

VHCIP Population Health  
Work Group  
Agenda 6-16-15

# *VT Health Care Innovation Project Population Health Work Group Meeting Agenda*

Date: Tuesday June 16, 2015 Time: 2:30-4:00 pm  
 Location ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier  
 Call-In Number: 1-877-273-4202; Passcode: 420-323-867

**All Participants: Please ensure that you sign in on the attendance sheet the will be circularized at the beginning of the meeting, Thank you.**

<b>AGENDA</b>					
Item #	Time	Topic	Presenter	Relevant Attachments	Action #
1	2:30	<b>Welcome, roll call and agenda review</b>	Karen Hein	<b>Attachment 1:</b> Agenda	
2	2:35	<b>Approval of Minutes</b>	Tracy Dolan	<b>Attachment 2:</b> Minutes	
3	2:40	Accountable Communities for Health Describe key elements of ACH Review national research Discuss activities and building blocks in Vermont  – PI at June Mtg. <ul style="list-style-type: none"> <li>• Collaboration with CMCM Work Group</li> <li>• Technical Assistance Request</li> </ul>	Leslie Mikkelson  William Haar	<b>Attachment 3:</b>  <b>3a:</b> PowerPoint <b>3b:</b> National ACH Profiles	
4	3:50	<b>Next Steps</b>  <i>What information do work group members need in order to continue our work together?</i>	Karen Hein		

OPEN ACTION ITEM LOG					
Date Added	Action Number	Assigned to:	Action /Status	Due Date	Date Closed
			• .		
			•		
			•		
			•		

Attachment 2

May 12, 2015

Minutes



## Vermont Health Care Innovation Project Population Health Work Group Meeting Minutes

### Pending Work Group Approval

**Date of meeting:** May 12, 2015; 2:30 PM – 4:00 PM; Calvin Coolidge Conference Room, National Life Building, Montpelier

Agenda Item	Discussion	Next Steps
<b>1. Welcome, Roll Call, &amp; Agenda Review</b>	Karen Hein called the meeting to order at 2:31pm. A roll call attendance was taken and a quorum was present. Karen Hein reviewed the meeting agenda.	
<b>2. Approval of Minutes</b>	Susan Aranoff moved to approve the April 15, 2015 minutes by exception. Penrose Jackson seconded. The minutes were approved with one abstention.	
<b>3. Project Updates:</b> <ul style="list-style-type: none"> <li>• <b>Prevention Institute</b></li> <li>• <b>Collaboration with the CMCM work group</b></li> <li>• <b>Technical Assistance Request</b></li> </ul>	<p><i>Prevention Institute</i> Karen Hein announced that Prevention Institute will be here in June to present on their work in researching examples of accountable communities for health around the country.</p> <p><i>Collaboration with CMCM work group</i> As part of the ongoing work looking to improve population health and to align the work efforts of both work groups, there is a collaboration effort between the Population Health Work Group and the Care Models and Care Management Work Group.</p> <p><i>Technical Assistance Request</i> The VHCIP Population Health Workgroup requests assistance in identifying policy levers that have been utilized by other States or communities, that enable them to incorporate population health specific goals into payment reform activities. A description of the request is included as Attachment 3 in the materials.</p>	
<b>4. Paying for Population Health Prevention: Presentation by Jim</b>	Jim Hester, who is a national leader in thinking about population health, presented from the slides contained in Attachment 4 of the meeting materials.	

Agenda Item	Discussion	Next Steps
Hester	<p>The presentation focuses on paying for population health – this is the third goal of the Population Health Work Group. This includes components of the financial models that could be used, including the elements and criteria, issues and some examples.</p> <p>The group discussed the following:</p> <ul style="list-style-type: none"> <li>• Chuck Myers asked what the nature of the CDFI investment is – Jim responded that this is about \$50 – 60 Billion.</li> <li>• AHEAD – a partnership between a CDFI (The Reinvestment Trust) and a public health organization (Public Health Institute) to fund these activities.</li> <li>• The financial model – a key component is a global budget for a defined population for a broad scope of services with aligned payments allocating funds to service providers.</li> <li>• Some potential models include <ul style="list-style-type: none"> <li>○ Allocation of global cap</li> <li>○ Employer subscription fee</li> <li>○ Transactional fees</li> <li>○ Reinvestment of savings</li> </ul> </li> <li>• A review of the chart from CMS – note that CMS has always defined the ACO Shared Savings Model as a transitional model – a step toward population based payments. This is where our current ACO SSP model resides (VT).</li> <li>• In generic issues, the presentation cited having no patient buy-in as a barrier – there is no way to engage the patient in changing behavior because the patient has no insight into the model – they are not aware of the payment reform that is happening.</li> <li>• There is an innovative idea – not yet implemented – that proposes to pay providers for an aggregate reduction in heart attack risk factors. The model includes a number of risk factors that can be identified, so as those are reduced for a given population, the provider is then paid.</li> <li>• The presentation highlighted a program for the city employees of Lexington KY – managed by Marathon Health where over a 2-yr period, nearly 40% of the population made improvements in measured risks. This is based on a model where Marathon is at risk for Triple Aim objectives.</li> <li>• The Oregon model included in the presentation uses a ‘global budget’ concept where the money is given to the CCO organization to administer.</li> <li>• In California medical groups under a global budget, the MD payment model changes according to the type of service – for example, fee for service is used for prevention services, but capitation type payments are used for chronic care services.</li> <li>• The Vermont model questions <ul style="list-style-type: none"> <li>○ How do we align payments</li> <li>○ How do we define the population</li> </ul> </li> </ul>	

