Primary Care Modernization Capability Summary
Community Integration: Primary Care Partnership with Community-Placed Services

Meeting Notes and Feedback from Design Group Meetings are attached at the end of this document.

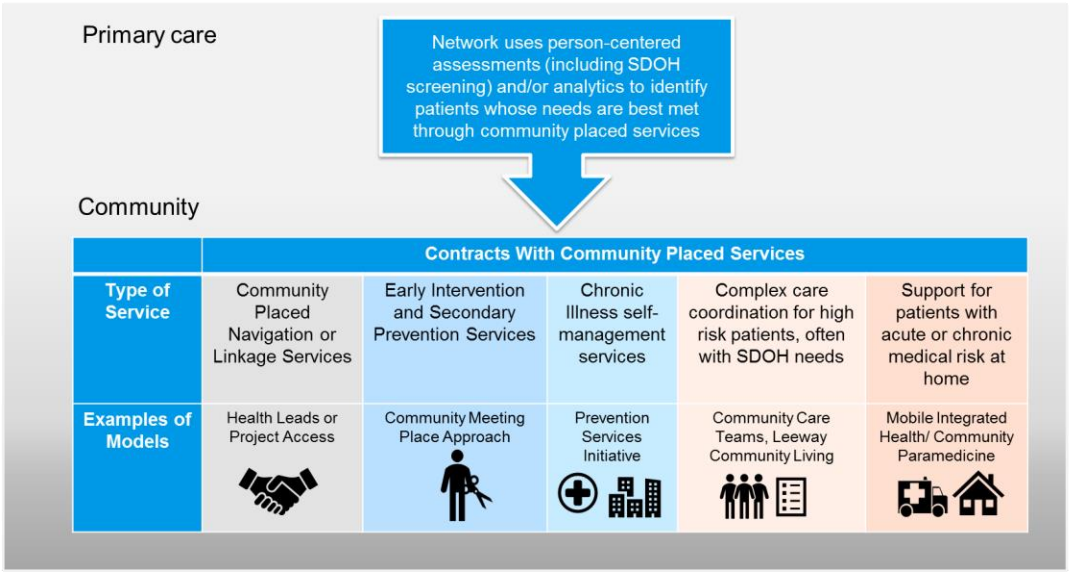
Definition of the Capability: Advanced networks or Federally Qualified Health Centers (FQHCs) purchase community-placed services that enhance patient care, better meet the needs of patient populations, address social determinants of health needs, and/or fill gaps in services.

Goal of the Capability: Promote the use of community-placed services when it is better for the patient and more efficient for these services to be provided by community programs than the primary care practice or network.

Consumer Input, Questions, and Concerns for Implementation:

- Need to define how Community Based Organizations (CBOs) will be identified and what their roles will be
- There will be gaps in what community services are available depending on geography and need for capacity building in those areas
- If primary care practices are doing needs assessments largely based on those accessing care, we might exacerbate disparities for those who don't seek care. Attribution methodology needs to address this.
- SDOH screening needs to be culturally appropriate and provided by the appropriate care team member
- Networks should respond, via partnering with CBOs, to community needs, not just their specific patient needs as this can exacerbate disparities
- Need to be inclusive of a variety of community organizations to connect their members/clients to healthcare, such as churches, barbershops, community centers, etc.
- Need to evaluate disparities in care to provide access to appropriate community placed services
- Need to establish a baseline of community health to understand whether services are meeting needs of patients
- Non-medical meeting places should not be burdened as healthcare hubs, but rather be sources for information connecting to healthcare services *(electronic feedback)*

Draft Concept Map for Community Integration



Summary of Capability

Practices identify service gaps and needs for community-based services	Identify needs via: assessing chronic care management, care transitions, complex condition management, high utilizers, and social determinants of health screening for community assessment and baseline establishment.
Practices partner with appropriate community-placed health services	Support evidence-based and pilot services including, but not limited to: community place navigation or linkages, early intervention and secondary prevention, chronic illness self-management services, complex care coordination for high risk patients, support for patients with acute or chronic medical risk at home
Practices track referrals and outcomes	Assess individual and community impact of services such as, ED utilization, readmissions, costs, and reduction in social determinants of health risks.

The PCM supplemental bundle would provide upfront payment for networks to invest in new capabilities:

- Purchasing community placed services may be an optional use of supplemental bundle payments

- How needs are identified is determined by the network (analytics, care teams, health risk stratification)
- Purchasers wouldn't be required to implement any particular service to allow flexibility
- There are several models put forth that networks could develop with community partners, but these are not the only options
- The State would offer Technical Assistance similar to the Prevention Services Initiative to help networks develop these capabilities

Understanding the Need

The Problem:
Our current primary care system does not provide flexibility or payment structures that allow practices to sufficiently address patients with social determinants of health needs, complex chronic conditions, and cultural, language, transportation and other access to care barriers (e.g. patients with limited mobility who have difficulty getting to medical appointments).

Providers are also not able to adequately address gaps in care, including for acute, preventive and chronic care, or social determinants of health needs. One study estimates that patients currently receive only 55% of care recommended in these areas (Cambridge Health Alliance). Social determinants of health have a significant impact on health outcomes and contribute to health disparities. One study suggests that social and economic factors account for as much as 55% of health outcomes. Other studies have shown that a substantial proportion of all deaths are attributable to poverty (2-6%), income inequality (9-25%), and lower socioeconomic status (18-25%) (The American Academy of Family Physicians, 2018).

