COMMUNITY-CLINICAL INTEGRATION MODEL LESSONS

Waterbury Case Study

Development of a Community-Clinical Integration Model for Patients with Complex Medical and Social Needs

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EXECUTIVE SUMMARY

Fulfillment of social needs such as food and housing are essential to well-being. To improve population health outcomes and reduce health disparities, both medical and health-related social needs must be met. Community-clinical integration is a promising approach to care that addresses the wellness of the whole person, with attention to health and social needs of patients. The objective is to coordinate care delivery across a multi-disciplinary network of health care and community-based organizations. In this manner, patients' plans of care can be co-developed, and access to care is supported with closed-loop referrals, case management, and navigation to health care and community resources.

Community-clinical integration approaches are seen as effective tools for advancing health equity and addressing social drivers of health. Such initiatives can vary in focus; for example, some are aimed at early detection and disease prevention to improve population health. A model of community-clinical integration in Connecticut is community care teams, which tend to be centered on people who are uninsured and have complex and overlapping health and social needs. The care teams strive to better meet patient needs while reducing inappropriate use of emergency department services and financial losses from uncompensated care.

Connecticut Health Foundation has invested in community-clinical integration efforts since 2018 with research, seed funding and grantee technical assistance. This included funding for the Waterbury community care team. The investments are intended to encourage collaboration across sectors that serve a common client, to improve integration of care, to better address health-related social needs, and to improve health outcomes.

About This Report

This report provides insights into replicating, expanding, and sustaining community care teams in Connecticut.

This report examines several core components of the Waterbury community care team as a case example for those interested in community-clinical interventions. These components are:

- Service delivery and workflow
- Partner relationships
- Data and outcomes
- Focus on health equity
- Funding and sustainability

Lessons Learned

A backbone organization brings capacity that benefits the entire partnership. A backbone organization serves as a care hub and should be engaged for leadership, data, and administrative functions. Examples of the wide-ranging services needed are:

- Relationship development
- Data-sharing agreements
- Data tracking and reporting
- Care team convening
- Leadership development
- Communications

The role and responsibilities of the backbone organization must be a dedicated and paid role, as it is too much for other service-delivery providers typically to effectively add on to existing workloads.

Waterbury's community care team staffing model is worth emulating. The direct-care workflow was effective due to the backbone organization having employed (not contractual) case managers, having a case management supervisor with both medical and social work expertise, and a vetting process to select cases for enrollment and for the care team agenda. Other key roles included a full-time data manager, an advisory committee, and a consultant for cost-study methods.

An effective collaboration creates a culture that nurtures relationships, trust, and respect among collaborators. In the Waterbury community care team, success was attributed to consistent communication, support structure, shared goals, and accountability. These factors overlap with what stakeholders perceived as the core components of the service delivery and what helped the work endure over time.

Successful Partnership Factors

Regular communications and respecting and valuing input. Virtually all Waterbury stakeholders mentioned the care taken with establishing an environment for consistent and inclusive communication, valuing the input from all partners, and setting the expectation and accountability that care team attendees have opportunities to weigh in on patient care.

Support structure. Many people mentioned the value of an executive body with a vision, the coordinated use of assets within the care team, and the excellent capability of the backbone organization for adaptive, skillful, connective, and problem-solving project management.

Shared goals and shared customers (patients/clients). Care team partners were motivated to support a coordinated care process in part because they recognized their own clients would

have better outcomes as a result. Partners appreciated each other's accountability and commitment to their shared goal.

Leverage a broad range of partner assets. Successes were also attributed to the diversity of partners that brought varying experiences and expertise to apply to the collective effort. This was noted for both leadership committees and the care team.

Direct communications can overcome data technology challenges. Lack of data access, especially lack of integration across data systems, is a well-known challenge in cross-sector collaborations. The Waterbury community care team has a shared data system (not integrated) called Unite Us that is designed for community-based organizations. The shared platform is used to log referrals, services, and case planning with multiple providers across sectors. However, not all provider organizations could or did use the platform, and duplicate data entry within each entity was the norm.

The Waterbury community care team identified several data-collection and data-sharing solutions, such as getting case manager/navigator permission to access hospital electronic medical records, having a dedicated full-time data manager, and expanding the number of human service providers that use the shared data platform. The Waterbury endeavor also relied on a tried-and-true workaround: direct verbal communication among partners via care team meetings, impromptu calls, and secure email. Direct communication was effective in maintaining patient care coordination and overcoming data-system limitations.

Cost studies can and should be conducted. Most community care teams in Connecticut have not developed detailed or robust data to demonstrate outcomes on health and health-related social needs such as stable housing, connection to primary care, or reduced use of emergency department, or the potential cost savings associated with these changes. This type of data is required to demonstrate the effectiveness of the work, and to highlight the value brought by human service providers in cross-sector work. When cost studies can demonstrate positive results, hospitals can then become better positioned for increased payment rates for outcome-based care. For the Waterbury community care team, undertaking the cost studies required technical assistance on methods, investment in staffing, leveraging the shared platform data, and obtaining data from the two city hospitals.

Telling the whole story requires services, cost, and qualitative data. The Waterbury community care team documented several key data points regarding costs:

- 74% of enrolled patients had a reduction in costs
- The total cost of care was reduced by $1.7 million dollars
- Uncompensated care for patients was eliminated, which had been estimated at $291,185

In addition to patient service utilization, health status, and costs, the qualitative impacts for patients are critical to demonstrating the full impact of a community care team. Examples are

quality of life, shifts in health-related social needs, and ability to utilize community resources, manage one's health, and maintain independence.