Agenda Item	Discussion	Next Steps
	<ul style="list-style-type: none"> <li>○ Should we test an enrollment model</li> <li>○ Should we align specialty care payments (i.e. bundled payments)</li> <li>● Questions – clarifications, how any or all of this applies to SIM/PHWG, how do we get from here to there?</li> <li>● Ted Mabel asked if there are there some communities who are closer to this than others? Yes – there are a host of partial-model – For example, Hennepin County has its own Medicaid MCO organization that captures the savings. Also, 11 testing states under the SIM program are now using some aspect of population health in their projects.</li> <li>● A follow up question was asked - Is the reinvestment at Dartmouth back in to the community? Yes, it appears it is back to the community and is how the ReThink Health initiative is being (at least partially) funded.</li> <li>● Laural Ruggles noted that the question around payment models is that holding primary care and/or just hospitals accountable for the overall health, but the incentives are going to the primary care organizations only... the whole alignment of the community providers just isn't there yet.</li> <li>● Jill Barry Bowen asked isn't that where the Blueprint UCC or RCPC is heading? Laural's point is that perhaps there is a difference in what is being proposed at the GMCB and what is being discussed in the communities.</li> <li>● Cathy Hency asked what size population is needed to pull something like this off? Jim Hester responded that when the analysis was done initially, roughly 15K was needed for shared savings models. – and some estimates range up to 200K to ensure the infrastructure cost is covered. This is one the areas in testing now</li> <li>● Steve Gordon commented that from the perspective of 'boots on the ground' there is only so much change that can be done at once – and there's no view yet into the impact of that to folks working in the provider practices and prospective results. There are already so many initiatives around the blueprint work, ACO collaboration and quality groups. In terms of assuming the risk in the Brattleboro area there are only 2500 participants in the Medicare program in that area and they wouldn't necessarily be willing to take the risk from that perspective.</li> <li>● Jenney Samuelson pointed out that it has to be done in steps – what types of steps can be taken to get to where we want to go.</li> <li>● Laural Ruggles, Jenney Samuelson and Jill Berry Bowen jointly commented that if all we do is include the clinical work, it doesn't allow for the work to be more systematic and thinking about the population overall by including the whole system – the care coordination is happening but the payment incentives are not happening. Jill's community is working to build the trust, establish measures and improve the care coordination. Some communities are further ahead and for example, Laural's community (St. Johnsbury) is further along in the care coordination and is looking to have the payments now follow the work.</li> <li>● Susan Aranoff pointed out that CMS is not waiting and they are moving now toward value based care and payment.</li> </ul>	

Agenda Item	Discussion	Next Steps
<b>6. Next Steps</b>	<b>Next Meeting:</b> Tuesday, June 16, 2015, 2:30 PM – 4:00 PM; Calvin Coolidge Conference Room, National Life Building, Montpelier	

# VHCIP Population Health Work Group Member List

Roll Call: 5/12/2015

*Sue Aranoff 1°  
Penrose Jackson 2°  
Motion carried  
1 abstention*

Member		Member Alternate		Minutes	
First Name	Last Name	First Name	Last Name		Organization
Susan	Aranoff ✓	<i>W</i>			AHS - DAIL
Jill Berry	Bowen ✓				Northwestern Medical Center
Mark	Burke ✓				Brattleboro Memorial Hospital
Donna	Burkett ✓				Planned Parenthood of Northern New England
Dr. Dee	Burroughs-Biron ✓	Trudee	Ettlinger		AHS - DOC
Daljit	Clark ✓	Jenney ✓	Samuelson	<i>A</i>	AHS - DVHA
Peter	Cobb ✓				VNAs of Vermont
Judy	Cohen				University of Vermont
Jesse	de la Rosa ✓				Consumer Representative
Tracy	Dolan ✓	Heidi	Klein		AHS - VDH
Joyce	Gallimore	<i>Katie</i> ✓	<i>Fitzpatrick</i>		CHAC
Karen	Hein ✓				Dartmouth Medical School
Kathleen	Hentcy ✓	Charlie ✓	Biss		AHS - DMH
Penrose	Jackson ✓				UVM Medical Center
Pat	Jones				GMCB
Patricia	Launer				Bi-State Primary Care
Lyne	Limoges				Orleans/Essex VNA and Hospice, Inc.
Ted	Mable ✓				DA - Northwest Counseling and Support Services
Carol	Maloney ✓				AHS - Central Office
Melissa	Miles				Bi-State Primary Care
Laural	Ruggles ✓				Northeastern Vermont Regional Hospital
Julia	Shaw ✓				VLA/Health Care Advocate Project
Melanie	Sheehan				Mt. Ascutney Hospital and Health Center
Miriam	Sheehey				OneCare Vermont
Shawn	Skaflestad ✓				AHS - Central Office
Chris	Smith ✓				MVP Health Care
JoEllen	Tarallo-Falk ✓	Lori	Augustyniak		Center for Health and Learning
Karen	Vastine ✓				AHS - DCF
Teresa	Voci	LaRae <i>Micha</i> ✓	Francis <i>Denvers</i>		Blue Cross Blue Shield of Vermont
Stephanie	Winters				Vermont Medical Society
	30		6		