There are many services available through community-based organizations that are equipped to extend primary care services into the community and can connect patients to community-based services to address these gaps. It is in some cases more efficient for a network of providers to purchase these services through community-based organizations that already provide them. However, because of the way networks are currently reimbursed under payment arrangements that allow them to share savings from improved care management, they must get double the return on their investment on services like these to not lose money on their investment (a 2:1 Return on Investment (ROI)). Moving to an upfront payment where networks are paid on a per member per month basis for patients allows networks to cover some of these investments, and so they only need better than a 1:1 ROI to make these investments.1 This allows networks to make incremental investments in efficiency and quality.

Proven Strategy:
Name: Community Integration
Definition: Advanced networks or Federally Qualified Health Centers (FQHCs) purchase community-placed services that enhance patient care, better meet the needs of patient populations, address social determinants of health needs, and/or fill gaps in services.

Community integration consists of:

1. Practices identify service gaps and needs for community-placed services
2. Practices provide access to appropriate community-placed health services by purchasing these services to better meet patients' needs
3. Tracking of referrals to community-placed services and outcomes

1. Practices identify care gaps and needs for community-based services

a. Practices identify needs for community-based services based on:
   i. Social determinants of health screenings
   ii. Gaps in chronic condition care management that can be addressed more efficiently by community-based services
   iii. Cultural, language, health literacy, and socio-economic needs of the population that align with community-based services

iv. Gaps in transition of care for patients moving from acute settings to home and community-based settings
v. Gaps in care for patients with complex conditions
vi. Analysis of high utilizers of Emergency Department and hospital services
vii. Community disparities analyses via HEDIS and CAHPS measures using member reported data (ex: language, race, gender, ethnicity) coupled with zip code or census data (Racial, Ethnic, and Gender Disparities in Health Care in Medicare Advantage, 2018).

Needs assessments for community placed services should be structured to establish a baseline understanding of the community's health and identify disparities by:

- Including patients who are not already engaged with the primary care practice but may be Emergency Department and other acute care utilizers to bring them into primary care.[1]
- Including SDOH data as well as looking at geographic access, language needs, and the diversity of the community to understand community health.

Social Determinants of Health Screening

To address social determinants of health, practices need to understand the social determinants risks for patients. The American Academy of Family Physicians (AAFP) defines social determinants of health (SDOH) as the conditions under which people are born, grow, live, work and age. Prominent factors of SDOH include socioeconomic status; racism and discrimination; poverty and income inequality; and lack of community resources (AAFP, 2018). Screening for social determinants of health includes:

1. A member of the primary care team conducts a manual or computerized patient assessment to identify both clinical and social determinants of health. The care team member should have training in social determinants of health, cultural sensitivities, and community services, such as a Community Health Worker. The screening tool should be linguistically and culturally appropriate and address food insecurity, housing instability, utility needs, financial resource strain, transportation, and exposure to violence (with childcare, education, employment, health behaviors, social isolation/engagement, and behavioral/mental health as optional categories) (Health Leads, 2017). Screening tools should be brief and simple with targeted questions that match the needs of patient populations (Health Leads, 2017). An example of an SDOH screening tool can be found in Health Leads' Social Needs Screening Toolkit.
2. A standard set of social determinants codes are captured in the patient's EHR.
3. A care team member (such as a Community Health Worker) connects patients to community services that address their individual needs.
4. Patients are screened annually. High-risk patients are screened every 6-months.

2. Practices partner with appropriate community-placed services

[1] The Payment Reform Council is considering auto assignment of ED utilizers in attribution methodologies to enable this.

Networks contract with providers of community-placed services to extend primary care services into the community and help patients access appropriate support services. Several models for purchasing community services may be used depending on practice needs:

Community Place Navigation or Linkage Services

Health Leads
Example: Primary care practices contract with Health Leads, an organization that provides on-site aids who meet with patients with SDOH needs during their medical encounter to connect them with needed social services. Health Leads is a national healthcare organization that connects low-income patients with the basic resources they need to be healthy. The model begins with families seeking medical care at one of Health Leads' fifteen clinical partner institutions. Families then complete a pre-visit survey to screen for unmet resource needs that a healthcare provider then addresses and refers to Health Leads. In-office, volunteer Health Leads' Advocates assist families in accessing basic resources like food, clothing, fitness programs, and housing. Health Leads Advocates then follow up with families and provide updates to the healthcare provider (Social Impact Exchange, 2016). This method helps healthcare staff devote more time to patient coordination and care by providing supplemental staff trained in community resources to make linkages.

Early Intervention and Secondary Prevention Services

Community Meeting Place Approach
Example: This method is applied when influencers and leaders in the community promote awareness of certain health conditions and educate other community members on health and condition management, serving as a resource directing communities to primary care services and lifestyle changes when needed. A recent cluster-randomized trial of blood-pressure reduction in black barbershops concluded that health promotion by barbers resulted in lower blood-pressure rates among black male barbershop patrons when coupled with medication management (NEJM, 2018). The control group consisted of barbers who encouraged lifestyle changes or referred customers with high blood pressure to physicians. In the intervention group, barbers screened patients, then handed them off to pharmacists who met with customers in the barbershops. They treated patients with medications and lifestyle changes according to set protocols, then updated physicians on what they had done (Carroll, 2018). In another example, doctors trained hair stylists to quiz 400 of their customers on stroke knowledge, talked with them as they did their hair, and then sent them home with wallet cards explaining stroke warning signs. Other groups have used beauticians to raise awareness of breast cancer and mammograms (The Associated Press, 2015).