Cross-sector collaboration, expanded access to care, and attention to unmet health-related social needs leads to greater health equity. Although achieving health equity may be too big for one initiative to claim, many Waterbury partners felt health equity was embedded in the programming with the intention to serve the most underserved people in the health system—those who are uninsured and have complex and overlapping health and social needs. The work was addressing health equity via its focus on people who have a significant volume of unmet health-related social needs in multiple dimensions—which in this case is men of color who are housing challenged. This approach aligns well with the Centers for Disease Control and Prevention's (CDC) description of how to address health equity in a community:

- Attempts to disrupt disparities with collective cross-sector efforts
- Designs programs and practices based on community needs and a health-equity agenda
- Removes barriers to secure access to health care
- Tackles the social determinants of health that affect health equity

The Waterbury community care team planned for sustainability from the start, providing a great learning example. Based on their experience, endurance of an initiative over a three-to-five-year horizon requires:

- Robust data that demonstrates intended patient outcomes are achieved
- Trust in the backbone organization, and demonstration of its strengths
- Deep commitment by partners and their attachment to a high-quality service-delivery model

However, longer-term sustainability will largely depend on the ability to:

- Fund, retain, and expand the staffing model, i.e., to allow for sufficient case management staff, a dedicated data person, and retention of the backbone organization
- Ensure consistent multiple-sources funding (including funding from hospitals)
- Secure a new value-based payment model

INTRODUCTION

Across the health care sector, there is growing recognition that-improving population health outcomes and eliminating health disparities will require more than clinical interventions. Social factors such as food and housing are critical to well-being, and improving health outcomes requires addressing unmet health-related social needs. Social factors like food and housing disproportionately affect people with lower incomes, and along with health behaviors, influence the majority of health outcomes in the United States.[i]

To better address the wellness of the whole person, many health care and social service organizations are considering community-clinical integration. This concept centers on coordinating the efforts of a multi-disciplinary network of health care and community-based organizations. While these models vary, hallmarks include having patients' plans of care co-developed based on assessments of social needs and other indicators, and using referrals, navigation to health care and community resources, and case management to ensure access to various modes of care, in order to improve health outcomes.

Proponents view community-clinical integration models as important tools in advancing health equity and addressing social drivers of health.[ii] Community-clinical integration initiatives can vary in the services provided and populations served and are frequently aimed at early detection and disease prevention, aid to people with complex and overlapping health and social needs, and those who frequently go to emergency departments. Typical community-clinical outcomes tracked include changes in patient health, access to care in both hospitals and through community providers, improvements in meeting social needs, and the intervention's return on investment to health systems.

Terminology: Social drivers of health (also known as social determinants of health) are the conditions impacting the health and well-being of communities. Social drivers of health and health-related social needs are sometimes used interchangeably. Unmet health-related social needs are directly related to poor health outcomes for individuals, while social determinants of health is a more apt way to describe population-level conditions.[iii]

About Community Care Teams in Connecticut

One model of community-clinical integration is known as a community care team. In Connecticut, this model is largely focused on people who are uninsured and have complex and

overlapping health and social needs.[1] The care teams strive to better meet patient needs while reducing inappropriate use of emergency department services and financial losses from uncompensated care. In addition to the outcomes listed above, care teams track access to primary care and preventable inpatient and emergency health care utilization.

The Waterbury Community Care Team

The Waterbury community care team aims to reduce hospital readmissions and emergency department utilization at two local hospitals, while improving patient care and outcomes, including health-related social needs. The project, which began in fall 2019, developed and implemented a citywide community care team that enrolls and provides patients with comprehensive case management and referrals to human service organizations. The project is led by the Greater Waterbury Health Partnership and operates with the following key partners: the Center for Human Development, New Opportunities, Inc., Saint Mary's Hospital, and Waterbury Hospital. Leadership for the initiative also comes from a steering committee and an advisory committee.

The community care team funding is from foundation, hospital, city, and state sources. This funding helps to cover the community care team's staff. Initially the staff consisted of the organization's executive director, part-time case managers, and associate director of case management. As the work scaled up, the staff grew to include two full-time case managers and a part-time licensed clinical social worker. The team also added a program manager, data analyst, and assistant director of programs and development, which in large measure were roles that had previously been filled by the executive director.

The care planning part of the team is a group of approximately 40 representatives from 25 agencies who serve many of the same patients or clients. They meet regularly to discuss clients' needs. As the backbone organization, Greater Waterbury Health Partnership employs community health workers, who provide patient navigation and case management.

The community care team served 46 patients from May 2020 to March 2023, of whom 42% were Black, 32% Latinx, and 26% white. Ninety percent were male, and the average patient age was 48. Potential patients were chosen by reviewing hospital records to find those with four or more emergency department visits in six months. Other criteria for inclusion included having housing challenges. Case managers then approached each patient with information about the program, and those who were interested signed a release and consent. The Waterbury community care team's work is ongoing.

[1] Areas where community care teams have been or are currently established in Connecticut include Bristol, Danbury, Greater Bridgeport, Greater New Britain, Greater Windham, Hartford, Manchester, Middlesex County, New Haven, New London, Norwalk, Norwich, Stamford, and Waterbury.

A note about terminology: Participating organizations differ in their use of the terms clients or patients, reflecting differences in standard terminology in health care and social services. For ease of readability, this paper will use the term patient.

KEY SUCCESS FACTORS

The Waterbury care team's essential offering is coordinated care between health and social service providers. Health and social service providers work together to address physical health, behavioral health, and health-related social needs for each patient. The Waterbury care team takes a person-centered approach to case management by examining the multiple issues that impact a patient's health, wellness, and quality of life. This approach helps identify challenges that are not readily addressed in a siloed, specialty-focused service-delivery system.

Discussed below are the core elements of the Waterbury service-delivery model as described by people who are deeply engaged in care delivery, staffing, or advisory oversight of the program. The success of the Waterbury community care team is due to its service-delivery and workflow approach.

