

# Community-Clinical Integration in the Connecticut Medicaid Context

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## BACKGROUND

The state of Connecticut (CT) is in a position to implement broad health reform with a focus on community-clinical integration. Although CT has lower average Medicaid costs than most states, it ranks only 43rd out of all states in terms of health equity<sup>1</sup>. Medicaid and the Child Health Insurance Program (CHIP) play an integral role in the care of people of color, who are more likely to be economically disadvantaged. For example, in Connecticut, Black residents make up 12% of the overall state population but 20% of the Medicaid population<sup>1</sup>.

**Connecticut Voices for Children (Voices)** is a research-based child advocacy organization that aims to improve the well-being of CT's children and families. As CT evaluates potential reforms to both HUSKY financing and delivery, Voices hopes to make recommendations on policies that will enhance community-clinical integration. In particular, Voices is interested in integration strategies that can positively impact outcomes for children living with Adverse Childhood Experiences (ACEs). ACEs can include child abuse, neglect, witnessing intimate partner violence, or other stressful experiences associated with poverty, such as food shortages and housing insecurity. ACEs have been linked to lifelong consequences and implications for adult health, healthcare, and costs.<sup>2</sup>

## OBJECTIVES

- **Understand** how community-clinical integration efforts may impact health equity
- **Identify** community-clinical integration strategies for preventing and treating ACEs
- **Determine** barriers to integrating social services into clinical care
- **Recommend** improvements for community-clinical integration for Medicaid-enrolled children and families in CT

## METHODS

- A logic model and program theory were developed to identify objectives and goals of the project.
- To study community-clinical integration programs, our team conducted an environmental scan of models of community-clinical integration programs in CA, CO, CT, DE, FL, MA, MI, MN, MO, NC, NY, OH, OR, PA, RI, TN, TX, VT, WA, and nationally.
- To identify best practices for and barriers to community-clinical integration efforts, our team conducted 6 semi-structured interviews at FQHCs across CT with care coordinators and quality improvement personnel. Interviews were conducted in-person, over the phone, and by video call and were thematically analyzed.

## CONCLUSIONS AND RECOMMENDATIONS

- Community-clinical integration programs can significantly aid in pediatric health services.
- Community health workers (CHWs) should be integrated more in the clinical context to assist in whole-patient care.
- Program designs need to reflect the different needs and outcomes of pediatric populations.
- Schools and early childhood programs are important community-clinical linkages for preventing and treating ACEs.

### FINANCIAL RECOMMENDATIONS

1. **Create mechanisms for upfront, global payments for primary care practices to invest in innovative services.**
2. **Both Health Enhancement Communities (HECs) and primary care practices targeting ACEs should seek support beyond healthcare funding streams.**
3. **Pooled community funds may be available for services not available within a HEC.**

### PROGRAM LEVEL RECOMMENDATIONS

1. **Screening.** Include Early Periodic Screening Diagnosis and Treatment (EPSDT) in the Medicaid fee schedule and create a standard for ACEs screening in the state. Comprehensive ACEs screening also requires expanding capacity for mental health treatment in CT.
2. **Medical Homes.** Expand Patient-Centered Medical Homes (PCMHs) into Family-Centered Medical Homes.
3. **Transportation.** Co-locate community resources near Federally Qualified Health Centers (FQHCs) and other healthcare provider locations to alleviate transportation barriers.
4. **Networks.** Creating an integrated community-clinical network such as HECs may be most successful when aligned with existing Medicaid structures or delivery reform entity (ACO, PCMH, etc).

## RESULTS: Community-Clinical Integration Models in Other States and Nationally

- Patient-Centered Medical Homes (PCMH) lead to reduced emergency department utilization, rate of serious illness, hospitalizations, ICU visits, infants born with low birth weight, inpatient admission rates, health system costs, and Medicaid payments.
- Accountable Care Organizations (ACOs) lead to reduced gastroenteritis admissions, NICU days, health system costs, hospitalizations (including behavioral health and complex medical needs), Medicaid costs, ER utilization, inpatient days, readmissions, and rehospitalizations.
- Collaborative Care Organizations (CCOs) lead to reduced White/Black disparities in primary care visits, outpatient visits, and preventative services; reduced White/American Indian disparities in primary care and outpatient visits; improved pediatric quality of care measures.
- Accountable Communities for Health (ACH) and Accountable Health Communities Model (AHC) - studies of outcomes are still being conducted.
- Non-clinical based Programs such as family-centered medical homes, head start partnerships, and grassroots school affiliate programs require more research to understand the impacts and outcomes.

## RESULTS: Perspectives of Connecticut Clinical Care Providers and CHWs on coordination

### **CHWs and care coordinators are invaluable:**

*“Our CHWs are located at each of the sites they take care of, so they are already in the same building, which really helps...they are invited to monthly team meetings where cases are discussed and each CHW will share their thoughts with the care team” [Healthcare Analytics & Delivery Specialist]*

### **Transportation is a significant barrier to care:**

*“Our community is rural, so transportation is a huge issue, as well as food insecurity. We have a patient assistance fund based on employee donations, which we use to pay for taxi rides, specialty visits, etc...” [Director, Systems of Care]*

### **Limited staffing is a significant barrier to integration of services:**

*“We serve close to 19,000 patients...That's a lot of patients. And we basically only have three care coordinators. So it's limited, you know, it's for the level of need and for the volume of patients that we have, workforce is really I would say the biggest barrier.” [Lead Care Coordinator]*

### **There is inadequate behavioral health capacity to meet the need:**

*“I think there's not enough resources for people who are already diagnosed...I think it's critical that if we're going to be [increasing ACEs screening] that there are resources to help” [Executive Director]*

## LIMITATIONS

- Original intent of project was to analyze specific payment models devised by CT's SIM workgroups on Primary Care Modernization and HECs to determine the most promising models for tackling ACEs while improving health equity. However, the workgroups delayed release of the models (still not available at the time of this report), so the project was reconceptualized to find best practices and recommendations for preventing and treating ACEs within community-clinical integration models similar to HECs.
- Interviews were conducted toward the end of the project, and several interviews had valuable information that could have provided guidance earlier in the project.
- There may be limited generalizability of findings due to the low number of interviews. Additional informants would have been invaluable to further our study.
- Leading questions and/or social desirability may have influenced answers during qualitative interviews.
- Literature review was not conducted systematically for two reasons: (1) the scope of our project was extremely broad and (2) peer-reviewed studies are not yet available due to the recent nature of many healthcare reform efforts.

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