Chronic Illness Self-Management Services

Prevention Services Initiative
Example: The prevention services initiative promotes prevention services delivered in community settings by accelerating partner implementation of 18 evidence-based interventions that target 6 high-burden conditions (i.e. tobacco use, high-blood pressure, associated infections, asthma, unintended pregnancies, and diabetes) (CDC, 2016). The PSI model will promote these prevention services by combining innovations in clinical healthcare delivery, payment reform, and population health strategies to support investments in prevention and community health improvement (CT PSI, 2018). Technical assistance will allow CBOs to: 1. Have a clear sense of their strengths, gaps, and goals as well as their

pathways for improvement, 2. Have improved capabilities and readiness to implement the Prevention Service Initiative Linkage Model with one or more healthcare providers (which includes developing a formalized referral process and workflow), 3. Deliver effective and financially sound prevention services, 4. Contract with at least one healthcare provider; and 5. Implement the contracted services, monitor progress, and assess gaps in processes (CT PSI, 2018). Seven Connecticut healthcare organizations and seven community-based organizations (CBOs) have been chosen to participate in Connecticut SIM's Prevention Services Initiative (CT PSI, 2018). The CBOs and healthcare organizations are receiving technical assistance to enter into new contractual agreements for CBOs to provide community-and evidence-based diabetes self-management or asthma home visiting services (CT PSI, 2018). The list of partnered organizations can be found here.

Complex Care Coordination for High Risk Patients (often with SDOH needs)

Community Care Teams

Example: Community Care Teams (CCTs), or community health teams (CHTs), are locally based care coordination teams employed to manage patient's complex illnesses across providers, settings, and systems of care (CHCS, 2016). While the structure of CCTs may vary by state and by community, CCTs generally incorporate a range of clinical and non-traditional health providers such as community health workers, peers, and navigators (CHCS, 2018). Care team members are deployed after information about a patient is sent between a clinical and non-clinical service, with special attention paid to transition care (CHCS 2016). CCTs help coordinate care between primary care providers and community resources to help providers deliver quality-driven, cost-effective, and culturally appropriate patient-centered care (CHCS, 2016). Connecticut is implementing Community Care Teams in several hospitals throughout the State. The Connecticut Hospital Association has formed a CCT coalition of service providers that meet regularly to review patient outcomes and identify frequent Emergency Department utilizers. After obtaining a Release of Information form from the patient, they develop an Intensive Case Management (ICM) plan for each patient and connect the patient to community-based services.

Case Study: Middlesex County Community Care Team is comprised of thirteen community agencies that specialize in the delivery of care for patients experiencing substance abuse and mental health disorders. The MC CCT team is comprised of members of Middlesex Hospital and Middlesex County Community Behavioral Health and Social Services. At a typical CCT meeting, the MC CCT discusses 10-20 patients per meeting (Middlesex Hospital, 2017). They come to the table having researched patient histories and psycho-social backgrounds and share outpatient and inpatient utilization, access to care issues/gaps, housing status and options, insurance status, and arrests/legal issues during the meeting (Middlesex Hospital, 2017). The team then brainstorms the best care management strategy, and collaboratively develops customized care plans. Follow-up is an ongoing, long-term process, and the team reviews progress and revises care plans as needed (Middlesex Hospital, 2017). The MC CCT measures impact metrics (number of ED and inpatient visits pre- and post-intervention) and cost and tracks the number of patients who have received care as well as their diagnosis category, gender, race/ethnicity, age distribution, insurance status, and housing status (Middlesex Hospital, 2017).

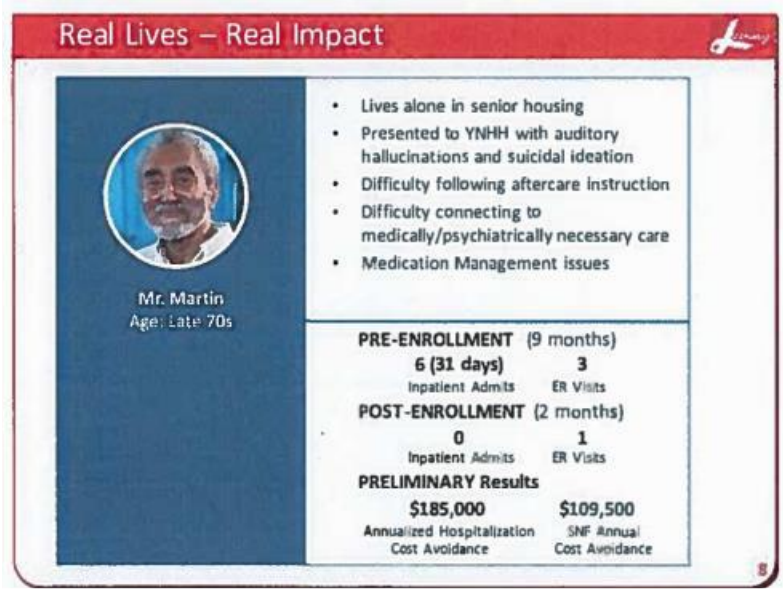
Case Study: Community Care of North Carolina (CCNC) has an established partnership between Medicaid, primary care physicians, and other local health care providers to achieve quality, utilization, and cost objectives in the management of care for Medicaid recipients (CHCS, 2016). Each CCNC network includes a local steering committee for oversight functions and is comprised of a diverse range of stakeholders, including primary care providers, hospitals, public health offices, social service agencies,

specialists, home health providers and school districts, all of whom work together to provide the best care for patients in need (CHCS, 2016). CCNC prioritizes patients who have higher hospital costs, ED visits, and readmission rates, and identifies patients in need through physician referrals, claims data, screenings, and chart reviews (CHCS, 2016). As a result, the CCNC avoided costs amounting to nearly $1 billion between 2007-2010, North Carolina is the only state with consistent declining growth rates in medical spending over a decade (including a visible decrease in emergency department visits and hospital admissions and readmissions), CCNC now ranks in the top 10% of health plans for managing diabetes, asthma and heart disease, and has successfully reduced waste and duplication (CCNC, 2018).