"We provide a holistic approach for our clients…it's a person-centered approach. That's a human being in front of you. This is not a number." — Care Team Member

Strong and Frequent Interagency Communications

One of the key functions of the community care team is the care plan team meetings. Every two weeks, 40 health and social service providers meet virtually to review a subset of patient cases and to identify and understand concerns and exchange information. As a result of the 60-minute meeting, partners identify resources, solutions, and follow-up steps to meet the patient's critical needs.

Consistency in care meetings (i.e., meeting every two weeks at the same time) supported collaboration and caseworkers' ability to manage the cases. The relationships developed through these meetings helped to foster communication outside the meeting structure and enabled partners to bridge gaps in electronic data sharing when a partner did not have access to a shared data platform. Partners routinely communicated about cases outside the care planning meetings, allowing them to gather and act on updated information. This was critical because not all agencies had access to the same data platforms. Once the agencies established working relationships, complete with approved data-sharing and consents in place, verbal exchanges were sufficient in coordinating patient care.

Co-Developed Care Plans

For community care team patients, partner organizations work together to co-develop care plans. This process was deemed essential to effectively address the health-related social needs of patients who are dually diagnosed or have chronic illnesses. This requires engagement of multiple partners—both clinical and social service—convened on a regular basis. In a care plan

meeting setting, a variety of perspectives, insights, and resources can be leveraged for a collaboratively developed plan of intensive case management that addresses multiple facets of a patient's life.

One care team member noted that the collaborative nature of the care plan development also has the benefit of showing the patients that many people are providing support and care.

The Waterbury community care team provides a good example of engagement of a diversity of care plan partners to effectively manage case planning. Participation spans many local human service agencies, along with law enforcement, an opioid response team, state agencies, mental health, and substance abuse treatment providers.

Commitment From a Network of Partners

Care team partners were committed to the care process and dedicated time, new staff when turnover occurred, and consistent attendance at meetings. Accountability is also key; this means being forthcoming in care meetings, being accessible between meetings, exchanging new information in a timely manner, and providing accurate information to the best of one's ability.

"[An essential component] is that we have a core team [community care team] that has been really committed since the beginning…that the initial level of commitment has been passed on to newer members. I think it has made it a very cohesive group." — Care Team Member

"Having that hospital connection has been very, very helpful…. But having all the partners [staff] on the community care team has made a big difference. It enables us to get the help that we want for our clients quicker." — Care Team Member

Navigation and Intensive Case Management

Patient navigators are trusted community or health care providers who understand the health resources available, and support, educate, and assist patients to navigate the complex health care system. They help patients access quality health care by addressing barriers such as lack of insurance, lack of transportation, or poor health literacy.[iv]

Waterbury stakeholders cited patient navigation of health care systems and human service offerings as key to the success of their service-delivery model. To be effective, the case

management must be intensive and hands-on. Case navigators (case managers) in Waterbury described their work as "really on the ground." The work goes beyond connecting patients/clients to resources, to bringing them to doctor appointments or accompanying them to court. Material and physical support, advocacy, and modeling are core elements of the intervention.[v]

> *"It's all about the hands-on, the really getting out of the office, and really looking for these clients and making a connection." — Project Co-Lead*

The navigation also requires monitoring to ensure that patients receive appropriate care. In this way, the case management offers a closed loop on understanding patient needs, accessing resources, monitoring results, identifying the interplay between multiple social needs, and following up on any gaps.

> *"It blows my mind how deeply connected the case managers are with the patients, how much they know about them, how much the patients feel connected with the case managers. It's like they're family…just treating the patients with dignity. I think our case managers are great at that. And that they're real people. They're not just numbers on a roster." — Care Team Staff*

The Waterbury community care team's patient navigation and case management are delivered by community health workers employed by the backbone organization (community care hub, described in the next section). Community health workers' key roles are to build trust and relationships and enhance communication between patients and providers. They are care managers who tend to bring a shared language and culture, and a deep understanding of their communities through lived experience.[vi] The skill set brought by case managers was deemed by partners, advisors, and community care team staff as appropriate, robust, and efficacious to help stabilize the health and life circumstances of the patient. In addition, people highlighted the skill sets of the staff that supervise the case managers and the monitoring of patients. The supervisor of the case managers has both clinical and social work skills; this was seen as a strength because the combination of skills allowed for insight into prioritization of cases for the care plan meetings, use of partner organization resources to meet the patient needs, and monitoring of results.

The Waterbury care plan meetings are led by a lauded associate director of case management who brought years of experience as a licensed clinical social worker and registered nurse. The effectiveness of the work was also attributed to their personal characteristic of a highly motivated connector.

A Centralized Administrative Role

The Waterbury community care team's backbone organization, Greater Waterbury Health Partnership, managed functions that were instrumental for collaboration, such as coordinating leadership and advisory bodies, promoting and securing funding, developing and executing a data-reporting plan, managing data-sharing, disseminating outcomes, and hosting the care plan team meetings. The care plan meeting is a heavy administrative burden and must be well-orchestrated to bring together scores of partners to work in concert.

A core element and success factor of the service delivery model was the role of the backbone organization in supporting the providers, allowing them to focus on the care planning and delivery. Waterbury partners robustly praised the project management skills of the backbone organization and specified some of the features that helped the team be cohesive and high functioning: sound management of care meetings with identification of cases for the agenda, effective time management, and use of virtual tools to maximize participation. Meeting management included tracking and maximizing attendance, maintaining meeting communications, engagement of all organizations to attend, and orienting new agency staff after turnover. Having an efficient, well-managed meeting was cited as essential for good engagement and a fruitful discussion of care. One care team member noted that it would be easy to talk about a single client for a whole hour, so having someone ensure there is time to address many clients is essential.