*# Quorum achieved*

# VHCIP Population Health Work Group Participant List

Attendance:

5/12/2015

C	Chair
IC	Interim Chair
M	Member
MA	Member Alternate
A	Assistant
S	VHCIP Staff/Consultant
X	Interested Party

First Name	Last Name		Organization	Population Health
Susan	Aranoff	here	AHS - DAIL	S/M
Julie	Arel		VDH	X
Lori	Augustyniak		Center for Health and Learning	MA
Ena	Backus		GMCB	X
Susan	Barrett		GMCB	X
Bob	Bick		DA - HowardCenter for Mental Health	X
Charlie	Biss	me	AHS - Central Office - IFS / Rep for AHS - DMH	X/MA
Mary Lou	Bolt		Rutland Regional Medical Center	X
Jill Berry	Bowen	phone here	Northwestern Medical Center	M
Mark	Burke	here	Brattleboro Memorial Hopsital	M
Donna	Burkett	here	Planned Parenthood of Northern New England	M
Dr. Dee	Burroughs-Biron		AHS - DOC	M
Jan	Carney		University of Vermont	X
Amanda	Ciecior	here	AHS - DVHA	S
Barbara	Cimaglio		AHS - VDH	X

Daljit	Clark		AHS - DVHA	MA
Peter	Cobb	phone	VNAs of Vermont	M
Judy	Cohen		University of Vermont	M
Amy	Coonradt		AHS - DVHA	S
Alicia	Cooper		AHS - DVHA	S
Janet	Corrigan		Dartmouth-Hitchcock	X
Brian	Costello			X
Mark	Craig			X
Wendy	Davis		University of Vermont	X
Jesse	de la Rosa		Consumer Representative	M
Trey	Dobson		Dartmouth-Hitchcock	X
Tracy	Dolan	phone	AHS - VDH	C/M
Kevin	Donovan		Mt. Ascutney Hospital and Health Center	X
Lisa	Dulsky Watkins	phone		X
Suratha	Elango		RWJF - Clinical Scholar	X
Gabe	Epstein	here	AHS - DAIL	S
Trudee	Ettlinger		AHS - DOC	MA
Erin	Flynn	here	AHS - DVHA	S
LaRae	Francis		Blue Cross Blue Shield of Vermont	MA
Joyce	Gallimore		Bi-State Primary Care/CHAC	M
Lucie	Garand		Downs Rachlin Martin PLLC	X
Christine	Geiler		GMCB	S
Steve	Gordon	phone	Brattleboro Memorial Hospital	X
Don	Grabowski		The Health Center	X
Maura	Graff	here	Planned Parenthood of Northern New England	X
Wendy	Grant		Blue Cross Blue Shield of Vermont	A
Thomas	Hall		Consumer Representative	X
Bryan	Hallett		GMCB	S
Catherine	Hamilton		Blue Cross Blue Shield of Vermont	X
Carolynn	Hatin		AHS - Central Office - IFS	S
Karen	Hein	here		C/M
Kathleen	Hentcy	here	AHS - DMH	M
Jim	Hester	here	SOV Consultant	S
Penrose	Jackson	here	UVM Medical Center	M