Leeway Community Living Model

Example: Building on Leeway's strength supporting health and well-being in the Greater New Haven area and through partnerships with diverse community stakeholders, Leeway's Community Living Model supports informed choice for individuals at risk for long-term skilled nurse home placement. Leeway was awarded a $2.7 million diversification grant from the Connecticut Department of Social Services (DSS) to demonstrate an effective Community Living Model (CLM) supporting patients with serious chronic illnesses post-acute hospitalization successfully reducing skilled nursing home placements. In 2016 Leeway facilitated a series of comprehensive community focus groups to co-create and develop a plan to implement an Intensive Community Case Management program. In October 2017, Leeway Community Living Model was launched. Leeway has had outstanding success to date with reducing admissions to skilled nursing homes and reducing frequency of hospital admissions and emergency room visits.

Case Study:



Leeway Community Living Model is a cost-effective team care model that has proven to improve the health of adults living with medical conditions by working with individuals in their homes and in their communities to manage complex health care needs, track changing care needs, and leverage needed social services. Specifically targeting individuals with multiple chronic diseases, the Leeway coordination care team is anchored to the primary care physician group to identify patients at high risk for hospitalization and/or nursing home placement. The core team begins their work with a social worker and registered nurse conducting a home visit and gathering a comprehensive medial and psycho-social

assessment from the medicine cabinet to the kitchen cabinet. Based on the findings a larger multidisciplinary team including a pharmacist, recovery coach, and registered nurse creates an individualized care plan consistent with what matters most to the patient.

Outcomes:
Yale University PhD statisticians have completed multiple statistical analysis demonstrating statistically significant relationship between program indicators. The data analysis demonstrates the strength of this evidence-based program:

- Supports the program is effective across multiple demographics and all participants benefit from the program equally across race, gender, and age
- Corroborates that the older a member is and the longer a member is engaged in the program, the more emergency room utilization decreases
- Demonstrates significant relationship between length of time in the program and increased savings per month. Typically, for individuals with multiple diagnoses the cost of care would go up. The longer in-service care, the higher the savings normalized by month.
- Reveals stable housing is significantly related to cost savings

For full statistical analyses, see the Appendix.

Medical Respite
Medical respite care is used to provide acute and post-acute medical care to high risk, homeless individuals who are too ill or frail for recovery from physical illness or injury without support, but are not ill enough to require hospital care. Medical and support services are provided within a short-term residential care facility that allows individuals to recover in a safe environment (National Health Care for the Homeless Council, 2016). Healthcare services may include care coordination, patient navigation, medication management, Medication Assisted Treatment, and self-management education.

Case Study: Yale New Haven Hospital partners with Columbus House to provide post-hospital care for homeless patients. Since 2013 the twelve-room facility at Columbus House has provided patients with three meals a day, housing case management, patient navigation for care coordination, medication management and other support services. Patients are identified and interviewed at YNHH and then a multi-disciplinary team collaborates to create a plan for the patient. Cases are reviewed weekly at care team meetings post transition to Columbus House. Success of the program include a reduction in 30-day readmission rates, reduced ED/observation re-visits, reduced hospital length of stay, and cost savings (Medical Respite Care: Reducing Readmissions, LOS, and ED Visits of People Experiencing Homelessness, 2017).

Clifford Beers Advanced Care Coordination (ACCORD)

Clifford Beers' home-based Advanced Care Coordination ("ACCORD") is a solution for individuals and families living with a complex mix of issues spanning physical, mental, and social determinants of health. The service is delivered by highly trained care coordinators and community health workers who are backed by an in-house multidisciplinary team including psychiatrists, social workers, and medical consultants. Key hallmarks of ACCORD service delivery include (1) involving and caring for *the patient's entire family* as needed, (2) using a mental health/trauma lens that recognizes and can address how adversity affects physical health and wellness, (3) collaboration with the patient's natural support

system (family, clergy, community groups), and (4) a keen cultural awareness that understands how individual circumstances can become barriers to care.

Outcomes

Following a three-year ACCORD-driven pilot, (funded by a $9.7 federal innovation grant), Clifford Beers served 1,943 highly complex individuals from 588 families, and, following discharge, 72% of parents were activated to manage their child's health while 58% were activated to manage their own health. All conditions were addressed with an integrated mental/physical/social wellness approach; patients presented with a complex mix of conditions including diabetes/pre-diabetes, depression, serious emotional disturbance, asthma, hypertension, heart disease, obesity, substance abuse and COPD.

Screenings were done in a setting most convenient for the individual and/or family (e.g., in the primary care setting, in the home, or at community-based location designated by the patient). Screeners pinpointed issues to be addressed and promoted warm hand-offs between providers. Note: Primary care providers can be trained in using these screening tools in their practices.

ACCORD cost analysis is promising. In the pilot, inpatient hospitalization costs decreased significantly – by 60%. In contrast, pharmacy costs rose slightly to indicate patients are securing -- and using -- the medicine they need to manage their health. In the pilot, before enrolling in care the spending per family was *increasing by $101 each month*, but spending per family post-enrollment *reduced by $83 each month.* (Exponentially, the spending gulf widens and becomes increasingly significant over time in a true breakaway from the traditional bell curve.)

Although enrollment in care lasted six months on average, individuals and families were projected to sustain for at least the next 1.5 years, and savings on health care spending was similarly predicted.

In the pilot, enrollees had very positive experiences. Following discharge, 81% said they were *very satisfied* with care and 18% said they were *satisfied*.