The backbone organization for community care teams can vary. Greater Waterbury Health Partnership is a community health collaborative initiative that was founded prior to the community care team. Before the community care team, the Partnership convened local hospitals, federally qualified health centers, and community-based organizations on data collection and population health interventions. It also coordinated the regional community health needs assessment. Most recently, funding from a federal State Innovation Model grant supported the Partnership to develop its current structure as a health-focused convenor, data collector, and lead on local health-improvement projects. In 2021, the Partnership merged with Waterbury Health Access Project, a patient-navigation/case-management initiative. The merger increased staff capacity to provide case management for the community care team.

DATA ACCESS

Direct communications resolved data technology challenges.

When multiple organizations collaborate to serve the same clients or patients, it is critical to have ways to share data to ensure patient care is effectively coordinated and outcomes are documented.[vii] Tracking outcomes is often difficult because data is typically siloed and hard to share (often partners use different electronic health record systems that cannot be integrated). As a result, community care teams can expect to face difficulties in accessing, sharing, and managing needed data.

The Waterbury community care team's experience revealed that direct verbal communications across the care team provided a feasible and highly effective workaround that enabled care coordination, even when partners could not use a shared data system. Due to the lack of a shared database, the backbone organization hired a full-time data manager to analyze outcomes.

The table below summarizes significant challenges and potential solutions for data access, based on the Waterbury community care team's experiences.

Table 1. Community Care Team Data-Collection and Data-Sharing Challenges and Solutions

Challenges	Solutions
Difficulty enrolling people because they are reluctant to sign consent forms that give permission to share data.	Clear communications and use of trusted community health workers. Acceptance that not all who are approached will enroll.
Delays in hospitals executing data-sharing agreements.	Polite persistence. Accepting that hospitals have their own timeline.
Data management and reporting is difficult with multiple electronic medical records and data systems.	Sharing information directly at care team meetings can be more valuable than electronic data in understanding patient needs. Find easy ways to communicate with partners to stay up to date on the patient.
Hospital data limitations: ease of access, uniqueness of each data system, lack of access to granular data about services, service types, and outcome indicators.	Engage multiple hospitals and service providers to get a more complete picture of patient status. Get case manager/navigator permission to access hospital electronic medical records. Dedicate a full-time role to data management.
Lack of universal use of the shared data platform (Unite Us) by community providers. Lack of use by hospitals, federally funded state agencies, and housing provider.	Expand the number of human service providers that use Unite Us to help track the referrals and outcomes (closed loop). Accept and plan for duplicated data systems that document referral and activity.

A common concern for any coordinated service effort is the myriad data systems that contain relevant information about shared patients. In Waterbury, there was much concern early on about the consequences of having multiple electronic medical records that did not connect. Among the systems were different electronic medical record platforms used by two hospitals, and Unite Us, a platform tailored to nonprofits that was used by some but not all participating community organizations. Fortunately, the backbone organization's case managers/navigators had access to both hospitals' electronic medical records.

The Unite Us platform is available throughout Connecticut and helps track the services, referrals, and communications among providers. Providers can sign up to use the platform for free. The Waterbury care team experienced both challenges and successes using the platform. Partners found Unite Us beneficial for its notification feature, tracking ability, and ease of referrals, which led to an increase in referrals made.

"We developed a workaround…talking with people gets [clients] better connected to services than any documentation and electronic medical record." — Care Team Member

"It's not easy to get the data. We're working through that with data-sharing agreements but in an ideal world there would be some type of universal collection of data." — Care Team Staff

Challenges included trouble onboarding service providers to Unite Us and federal requirements that prohibit certain housing providers and state agencies from using such systems. A key limitation of Unite Us is its lack of use by hospitals (which could purchase a license). The barrier could be resolved if partners invest in integrating Unite Us software with health management information systems and various electronic medical records. Even human service providers that are in-network are challenged to use Unite Us because they typically have a large number of data systems that they are required by funders to use. The case managers use Unite Us to log a referral but then must also use the standard referral process that a provider requests; the process represents a significant level of manual data entry for community care team case managers.

OUTCOMES

The Waterbury community care team was deliberate in documenting the impact of its work to demonstrate outcomes and cost-savings.

> *"What we really want to do is for the client to have a better quality of life, manage their health better, and be a partner in their health." — Care Team Staff*

Given the complex social and health needs of community care team patients, the coordinated intervention can be expected to lead to many positive outcomes: patients become stabilized, maintain stable housing, and get connected to primary care or other services, as well as reduced use of emergency department and preventable hospitalizations and related cost savings to hospitals. Despite this, most community care teams in Connecticut do not have detailed or robust data to demonstrate these outcomes or the potential cost savings they produce.

By contrast, the Waterbury community care team diligently invested staffing and resources to analyze hospital and Unite Us data for cost studies. The Waterbury community care team conducted multiple cost studies. The cost analysis reflected data for 23 patients enrolled from May 2020 to April 2022. The study used 12 months pre-enrollment and at least 6 months post-enrollment data from four encounter categories (emergency, inpatient, outpatient, and observation) from both hospitals. A September 2022 report from the Waterbury community care team indicated that 74% of the patients had a reduction in costs, and the total cost of care was reduced by $1.7 million dollars. The Waterbury community care team also reported an elimination of uncompensated care for patients served by the community care team, with an estimated total reduction in uncompensated care of $291,185 for both hospitals engaged in the partnership.[viii]

In addition to a reduction in recurrent uncompensated care, the hospitals became better positioned for increased payment rates for outcome-based care. The Waterbury community care team experienced improvements in staff retention/morale, client satisfaction, and trusting relationships between patients and hospitals, and reported efficiency improvements in terms of:[ix]

- Improved equity
- Improved access
- Improved effectiveness
- Cost-efficient health care

The cost studies were a critical step to demonstrate the value of the Waterbury community care team, and in particular the role of the social service providers in generating outcomes of great

value to the health care sector. The community care team is seeking a new value-based payment model which has not been approved at the time of this writing.

Telling the patient's story is important.