Pat	Jones		GMCB	S/M
Joelle	Judge	here	UMASS	S
Sarah	Kinsler	here	AHS - DVHA	S
Heidi	Klein		AHS - VDH	S/MA
Norma	LaBounty		OneCare Vermont	A
Kelly	Lange		Blue Cross Blue Shield of Vermont	X
Patricia	Launer		Bi-State Primary Care	MA
Mark	Levine		University of Vermont	X
Lyne	Limoges		Orleans/Essex VNA and Hospice, Inc.	M
Nicole	Lukas	here	AHS - VDH	X
Ted	Mable	here	DA - Northwest Counseling and Support Services	M
Georgia	Maheras	phone	AOA	S
Carol	Maloney	here	AHS	X
Mike	Maslack			X
Jill	McKenzie			X
Melissa	Miles		Bi-State Primary Care	M
MaryKate	Mohlman	here	AHS - DVHA - Blueprint	X
Chuck	Myers	here	Northeast Family Institute	X
Annie	Paumgarten		GMCB	S
Luann	Poirer		AHS - DVHA	S
Carley	Riley			X
Brita	Roy			X
Laural	Ruggles	here	Northeastern Vermont Regional Hospital	M
Jenney	Samuelson	here	AHS - DVHA - Blueprint	M
seashre@msn.com	seashre@msn.com		House Health Committee	X
Julia	Shaw	phone/here	VLA/Health Care Advocate Project	M
Melanie	Sheehan		Mt. Ascutney Hospital and Health Center	M
Miriam	Sheehey		OneCare Vermont	M
Shawn	Skaflestad	here	AHS - Central Office	M
Chris	Smith	phone	MVP Health Care	M
Kaylan	Sobel		The Council of State Governments	X
Kara	Suter		AHS - DVHA	S
JoEllen	Tarallo-Falk		Center for Health and Learning	M
Karen	Vastine	here	AHS-DCF	
Teresa	Voci		Blue Cross Blue Shield of Vermont	M

Nathaniel	Waite		VDH	X
Marlys	Waller		DA - Vermont Council of Developmental and Mental Health Serv	X
Kendall	West		Bi-State	X
James	Westrich		AHS - DVHA	S
Stephanie	Winters		Vermont Medical Society	M
Mary	Woodruff			X
Cecelia	Wu		AHS - DVHA	S
McKenna	Lee		OneCare Vermont	
				90

Katie Fitzpatrick  
 Micah Demers

CHTC  
 BCBSVT

Attachment 3a  
Prevention Institute  
Accountable Communities for  
Health Research



# Accountable Communities for Health Research

Vermont Population Health Work Group  
June 16, 2015

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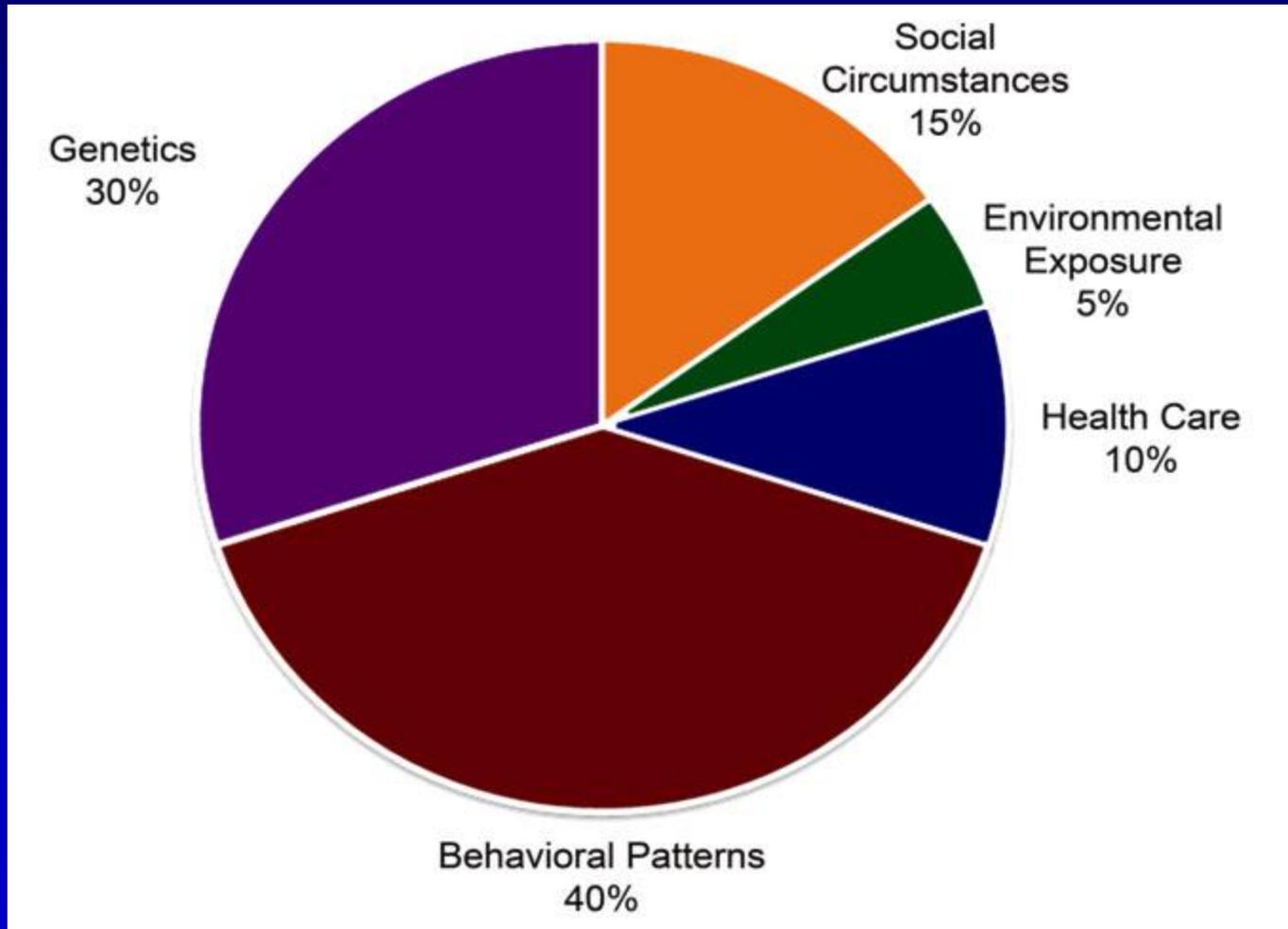
Leslie Mikkelsen, MPH, RD  
*Managing Director, Prevention Institute*