Support for Patients with Acute or Chronic Medical Risk at Home

Community Paramedicine

Example: Community paramedicine (CP), also referred to as Mobile Integrated Health (MIH), expands the role of paramedics and emergency medical technicians (EMTs) with the goal of improving access to care and serving as an extension of the primary care team. Community paramedics aim to enhance patient care and outcomes, provide ongoing treatment within the home to keep patients in their home, help lower preventable emergency room visits and readmissions, and reduce costs for hospitals, insurers, and patients (NGA, 2017). Community paramedics are supervised by trained clinicians through teleconsultation and receive the education and training to be able to provide SDOH-risk patients the care they need (i.e. primary care, behavioral health assessments, post-discharge follow-up care, health education, medication management, and patient referrals) (NGA, 2017). CPs help lower ED visits and healthcare costs and can reach SDOH-risk patients in the comfort of their home. A recent Connecticut Senate Bill 317 was passed that allows paramedics to provide patient care when ambulance transportation is not needed. The legislation established a pilot program allowing paramedics to provide the expanded medical care they are trained to administer, rather than being limited to transporting patients to a hospital (New Haven Register, 2017). Connecticut now has a Mobile Health Integrated

workgroup which has recommended several options for community paramedicine including the following uses (MIH Sub-Committee, 2018):

- Use of alternative destinations, or licensed medical facilities (which include urgent care, orthopedic, or other specialists)
    - Should be regulated by DPH and have an affiliation with an acute care hospital to promote continuity of care and communication for quality oversight, patient navigation, data collection and management
- Decreasing the likelihood of re-admissions by filling in coverage gaps
    - Focused on patients at high risk for readmission due to medical needs and non-compliance where medical management strategies can be augmented by EMS MIH protocols
- Non-emergent or primary care treatment of high utilizers of EMS services
    - High utilizers identified based on universal threshold such as number of calls to EMS per month
    - Cross-stakeholder collaboration to review cases, identify patient needs, and link patients to appropriate resources
- Hospice revocation avoidance
    - Universal standardization of discharge plans will help improve identification of those at high risk and communication between various care providers
- A regional, structured nurse triage system integrated with Emergency Medical Dispatch programs
    - Identify low-acuity users of 911 system and non-emergent patients who may later be at risk for readmission and link to appropriate services
- Wellness, Safety & Prevention
    - Incorporation of paramedics in vaccination clinics and other wellness screenings as adjunct practitioners working with other healthcare practitioners as appropriate

Case Study: Between 2014 and 2015, the Massachusetts-based Commonwealth Care Alliance (CCA) piloted a community paramedicine program, Acute Community Care (ACC), to serve its members in the Greater Boston area. The CCA partnered with the EasCare Ambulance company and the Massachusetts Department of Public Health to dispatch paramedics to patients who called the CCA's urgent care line after business hours or were identified by CCA clinical staff (CHCS, 2016). On-call clinicians (typically nurse practitioners or physician assistants) assess whether callers are appropriate for an ACC paramedic visit, and, if dispatched, ACC paramedics visit patients in their homes to provide assessment and treatment, and concurrently communicate with primary care teams (CHCS, 2016). The ACC has been effective in diverting use of emergency services and helping patients remain in their home while receiving quality care. A business case analysis found that CCA accrued significant savings of $538 per patient per month by preventing unnecessary ED utilization (NGA, Community Paramedicine Models).

3. Tracking referrals and outcomes

Care team members track referrals to community-based services and whether patients have accessed them. Networks track how purchased services are being used and changes in target outcomes, such as ED utilization, readmissions, costs, and reduction in social determinants of health risks.

Intended Outcomes (CHCS, 2017)**:**

- Highlight social determinant needs of patients
- Increase access to prevention and primary care services in community-based settings

- Expand the capacity of the primary care team by extending primary care services into the community
- Lower emergency department (ED) visits and readmissions amongst high-risk, low-income patients
- Improve long-term health outcomes
- Improve management of chronic conditions
- Increase capacity for and access to CBOs providing non-healthcare services
    - Payments may not go to CBOs who provide non-healthcare services but will go to CBOs connecting patients to non-healthcare services. If CBOs provide both types of services, PCM would support the linkage functions. Therefore, the PCM payment has potential to increase capacity/access to those CBOs providing these services, which is particularly beneficial for grant funded CBOs.

Consumer Input, Questions and Concerns: *Updated based on feedback from Design Group 1*

- Transportation barriers
- Access to community-based services
- Improvement of health outcomes particularly in low-income communities
- Help for patients in navigating available/affordable resources
- Religion/language barriers and other cultural differences
- Addressing a variety of support services beyond traditional medical care (i.e. mental health services, nutritional services, etc.)
- Need to define how Community Based Organizations (CBOs) will be identified and what their roles will be
- There will be gaps in what community services are available depending on geography and need for capacity building in those areas
- If primary care practices are doing needs assessments largely based on those accessing care, we might exacerbate disparities for those who don't seek care. Attribution methodology needs to address this.
- SDOH screening needs to be culturally appropriate and provided by the appropriate care team member

Health Equity Lens:

- Provides a better understanding of a patient's health and environment who is living below the FPL, in a poverty-stricken community, in a food-insecure household, is unemployed, is subject to domestic abuse, experiences religion, race, and language barriers, is currently homeless, and the like.

Implementing the Strategy

HIT Requirements:

- Electronic Medical Record system that captures SDOH risk assessment results in an exportable format

- Electronic Medical Record system that captures referrals to community-based services and encounters that happen within the community

Implementation Concerns (CHCS, 2017)**:**

- Communicating appropriately with patients about SDOH to avoid jeopardizing patient/provider relationships.
- Building an adequate referral network of agencies that offer expertise, services, or resources that effectively address identified social needs and keeping resource lists updated
- Integrating electronic assessment tools and resource inventories appropriately into existing EHR systems.
- Organizations who may need assistance in forming partnerships with social service agencies, developing strategies to align their systems, and building a streamlined referral process to track and deliver comprehensive resources to patients with complex needs.