"In terms of outcomes, I think data is always important but it's really important to get the human story…not just reducing utilization in our cost reduction, but the improved quality of life of our patients." — Care Team Staff

While data is important for sustainability and funding, Waterbury stakeholders said it was important not to lose sight of the purpose of the work: improving people's lives. Indicators to track this included becoming more independent, adherence to treatment, medication adherence, and being housed.

HEALTH EQUITY

Community care team members view their work as focused on health equity, but do not focus specifically on race and ethnicity.

The Centers for Disease Control and Prevention (CDC) defines health equity as the "state in which everyone has a fair and just opportunity to attain their highest level of health" and notes that the continual communal efforts needed to realize this aim include addressing injustice, eradicating preventable health disparities, and "overcoming economic, social, and other obstacles to health and health care."[x]

> *"The entire program itself is addressing health equity [because] the entire intention of this program is to serve the most underserved people in the health system…the most underserved people in Waterbury by definition of the community care team tend to be male people of color who are housing challenged." — Project Co-Lead*

Tackling health equity means changing systems and policies that have led to injustice and health disparities. Even with a constellation of partners that have equity at the forefront of their work, health equity is bigger than what one partner or one initiative can address on its own. Nonetheless, Waterbury community care team stakeholders felt that the initiative as a whole addressed health equity. The features of the community-clinical integration model when applied to people who are uninsured and have complex and overlapping health and social needs aligns with the CDC's description of how to address health equity in a community. The CDC description refers to a model that:

- Attempts to disrupt disparities with collective cross-sector efforts—typically community organizations, health care systems and providers, and public health agencies.
- Designs programs and practices based on community needs and a health-equity agenda.
- Removes barriers to secure access to health care.
- Tackles the social determinants of health that affect health equity.

> *"The understanding is the main qualification of being a client in community care team is they're high-risk. — Care Team Member*

In the case of the Waterbury community care team—where the model is oriented toward intervening at the patient level rather than with broader preventative or public health reforms—some partners stated that health equity is embedded in the intervention because of the intention to serve the most vulnerable people in the health system. In this region, that demographic is men of color who are housing challenged.

The Waterbury community care team approached health equity through a lens that emphasized the social determinants of health rather than race and ethnicity. More specifically, it defined the target population as those most vulnerable with the highest level of needs in multiple dimensions. Virtually all partners who mentioned enrollment said that race and ethnicity were not enrollment criteria; they acknowledged that the high-risk focus addressed health equity without directly conferring race or ethnicity as a qualifying factor. In other words, they saw the work as addressing equity regardless of whether race or ethnicity was a qualification for entry into the program because of the focus on whether a patient had significant unmet health-related social needs. In keeping with the care team's approach, program results were not framed in terms of health equity but instead highlighted patient demographics and social-related health needs.

> *"I think it comes up on every patient that we discuss….We may not use the term health equity, but we are talking about those social determinants. We're talking about employability, we're talking about housing, we're talking about any barriers, and it has a lot to do with poverty and any other barriers to health care and wellness." — Advisory Committee Member*

A Framework for How to Center Equity in CCI Efforts

The idea of collective impact gained widespread attention after the seminal article by Kania and Kramer in 2011[xi] and has been built upon and adapted extensively since then. Collective impact is a framework that can be used by collaborations to create community solutions for complex social issues. Recently Kania and Kramer recognized that collaborative efforts fail to have impact when they do not center equity in the work.[xii] In a 2022 article, they offered a revised definition: collective impact is a network of community members, organizations, and institutions that advance equity by learning together, aligning, and integrating their actions to achieve population and systems-level change.

They suggested the following emerging strategies as critical to centering equity:

1. Ground the work in data and context, and target solutions.
2. Focus on systems change, in addition to programs and services.
3. Shift power within the collaborative.
4. Listen to and act with community.
5. Build equity leadership and accountability.

In the following table, we look at emerging strategies to center equity and how this might be expressed in community-clinical integration as tactics, with some examples from the Waterbury community care team.

Table 2. Emerging Strategies to Center Equity and Related Tactics for Community-Clinical Integration

Strategies to Center Equity in Community Collaborations	How it Could Be Used in Community-Clinical Integration Efforts
Ground the work in data and context, and target solutions.	The community-clinical integration model should be based on a deep understanding of the community it would serve. Partners should use local data on health priorities that has been informed by community input to understand the context and target interventions. In Waterbury, for example, community data related to health disparities was extensively leveraged when planning programming. Data sources included the community health needs assessment and the community health improvement plan, which addresses the health disparities in greater Waterbury.
Focus on systems change, in addition to programs and services.	A system change approach attends to how parts of an ecosystem (e.g., a natural environment, an agency, education sector, or the economy) are organized and interact dynamically, rather than look only at the individual parts, such as one service. Truly effective and sustainable system change must impact multiple levels: structural (policies, practices, and resource flows), relational (including individual and organizational power dynamics), and mental model interpretations of social problems.[xiii] Systems change relies partly on the environment within engaged organizations. Systems can be strengthened where community-clinical integration partner organizations have an orientation to health equity and strategic efforts to address it through staff training, staff diversity and cultural competency, and familiarity with the community needs. Significant cross-sector engagement is a true divergence from long-established silos of care. In the case of Waterbury, cost studies were conducted to inform a concept for a value-based payment model; the uptake of a new payment structure would signal a dramatic shift in how each sector is valued for its contribution to outcomes.