William L. Haar, MPH, MSW  
*Program Coordinator, Prevention Institute*

Lisa Dulsky Watkins, MD  
*Principal, Granite Shore Consulting, LLC*

Kalahn Taylor-Clark, PhD, MPH  
*Senior Advisor, Center for Health Policy Research & Ethics*

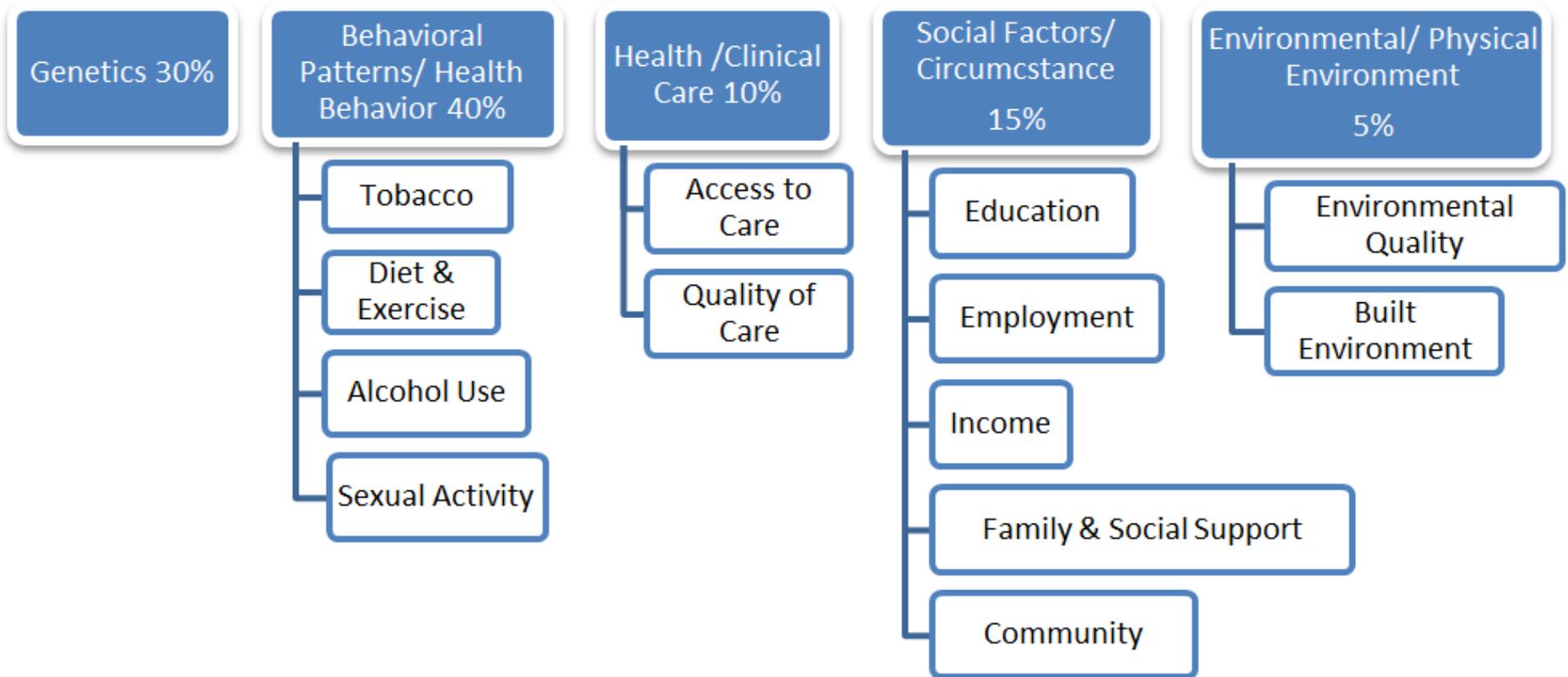
# Determinants of Health: Factors Influencing Health Status



Source: Schroeder, Steven. N Engl J Med 2007;357:1221-8

Adapted from: McGinnis JM, et.al. *The Case for More Active Policy Attention to Health Promotion.* Health Aff (Millwood) 2002;21(2):78-93.