Example Scenario: A single mother of two, living below the FPL and in a food-insecure household with diabetes, checks in to her primary care provider's office. While waiting to see the doctor, she is distributed a social determinants of health screening tool. A Community Health Worker (CHW) trained in SDOH assessments and community linkages reviews the patient's SDOH risk and enters it into her electronic health medical records. The CHW connects the patient with a local food pantry and an organization in her community offering diabetes self-management courses. The CHW calls the patient the following week to confirm that the patient was able to access the community services.

Impact

Aim	Summary of Evidence
Health promotion/prevention	Evidence suggests that population health improvement will rely on continued and enhanced collaboration between the healthcare and human services sectors (CHCS, 2017). Community-based services that promote prevention, like the services provided by CBOs participating in PSI can increase use of preventive services and improve self-management for chronic conditions.
Improved quality and outcomes	***Readmissions:*** A recent Community Paramedicine case study showed a pilot program in five California communities reduced hospital readmissions within 30 days of discharge across most pilot sites. Only one site that served only heart failure patients and provided less intensive services than the other post discharge pilot sites produced dissimilar results (CHCF, 2017). ***Health outcomes:*** A randomized clinical trial evaluating the health outcomes of a pediatric social needs navigation program showed the program significantly decreased a families' reports of social needs and improved children's overall health status as reported by caregivers (JAMA Pediatrics, 2016). ***Health Equity:***

	A recent study found that a model integrating primary care with existing public health infrastructure (i.e., community-based resources) may promote greater health equity by addressing the unmet basic needs that low-income families disproportionally face (CPJ, 2012).
Patient experience	One study examining an interactive risk screening tool for families in a school-based pediatric clinic found that the majority (87%) found the survey easy to understand. There are limited studies evaluating patients' satisfaction with integrated community services like community paramedicine.
Provider satisfaction	One study addressing social determinants of health in a clinic setting found that the role of medical assistants (MAs) in identifying social problems and using CHWs in interventions led to lighter workloads for providers, leading to improved quality of care for patients (JABFM, 2015).
Lower Cost	One study of a program that connects high-risk patients to critical services (such as access to medical homes, housing, fresh food and nutrition, transportation, and social support for transitions back to the home) in San Diego demonstrated success at reducing patient readmissions. Patients referred to the CI program experienced a 9.6% readmission rate compared to a 30% rate in a comparison group. The CI program provided a return on investment of roughly $17,562 per inpatient admission and $1,387 per ED admission, with higher returns for uninsured populations (CHCS, 2018).

APPENDIX

Learning from Others

***Case Study*:** Project Access NOW, or PANOW, connects individuals in Portland, Oregon to needed paid community-based services along with social services to ensure safe discharge from emergency and inpatient hospital settings. Since 2008, PANOW has partnered with local health systems, hospitals, and CCOs to: (1) provide uninsured low-income community members with primary and specialty care; (2) pay health insurance premiums for people who qualify for coverage under the Affordable Care Act, but cannot afford their premiums; and (3) connect low-income people being discharged from the hospital to non-medical resources to help them get home safely and ensure access to follow-up care via the program known as C3CAP. In addition, PANOW's Pharmacy Bridge Program offers prescriptions at no cost or with low-copays (CHCS, 2018).

Results

- Since its inception in 2014, PANOW's C3CAP has served more than 17,000 clients, and filled more than 26,000 requests (CHCS, 2018).
- C3CAP program costs are roughly $638,000 per year, while the program helps to avoid nearly 740 inpatient days annually, saving an estimated $2.78 million (CHCS, 2018).

- Through C3CAP, hospitals and CCOs have access to a secure, electronic referral system, which serves as a screening and monitoring tool, and allows frontline hospital staff to connect eligible patients with vouchers for an array of services and programs to meet their needs (CHCS, 2018).

Lessons Learned

- It's important to maximize trusted partnerships with vendors for the program to run smoothly (CHCS, 2018).
- An automated request system (on a secure web-based platform) that allows providers to submit requests at any time is key to tracking patient utilization and associated costs and monitoring community needs (CHCS, 2018).
- Estimating program cost and financial stability is difficult since PANOW must renegotiate contracts with each health care partner on an annual basis (CHCS, 2018).
- Demonstrating avoided hospitalizations and associated costs is also difficult due to external factors, but is key in ensuring PANOW's sustainability (CHCS, 2018).

Additional Reading:

Addressing Social Determinants of Health in Primary Care-Team-based Approach for Advancing Health Equity. The EveryONE Project. The American Academy of Family Physicians. 2018. https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/team-based-approach.pdf

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PCM Community Integration Design Group Meeting 1 09/17/18

Participants: Anne Klee, Maria Dwyer, Raffaella Coler, Jeannette Weldon, Linda Green, Terry Nowakowski, Denise Smith, Mark Schaefer, Alyssa Harrington, Ellen Bloom, David Wasch, Kimberly Turner, Heather Aaron

Summary of Design Group 1 Feedback: Approach

- Requires process for how networks and practices will identify gaps in care and services
- Requires process for how CBO network will be identified
- Practice should identify needs beyond just population seeking care
- Need way to monitor that primary care CBO linkages are happening and impacting outcomes
- Networks would not contract with CBOs providing non-healthcare related services, but could contract with CBOs that connect people to those services
- All practices should screen all patients for SDOH needs

Summary of Design Group 1 Feedback: Consumer Input, Questions and Concerns

- Need to define how Community Based Organizations (CBOs) will be identified and what their roles will be
- There will be gaps in what community services are available depending on geography and need for capacity building in those areas
- If primary care practices are doing needs assessments largely based on those accessing care, we might exacerbate disparities for those who don't seek care. Attribution methodology needs to address this.
- SDOH screening needs to be culturally appropriate and provided by the appropriate care team member

