather than how many patients they see. Vermont's Blueprint for Health is reducing health care costs, emergency department visits, and hospital admissions.[11]

WHAT WE DON'T KNOW: LONG-TERM SUCCESS AND SUSTAINABILITY

Even with state-level investments, questions remain about how clinical-community integration programs can be fiscally and structurally sustainable. In addition, because many programs are newly implemented or designed, there is less available data on the probability of long-term success. Although assessments are being developed for clinical-community relationships,[12] each model will likely require measures tailored to fit its unique context.

Financing is also a significant challenge: While clinical-community integration requires "boots on the ground" such as community health workers, many programs have difficulty figuring out how to pay for and support them.

KEY CONSIDERATIONS FOR CONNECTICUT

Improving health and eliminating health disparities requires coordinated efforts between clinical care systems and community organizations. Nationwide, clinical-community integration programs have been started by organizations including governments, hospitals, insurance companies, and community-based agencies. Each sector has a role in these partnerships, and a stake in ensuring they succeed. While there are state-level efforts to support clinical-community integration in Connecticut, the private sector, local governments, and community organizations can also take the lead in building and supporting these partnership models. Considerations for this work include:

- **Build on what exists.** Start with existing relationships between traditional clinical care systems and communities and create stronger, more systematic partnerships.
- **Bring people along.** Create a strong governance structure with buy-in from a wide range of organizations. Representation from clinical and community organizations must be balanced and reflect an understanding of historic power imbalances.
- **Share data.** Ensure all partners have access to data about shared patients.
- **Prove it works.** Secure initial investments – such as through grant funding or venture capital – to prove the effectiveness of the model and develop plans for sustainability.
- **Ask what people need.** Develop multiple methods for gathering input to increase opportunities for community and patient voices to be included. Build on existing community needs assessment work and consider alternative methods for collecting feedback such as text or video messaging.

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