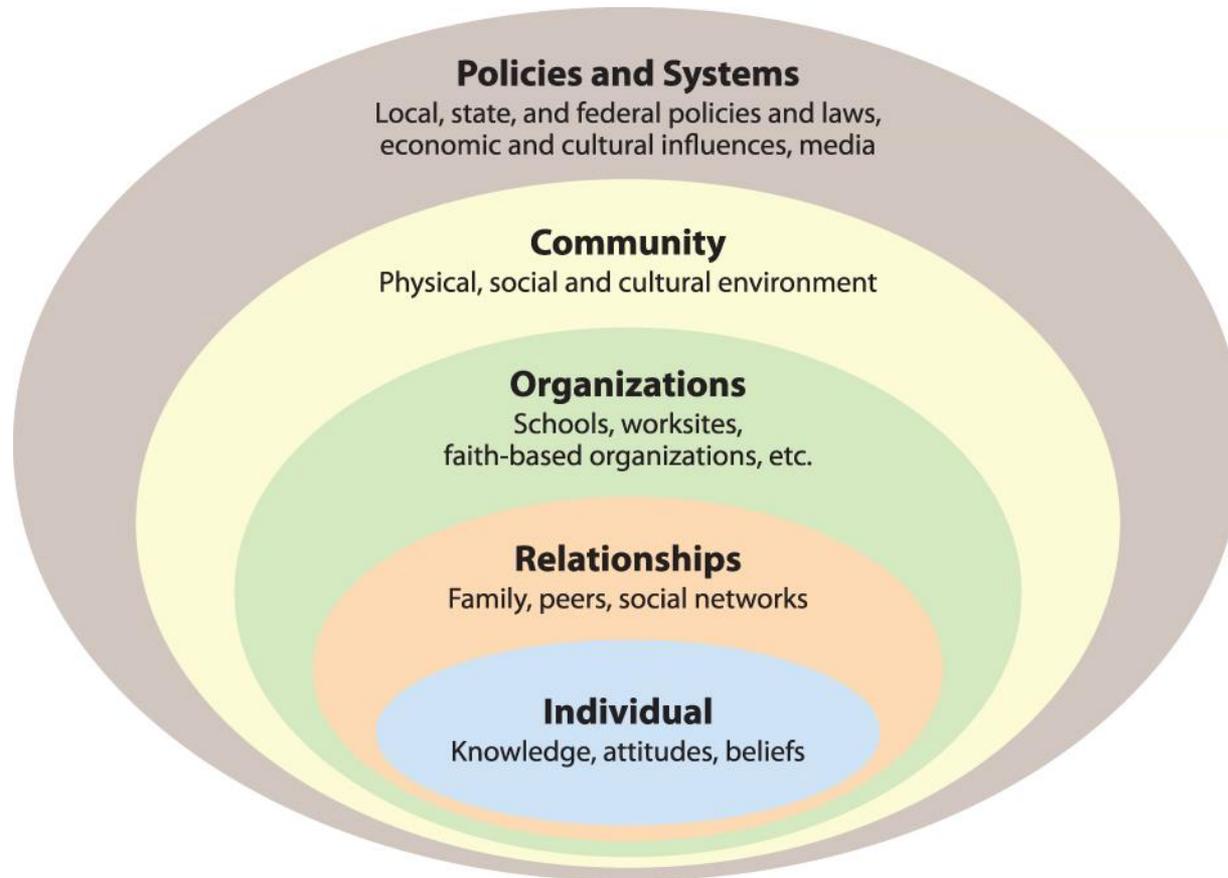
# Factors Affecting Health Outcomes



Source: Schroeder, Steven. N Engl J Med 2007;357:1221-8

Adapted from: McGinnis JM, et.al. *The Case for More Active Policy Attention to Health Promotion.* Health Aff (Millwood) 2002;21(2):78-93.

# Vermont Prevention Model



# Accountable Communities for Health (ACH) Definition

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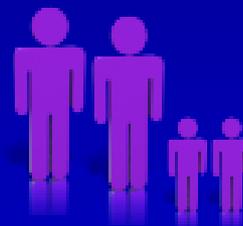
An ACH works across the entire population of its defined geographic area to support the integration of:

- ◆ Medical Care
- ◆ Mental and Behavioral Health Services
- ◆ Social and Community Services
- ◆ Community-Wide Prevention Efforts

