

## Community Integration Design Group 2

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### 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? Are 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 or 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