Meeting Notes

Community Integration Definition and Recommendations

1. Consumer Needs
    a. Patients and families need a variety of support services beyond traditional medical care
    b. Support navigating the healthcare system, making lifestyle changes, connecting with other providers, coordinating care, managing chronic conditions
    c. Support services beyond traditional medical care that connect patients with affordable solutions and community resources
    d. Improvement of health outcomes particularly in low-income communities
    e. Care and care teams that address religion/language barriers and other cultural differences
    f. Support securing transportation and child care for in-office visits and/or alternative ways to access care

2. What are we missing?
    a. Ralph: How do we evolve EMS system? How do we better utilize EMS for non-emergency transports?
3. Community Integration
    a. Extends primary care services into the community and connects patients to community-based services for patients with high-risk, social determinants of health needs, and/or chronic conditions
        i. Denise: If these are contracts, these are closed network→ how are organizations going to be identified? Is this based on a geographic area with a focus on prevention? What else are we looking for community organizations to bring to the table?
        ii. FHC: Advanced Networks and FQHS that are currently participating in a shared savings arrangement with payers (rather than single networks)
        iii. Denise: Is the expectation that one organization is going to be able to respond?
        iv. FHC: Not a single organization.
        v. Denise: How are these organizations identified by primary care?
        vi. FHC: The network would need to work with the practice to determine needs assessment.
            1. Denise: Consider in certain geographic areas that you are going to have a lack of available services (diabetes management, mental health support groups)→ once there's an identified need, there may be some capacity building in the community needed (gaps in services available depending on geographic areas)
            2. Denise: If the assessment is largely based on those accessing care, we can exacerbate disparity for those who don't seek care (particularly men of color)
                a. Communication directly with CBOs for those not seeking care (data collection by practices is necessary)
        vii. Have multiple venues or at least more than one avenue to do the assessment
        viii. Mark: Distinguish the two grey boxes in diagram
            1. FHC: 1. In-home services or community delivers PC services; 2. people are linked to community-based services within medical settings
            2. Mark: Health Leads model use students or interns but could also be community health workers, they work within the primary care setting
                a. They are on-site
            3. Terry: What kind of information system technology is monitoring this?
            4. Assess and monitor ED visits, hospitalization, post hospitalization appointments→ a robust electronic system that helps produce data
                a. We have a reporting mechanism as well.
                b. We do a year look-back and can conduct comparative analysis with patients
            5. FHC: Do you share this with the primary care providers you work with or do you have the same EHR system as them?
                a. We use EHR and our APRN is able to connect with providers

6. Denise: UPenn impact model
    a. FHC: We will look into this
7. Mark: The clinical examples were biased to picking CT-based examples
8. Mark: FQHCs also have a method of tracking
9. Mark: If someone needs services that are not primary care in nature (healthy food or housing), the network wouldn't be contracting for those services they would either work with a CHW or contracting with a Health Leads organization
    a. Where does this fit into the diagram?
    b. Links to community-based services in primary care
        i. Primary care is doing the link to those community-based services→ call it links to community-based services and reports
        ii. Terry: Feedback loop is important from consumer and provider perspective
            1. FHC: Annual survey?
            2. Terry: No, someone that manages the network.
            3. Denise: How CBOs will be brought in and what the network is going to look like→ to what extent are these initiatives going to really address SDOH risk patients not seeking care.
            4. FHC: How do we do those assessments? Needs-based and ongoing?
        iii. Mark: Payment Reform Council's work: the primary care modernization is focused on patients attributed to a network; being not attributed means you don't end up on an over-use of ED score card
            1. You don't allow people to be unattributed.
            2. Denise→ Why would somebody try to extend into the ED to try and get these patients needs met? Mark: Get these people auto-assigned and they get put on a provider's roster.
            3. Mark: Paying for housing, food, cell phones→ not clear that we are trying to solve for a service is care-related (unsure if we can imbed non-health-related activities, suspect the feds will say this is part of the shared-savings) Build-in of community supports = skeptical

4. Social Determinants of Health Screening
    a. Should all practices be required to screen for SDOH?
        i. Terry: Yes.
        ii. Mark: Targeted screening is preferable to non-targeted screening because it takes admin time and energy to screen for anything
            1. Broad-based universal screening vs. targeted screening

2. In the absence of a health problem- is it the role of primary care to screen for SDOH risk?
3. Terry: Isn't the point of this to screen for whole health outcomes?
4. The ACC intervention is focused on screening for risk focused on acute to chronic illness and injuries
5. FHC: There should be SDOH screening even for people who may not appear high risk to work towards healthier lifestyles
6. FHC: What networks resources are needed to enable this? Screening tool? EHR that can capture this?
7. Terry: When someone gets attributed to a network, do they have to fill out info about themselves and where they are in their life?
    a. FHC: Get attributed based on PCP they've been seeing or if they visit an ED
    b. FHC: There's a need for patient engagement outreach
    c. Denise: We must be careful how you find these people or who approaches the individuals → concern over engagement and initial introduction
    d. Denise: Her phone Once our staff go into the home→ they're welcomed, an assessment is done and then a social worker does a psycho social assessment
    e. FHC: So, there's a need for the care team to do an outreach to the patient
    f. FHC: Approach we need to make sure we are considering?
        i. Denise: Who is that point of contact for the SDOH assessment and where it takes place? Needs to be culturally appropriate
        ii. Denise: Understanding the capacity of the CBOs is important
        iii. Denise: Training CHWs is also a certification process and unsure if this should happen in primary care
            1. Better to have a CHW to do it than a PCP

PCM Community Integration Design Group Meeting 2 10/12/2018

Participants: Vinayak Sinha, Alyssa Harrington, Judy Levy, Pano Yeracaris, Alice Ferguson, Russell Barbour, Raffaella Coler, Maria Dwyer, Denise Smith, Kim Haugabook, Anne Klee, Mark Schaefer, Stacey Durante