Strategies to Center Equity in Community Collaborations	How it Could Be Used in Community-Clinical Integration Efforts
	Community-clinical integration efforts can remove barriers to health care access when they include providers that address medical, behavioral, and health-related social needs. The person-centered navigation approach in community-clinical integration efforts deals directly with social drivers such as employment and housing.
Shift power within the collaborative. Listen to and act with the community.	A significant step in shifting power is to bring a patient representative into executive or care teams, to be a direct community voice. The Waterbury approach was less direct, and relied upon the community health needs assessment inputs and proxy inputs from human service organizations to speak for the community. The listening to and acting with the community comes primarily from community health workers who are meeting people where they are, advocating directly, and encouraging self-empowerment. The Waterbury community care team's work occurs directly in places where people would be naturally, such as at the homeless drop-in center, to address social and health needs and barriers. Waterbury community care team partners felt that advocacy and patient education help empower patients, and that, along with wraparound care, helps to address health equity. The care team perceived their efforts to be impactful in meeting needs, due to a practical, multi-faceted, and respectful approach that reinforced patient autonomy and capacity to identify needs and make choices. *"I guess we are advocating for them…. That's excellent, but I feel that we aren't their eyes, their voice, and on our end, we just have to continue to encourage them to speak up, to ask [questions of providers]." — Case Management Team Member*
Build equity leadership and accountability.	Kania et al. (2022)[xiv] indicate that this particular strategy is essentially the ownership of the preceding strategies—and that this leadership must not be centralized but dispersed widely such as across partner organizations, the community, work groups, and steering committees. For a community-clinical integration initiative, we suggest that establishing a robust orientation to health equity is the responsibility of the initiative's leadership body. Fulfilling that health equity direction is likely to rest with the care team, with daily attention to patients' health-related social needs, advocacy, and by working in the spaces where people live, work, and play. To embrace accountability, the leadership of these initiatives should be representative of multiple sectors, a broad swath of partnering organizations, and, ideally, people from the population being served. If hospitals become major funders of community-clinical integration efforts, accountability to the collective implies that they should not also assume all decision-making powers at initiative leadership, management, or care levels. Community care teams can help community-based partners to expand their ownership of the endeavor with a more proactive role in referrals. For example, in Waterbury, the process for identifying potential participants evolved over time. Initially, the community care team staff reviewed the records from hospitals to identify high utilizers of emergency departments. Eventually all members of the care team were invited to use a standard referral process to request admission of a specific patient. This approach helped the backbone organization establish a proof of concept, grow the program, and work out the logistics before inviting more ownership among partners.

FUNDING AND SUSTAINABILITY

The Community care team sustainability rests with demonstrating outcomes, a strong backbone, a quality intervention, and deep partnership commitment.

A key ingredient for any initiative is its strategy for long-term sustainability, i.e., the ability of a program to carry on regardless of funding changes. Endurance can be fostered by a variety of factors, such as strong partnerships, management capacity, and alignment between the program benefits and community need. [xv] We investigated what factors influenced the sustainability of Waterbury programming to date, and what leadership, financing, and stewardship assets are needed for sustaining and scaling up the Waterbury community care team into the future.

There was widespread agreement among Waterbury stakeholders that the community care team program is well-positioned to be sustainable into the future. Stakeholders weighed in on the factors that have influenced the sustainability of the community care team to date. These in large measure mirrored the factors mentioned as the cause of its success:

1. **Demonstration of outcomes.** All partners benefit from improved patient outcomes. Robust data must be presented to document that the community care team has achieved the intended patient outcomes of reduced emergency department visits and admissions, and quantify the cost savings to hospitals, including any drop in uncompensated care and improved performance on quality benchmarks.
2. **Trust in the backbone organization and its demonstration of strengths.** As a hub, the backbone organization should be trusted by the community. In the case of Waterbury, many stakeholders noted this trust and called out the strengths of the backbone organization leadership, in particular the long-term vision, and project management, communication and organizational skills, and its solid reputation for case management.
3. **Quality of the intervention.** Partners cited the level of care coordination, including exceptional communication regarding patients both in and after care plan meetings, having all partners contributing to the care, and the importance of services by paid employees (not contractors).
4. **Deep commitment by partners to the service-delivery model.** The human service providers were cited as being highly motivated, invested, and committed to helping people. Hospitals and community providers had strong buy-in because they perceived the value of an integrated person-centered approach to serving a very vulnerable population.

A value-based payment model, multiple funders, and a funded staff model are key ingredients to attain community care team sustainability.

Looking to the future, several factors were deemed necessary to solidify sustainability for the Waterbury community care team. These included demonstration of the patient outcomes and

"So as far as sustainability goes, I think caseload is the biggest concern" — Care Team Member

return on investment, retention of the service-delivery model, shared ownership, continued buy-in and advocacy by a wide range of partners, use of the Unite Us platform by community partners, and a health-equity orientation. More fundamentally, Waterbury stakeholders believe that future sustainability will be bolstered by:

1. **Funding, retaining, and expanding the staffing model.** This must include maintaining the dedicated level of case-management staffing or increasing hires for case management to ensure a reasonable caseload; a dedicated data person; retention of the backbone organization for ongoing engagement and communication; and case navigation oversight by staff with both medical and social work backgrounds. In addition, a stipend for community-based partners that is tied to participation should be considered.
2. **Consistent funding and new value-based payment models.** Ideally funding will come from multiple sources and be consistent rather than fragile or unstable. However, it was widely understood that hospitals ought to provide the bulk of funding due to significant cost savings they would gain from the initiative under a to-be-defined value-based payment model. Hospitals may also be motivated if other sources were leveraged, so the cost could be shared by other entities that might benefit. At the time of this writing, no new payment model had been approved by hospitals.

"Any community care team needs to have a person dedicated to the data…. If you can't track outcomes, you won't be successful. And there's a lot of stuff to track." — Project Co-Lead

Research Methods: In addition to a review of administrative data and literature, the evaluation relied upon interviews as an essential source for answering research questions. To gain perspectives from multiple stakeholder types, PPA conducted 23 interviews between October 2022 and March 2023. Interviews were completed with 2 state government officials, 2 national community-clinical integration experts, 3 other Connecticut community care teams, and 16 Waterbury stakeholders, which included:

- Project leadership including two co-leading organizations, project manager, and director of case management
- Project staff including program manager, case managers, administrative assistant, data analyst, and social work consultant
- Community care team Oversight and Sustainability Committee
- Care team participants/attendees (health and community providers)

LESSONS AND RECOMMENDATIONS

The Waterbury community care team staffing model is a best practice.