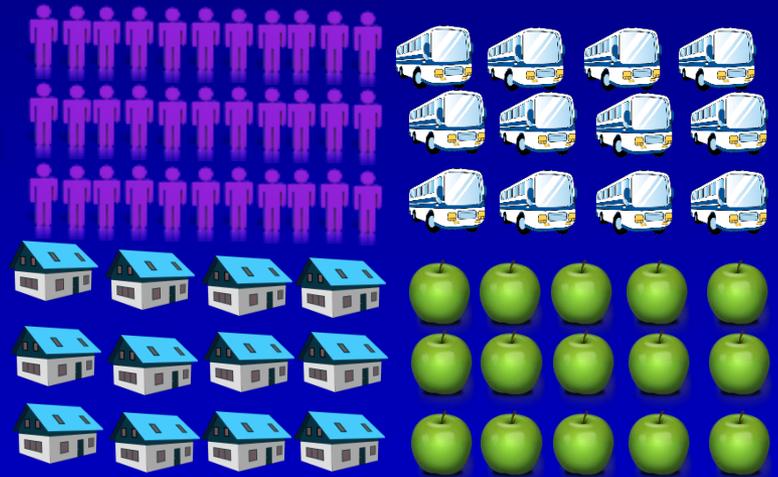
# Medical Care



# Behavior Health & Social Services



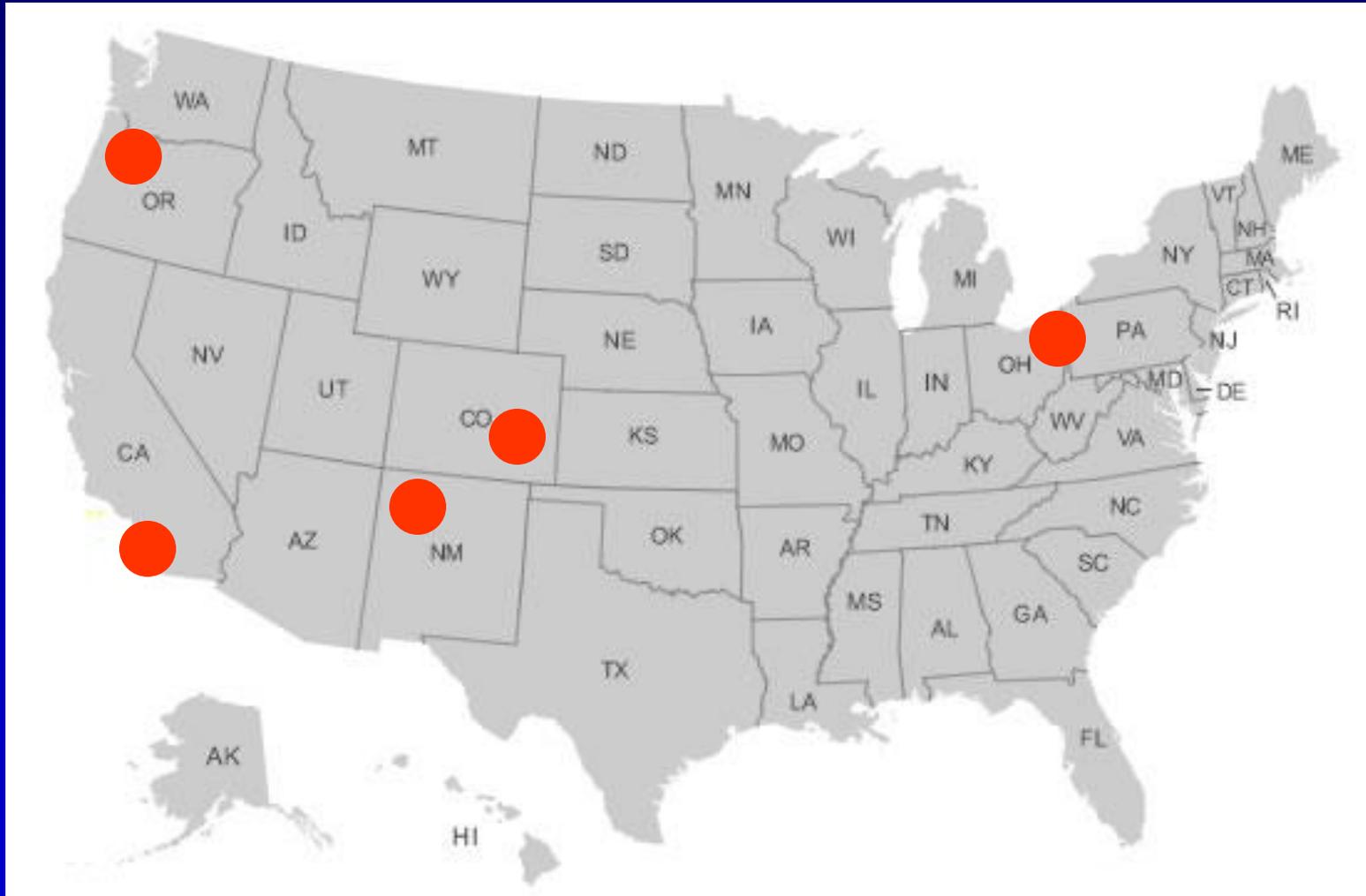
# Community-Wide Prevention



# Accountable Communities for Health



# National Sites



# National Sites

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- ◆ Summit County, Ohio
- ◆ Pueblo County, Colorado
- ◆ Lane County, Oregon
- ◆ San Diego County, California
- ◆ Bernalillo County, New Mexico