Summary of Design Group 2 Feedback:

- We clarified that PCM payments will not go to CBOs who provide non-healthcare services but will go to CBOs connecting patients to non-healthcare services. If CBOs provide both types of services, PCM would support the linkage functions. Therefore, the PCM payment has potential to increase capacity/access to those CBOs providing these services, which is particularly beneficial for grant funded CBOs.
- Programs that train community members to provide brief education and connections to health services for their customers should delineate topics community members should cover and which should be discussed with healthcare professionals
- PCM should encourage community programs to leverage EMS as appropriate
- Payments to networks should support innovative pilot community placed services as long as they collect quality and cost data as well as established evidence-based services
- Social determinants of health screening should be universal with more targeted screenings depending on results

Summary of Design Group 2 Feedback: Consumer Input, Questions and Concerns

- Networks should respond, via partnering with CBOs, to community needs, not just their specific patient needs as this can exacerbate disparities
- Need to be inclusive of a variety of community organizations to connect their members/clients to healthcare, such as churches, barbershops, community centers, etc.
- Need to evaluate disparities in care to provide access to appropriate community placed services
- Need to establish a baseline of community health to understand whether services are meeting needs of patients
- Non-medical meeting places should not be burdened as healthcare hubs, but rather be sources for information connecting to healthcare services *(electronic feedback)*

Meeting Notes

Summary of last session

- Information missing from summary:
    - None

- Consumer: What if a CBO that is connecting patients to non-healthcare related services (paid for via PCM) also provides those non-healthcare related services?
  - State: The network could contract with organizations that provide non-healthcare services, but they would have to purchase coordination functions, not the actual non-healthcare services because they're not healthcare services
  - Consumer: This funding would allow the CBO to continue the program, therefore these coordination payments can potentially provide capacity building funds, particularly beneficial for grant funded CBOs

Types of Services and Examples of Models

- It was highlighted that associations for community-based organizations would be funded by the supplemental bundle as decided by provider networks

Chronic Illness Self-management Services

- CT SIM Prevention Services Initiative example:
  - Goal is to utilize services provided by existing community-based organizations rather than having networks create these services as this will be more costly

Community Placed Navigation or Linkage Services

- Health Leads
  - Outcome: Improved health outcomes
- Project Access
  - Outcomes: Reduced wait times, increased show rates for medical appointments, improved health and quality of life, increased ease of getting care, high program satisfaction

Early Intervention and Secondary Prevention Services

- Barbershop program
  - Community members trained to support the healthcare of individuals
  - Outcomes: Improved health outcomes
  - State: Are individuals placed in these establishments or are employees provided training on healthcare in addition to the services they're providing?
    - FHC: The employees would receive training and help educate clients as they're trusted members of the community. They would then be able to link clients to services.
    - State: How does this training work? At they reimbursed for this training? How do we know they're qualified to conduct these discussions/referrals?
      - State: We are not necessarily endorsing any particular program, but rather enabling networks to contract within the community with organizations using evidence-based approaches to improve population health
  - Provider: Mind Stylez is an example of another program that does similar work in the mental health space

- State: "Community members are trained to screen" – wording sparks caution around enabling lay people to perform healthcare duties

Complex Care Coordination for High Risk Patients (often with SDOH needs)

- Community Care Teams and Leeway Community Living Model
- Community Organization: Leeway teams consist of nurse, pharmacist, recovery coach, APRN, and community health worker
    - State: Any thought on having EMS on the care team?
        - Community Organization: There is place for EMS to fit since the model is scalable and adaptable

Support for Patients with Acute of Chronic Medical Risk at Home

- Community Paramedicine/Mobile Integrated Health
    - Goal: Provide services in the home to reduce ED admissions and cost of patient treatment
    - State: There are other outcomes being considered as well, particularly around paramedic communication with primary care to enhance patient outcomes, not just reduce ED utilization

Discussion:

- Should networks have the option of requesting they use a portion of the supplemental bundle for these services?
    - State: Agree
    - Community Organization: Incentives for networks to contract with CBOs?
        - FHC: Allows network to connect patients to services they may not already provide, without needing to build infrastructure for these services
        - State: The pressure for accountable care organizations to achieve quality and cost effectiveness goals is mounting and therefore PCM would potentially provide money for networks to improve health
        - State: List of functions endorsed by community paramedicine group should be included
- Are these the right kinds of services to provide as examples of how to use supplemental payments?
    - None
- Do networks need to demonstrate the community placed service is evidence-based service or should they be allowed to pilot programs (with requirement that they collect quality and cost data)?
    - Payer: It would be important to allow for creativity and pilots as long as data on quality and cost is collected.
    - State and Community Organization: Agreed
- Should SDOH screening be universal (especially if it is used for adjusting the supplemental bundle for illness severity and SDOH needs)?
    - State: Would want a universal screening process and then target specific populations to improve health based on screening

- What are ways to monitor adequate access to community placed services and services are meeting needs of patients?
    - Community Organization: Leeway conducts qualitative research in the form of surveys and interviews to assess whether patient needs are being met
    - FHC Expert: Could evaluate disparities in care via NCQA or HEDIS measures to understand which models are able to alleviate healthcare disparities and support patients who have not been able to avail of needed services
    - Consumer: There needs to be a baseline to understand how the programs are impactful, such as understanding language access. Networks should be able to respond on community needs, not just their specific patient needs as this can exacerbate disparities.
    - FHC Expert: Worth thinking about what data should be collected to inform CT state agencies. Rhode Island is using a few screenings to understand community health and enable to set a baseline. Ex: Transportation, housing and food insecurity, prescription funding, domestic violence, etc.
- Changes and improvements to concept map for community integration?
    - None