Any community care team will require an overarching administrative role that holds responsibility for relationships, data-sharing agreements and data tracking, care team convening, leadership development, and communications. To be most effective, this role must be a dedicated and paid role, as it is too much for other service-delivery providers typically to effectively add on to existing workloads.

Other community care teams would benefit from a staffing model that emulates the Waterbury model. Specifically, the workflows would benefit from having a backbone organization that employs the case managers, oversees the case management with both clinical and social work expertise, and oversees the vetting process to select cases for enrollment and set the cases for the care team agenda.

Strong, consistent relationships are central to the model's effectiveness.

Development or expansion of a community care team should recognize the interdependent role of all partners in providing care and shared responsibility. The ideal of coordinated care is operationalized by intense communications, which inspire accountability, partner trust, and attachment to the initiative. For community care teams focused on emergency department high utilizers, a broad range of community and clinical partners need to be brought to the table. Key success factors for partnerships include consistent communication, a clear support structure, shared goals, and accountability.

Transparency regarding partner obligations is critical.

Potential partners should be aware of obligations and benefits of participation in a community care team. Organizations that participate in a community care team collaborative focused on people with complex and overlapping clinical and social needs should expect to prioritize the timeliness of community care team patients' needs; when a partner is called upon for information or resources, a prompt response is appropriate. Organizations should be alert to the level of ownership and responsibility they will undertake in managing patient care. Partners need to be accountable for full participation in care planning in specific ways: to assign staff and allocate time to this task; to actively prepare for care plan meetings and to provide verbal updates on interactions with a specific patient; and to be accountable for follow-through on care plans. Data-sharing will also be expected via engagement with any common platform required for tracking activity across organizations, despite the extra effort that will entail for most organizations.

In a community care team model, the capacity brought by the backbone organization, as it serves as a care hub, offers multiple benefits to hospital partners and community-based

agencies. The backbone should establish a structure for decision-making, accountability, and reporting. More specifically, it would take the lead to define metrics, create a data repository, and analyze outcome data. Participating partners should expect that the process and outcomes of the collaborative effort will be aligned with their own organizations' interests.

Many organizations may not feel a substantial shift internally if they have a significant history with an integrated comprehensive approach or otherwise have been preparing for a high level of collaboration. However, organizations might expect to scale up the work, due to an increase in referrals and additional connections with other community providers. For a collaboration to flourish, there must be community-level capacity to take on increased referral volume.[xvi]

Ownership of data and outcomes should be collective.

Responsibility for the development of outcome data rests with multiple parties. Ideally the backbone organization should be charged with identifying and developing metrics, building a data repository, and reporting outcomes. Steering and advisory bodies with cross-sector representation should guide the selection of indicators of progress and outcomes.

A funded and dedicated data management role is necessary to track and report project outcomes. Dissemination of outcomes is essential to convey specific benefits and value, which influences support opportunities and sustainability.

Community care teams must plan for overcoming technical barriers to data-sharing (e.g., requirements attached to federal funding). A highly effective workaround is the direct communication (verbal) sharing across providers consistent with data-sharing agreements and patient releases. This avenue is made possible with well-run care plan meetings and timely follow-up in between meetings.

Sustainability can occur through demonstration of results and commitment to long-term change.

Lessons related to sustainability are in large measure about dissemination of an initiative's value and impacts. Community care teams, especially in the early stages of development, will need diligent efforts to define the value of community-based organization contributions to outcomes to the health care sector, which may not be widely understood. This can be effectively communicated by a combination of quantitative outcomes and qualitative stories that vividly illustrate the changes in the environment of a patient. Clear demonstration of improved social and health status and access to appropriate social and health care is essential for generating interest in a value-based payment model. Data presentations and human storytelling must relate in a compelling way the benefits and value of participation in the community care team for partnering organizations and the people that they serve.

Sustainability efforts must start with a recognition that collective impact work is a long-term venture for long-term change. This mindset must inform commitments, funding strategies, and the development of an evidence base. Weaver (2016) suggests those engaged in collective work should pay attention to program outcomes but not to the exclusion of needing to scale change

through systems, policy, and environmental shifts.[xvii] Long-term sustainability requires a consistent funding model and staff funding. In the case of Waterbury, this means a new value-based payment model, multiple funders/shared ownership, and a funded staff model. Common approaches to secure ongoing funding include (1) hospital foundations, a model used by the Norwalk community care team; (2) charitable sources like the approach used by Danbury's community care team; and (3) value-based payments for care teams by insurers or hospitals. Where services are billed, Medicaid will see the greatest cost savings. Pressure to change Medicaid policy to more robustly and reliably deal with health-related social needs is likely to increase in the coming years. This could take the form of waivers and other flexibilities, broader mandates or incentives, support of organizations to conduct community care teams, or movement to more whole-person and value-based care. State-level efforts to build an interconnected data infrastructure, supports for public-private partnerships, and leverage of community engagement could also aid the sustainability of community care teams.

Address health equity through systemic change and genuine empowerment of the people served.

Community-clinical integration is a valuable tactic in a larger strategy to address health equity due to its cross-sector efforts to disrupt disparities and confront social drivers of health. Good practices at an individual level include improving engaged parties' knowledge and awareness of internal bias. An example is educating providers to recognize barriers facing patients and offering responsive solutions such as handouts with visual information to describe medical issues for those with limited education.

