

Shared Governance & Community 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 including this convening responsibility 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.

Description: The Shared Governance & Community 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 shared governance 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 Governance Development Process:

1. Transformation vendor responsibilities
2. Identify and convene stakeholders impacted by the governance model in defined area(s)
3. Develop standardized protocols and processes for network linkages to shared services
4. Implement continuous assessment and improvement process

Detailed Shared Governance Design Standards for Technical Assistance Vendor:

Standards

1. Transformation vendor expectations -

- The transformation vendor develops policies to ensure the shared governance 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
 - Goals and objectives

2. Identify and convene stakeholders impacted by governance 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 governance 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 community collaborative, with facilitation by the vendor, identifies operational areas appropriate for standardization.
- The community 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:³
 - Solicits input from patients and consumers to ensure the needs of the community are reflected⁴

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 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); and management of referrals and systems for verifying follow-up appointments.

⁴ This includes ensuring that communications around processes for accessing needed services are culturally and linguistically appropriate

- Considers the capacity and capabilities of the healthcare and social service providers in the community⁵
- The community collaborative develops an implementation plan and process for proposed standardized processes and protocols across the networks and community partners

4. Implement continuous assessment and improvement process -

- The community collaborative holds regular meetings and forums to collect concerns and feedback on potential improvements
- The community 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 community collaborative will update and modify these protocols over time given the results of the analytics and the feedback from collaborative participants

⁵ 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.