A robust health-equity strategy will also pay attention to system-change opportunities. Community-clinical integration initiatives will need to assess potential challenges in the local environment. Examples include the level of readiness in regional leadership (e.g., local government has a formal health-disparities plan); the amount of human capacity available to be dedicated to a care team; and the extent to which likely partners have engaged and will continue to engage in education about health equity. Staffing of programs also makes a difference; patient navigation can reduce health disparities and improve patient engagement.[xviii]

There is a tendency to implicitly allow community-based organizations to act as a proxy voice for patient needs and interest. With such reliance, it is important to understand the organizational orientation to trauma-informed care, asset or deficit approaches, shared understanding of equity, and engagement in any patient advocacy or a community advisory group.

Beyond that, a key method to centering equity is to shift power more directly to the community to amplify the voice of the people served.[xix] There are significant challenges to accomplishing this with people who are profoundly struggling with basic needs, but it is imperative that a community care team consider alternative avenues. Paths forward include:

- Adding a peer-based engagement role in the care team, as is done in Norwalk's community care team
- Integrating peers in advisory or executive bodies

- Expanding the use and elevating the role of community health workers in the care team
- Periodic reporting on status of health-related social needs
- Implementing a patient satisfaction survey with attention to anonymity, cultural responsiveness, language, and an intervention that involves multiple agencies
- Creating a forum or leveraging an existing regional forum, such as the homelessness Continuum of Care, to gather public input

END NOTES

[i] Anna Spencer, "Supporting Health Care and Community-Based Organization Partnerships to Address Social Determinants of Health," *Grant Makers in Health*, March 18, 2019, last accessed August 10, 2022, https://www.gih.org/views-from-the-field/supporting-health-care-and-community-based-organization-partnerships-to-address-social-determinants-of-health/.
[ii] Ellen Breslin, Heidi Arthur, and Dennis Heaphy, *Achieving Health Equity and Wellness for Medicaid Populations: A Case Study of Community-Based Organization (CBO) Engagement in the Delivery System Reform Incentive Payment (DSRIP) Program* (Washington, DC: AcademyHealth in partnership with Health Management Associates and the Disability Policy Consortium, n.d.); *Strengthening Community-Clinical Linkages to Improve Health Outcomes: Convening Summary* (Arlington, VA: Association of State and Territorial Health Officials, 2019); Melinda Dutton, Elizabeth Osius, Natassia Rozario, Justine Zayhowski Segal, *Working With Community Care Hubs to Address Social Drivers of Health: A Playbook for State Medicaid Agencies* (Los Angeles, CA: Manatt, November 2022), https://www.manatt.com/Manatt/media/Documents/Articles/Manatt-CCH-Medicaid-Playbook_Final-11-17-22.pdf.
[iii] *R3 | Requirement, Rationale, Reference*, Issue 36, (Washington, DC: The Joint Commission, June 20, 2022, https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_disparities_july2022-6-20-2022.pdf.
[iv] "Who is a Health Navigator?" Colorado Department of Public Health and Environment, https://cdphe.colorado.gov/chronic-disease-prevention/health-navigator-workforce-development/who-is-a-health-navigator#:~:text=A%20health%20navigator%20(also%20known,transportation%2C%20child%20care%20and%20more.
[v] For more distinction on patient navigators and case managers See KJ Kelly, S Doucet, A Luke, "Exploring The Roles, Functions, And Background Of Patient Navigators And Case Managers: A Scoping Review," International Journal of Nursing Studies, 98 (2019): 27-47.
[vi] Community Health Workers: Evidence of Their Effectiveness (Arlington, VA: Association of State and Territorial Health Officials, n.d.).
[vii] Victor G. Villagra, *Clinical-Community Integration: The Role of Health Information Technology, Policy Brief* (Hartford, CT: Connecticut Health Foundation and UConn Health, April 2018); Kelly Cronin [Health & Equity Policy Advisor, Executive Office of the Governor], "Closing Plenary: Innovative Partnerships to Support Priority Populations," January 25, 2023. MDHHS Social Determinants of Health Summit January 24-26, 2023.
[viii] Community Care Team Oversight Meeting, September 19, 2022, Greater Waterbury Health Partnership.
[ix] Ibid.
[x] "What is Health Equity?" Centers for Disease Control and Prevention, https://www.cdc.gov/healthequity/whatis/index.html#:~:text=Overcome%20economic%2C%20social%2C%20and%20other%20obstacles%20to%20health,give%20rise%20to%20racial%20and%20ethnic%20health%20disparities.
[xi] John Kania and Mark Kramer, "Collective Impact," Stanford Social Innovation Review, Winter 2011, 9, no. 1 (2011): 36-41, accessed August 10, 2022, https://ssir.org/articles/entry/collective_impact#.
[xii] John Kania et al., "Centering Equity in Collective Impact," *Stanford Social Innovation Review* 20, no. 1 (2022): 38–45, https://doi.org/10.48558/RN5M-CA77.
[xiii] Ibid.
[xiv] Ibid.
[xv] Andrea Bodkin and Shawn Hakimi. "Sustainable by design: a systematic review of factors for health promotion program sustainability," *BMC Public Health* 20 (2020): 964.
[xvi] Cronin, "Closing Plenary."
[xvii] Liz Weaver, "Possible: Transformational Change in Collective Impact," *Community Development*, 47, no. 2 (2016): 274-283, DOI: 10.1080/15575330.2016.1138977.
[xviii] "Who is a Health Navigator?" Colorado Department of Public Health and Environment.

[xix] Jessica Smart, *Collective Impact: Evidence and Implications for Practice* (Southbank, Victoria, Australia: Child Family Community Australia, CFCA paper no. 45, 2017); Kania et al., "Centering Equity"; "Collective Impact Principles of Practice: Putting Collective Impact into Action." Sheri Brady and Jennifer Splansky Juster, Collective Impact Forum, April 17, 2016, accessed February 9, 2023, https://collectiveimpactforum.org/blogs/1301/collective-impact-principles-practice-putting-collective-impact-action.