# Elements of Accountable Communities for Health

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- ◆ Integrator
- ◆ Partnership
- ◆ Assessment, Planning, and Comprehensive Strategies
- ◆ Data, Metrics, and Accountability
- ◆ Community Resident Engagement
- ◆ Funding and Sustainability

# Integrator

- ◆ Facilitated by an internal or external integrator that coordinates the roles and capacities of the partners within the AHC according to its governance structure

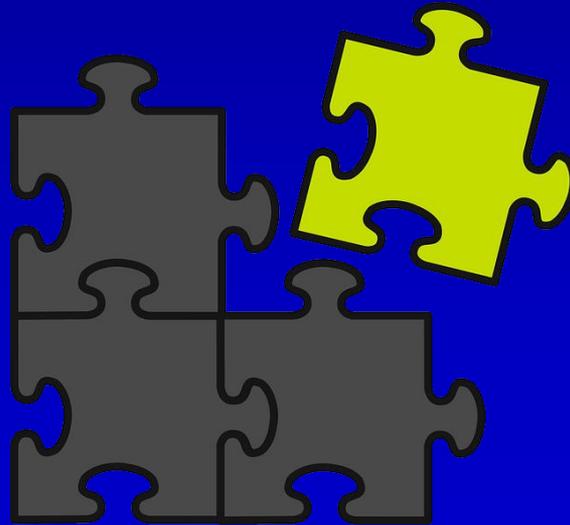


# Integrator

- ◆ San Diego/Summit: HHS/ public health is integrator
- ◆ Lane: Health plan is integrator
- ◆ Bernalillo/Pueblo: External integrators
- ◆ No significant difference observed between internal and external integrators

# Partnership

- ◆ Structured, integrated partnership of healthcare delivery systems, social service agencies, public health departments, government, and community organizations



# Partnership

- ◆ Hospitals and public health always included (except Bernalillo)
- ◆ Pueblo: Signed commitments to a work plan
- ◆ Lane: CHIP assigns responsibility to specific organizations for work
- ◆ Pueblo: External integrator's board requires C-level participation from partners

# Assessment, Planning, and Comprehensive Strategies

- ◆ Engages all partners in a process for assessing and planning health improvement approaches, as well as implementing a comprehensive set of strategies that span the Spectrum of Prevention



## Spectrum of Prevention

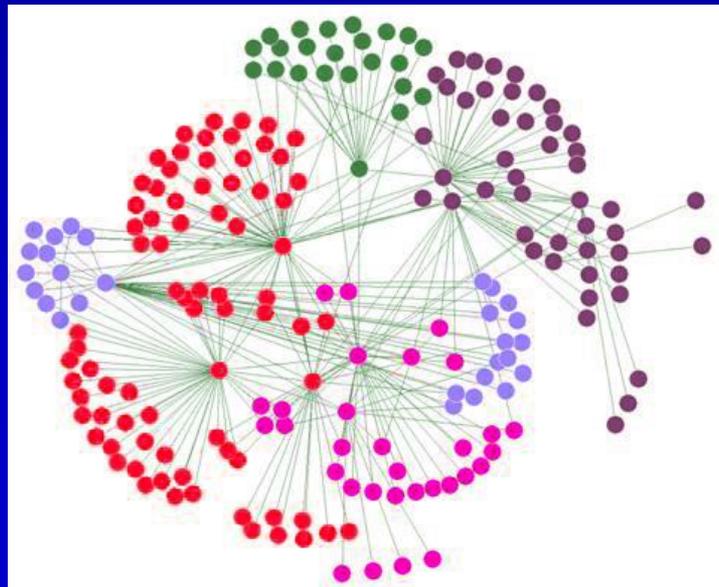


# Assessment, Planning, and Comprehensive Strategies

- ◆ Lane/Pueblo: Metrics span the entire spectrum of prevention
- ◆ All CHIPs include a broad spectrum of strategies
- ◆ Health education and services are emphasized, while community prevention is less well represented
- ◆ San Diego: Partnership structure allows coalition to pursue policy work even though county government is at the center of the effort

# Data, Metrics, and Accountability

- ◆ Includes the exchange of health and community data useful for assessing and developing strategies to improve population health. Measures of quality and performance ensure accountability in planning and implementation



# Data, Metrics, and Accountability

- ◆ San Diego: Data central to planning, evaluation, and communications. Public annual reports on progress.
- ◆ Pueblo: Hospitals share proprietary data with other sectors to measure success
- ◆ Lane: Health plan receives incentivized awards if it meets metrics
- ◆ Bernalillo: Evaluation determines pay. Lack of health outcome data self-identified as limitation

# Community Resident Engagement

- ◆ Prioritizes authentic community participation throughout assessment, planning, implementation, and evaluation processes



# Community Resident Engagement

- ◆ Lane: Community Advisory Council has representation on executive board
- ◆ Overall, community participation is far more likely to involve “grass tops” than grassroots.

# Funding and Sustainability

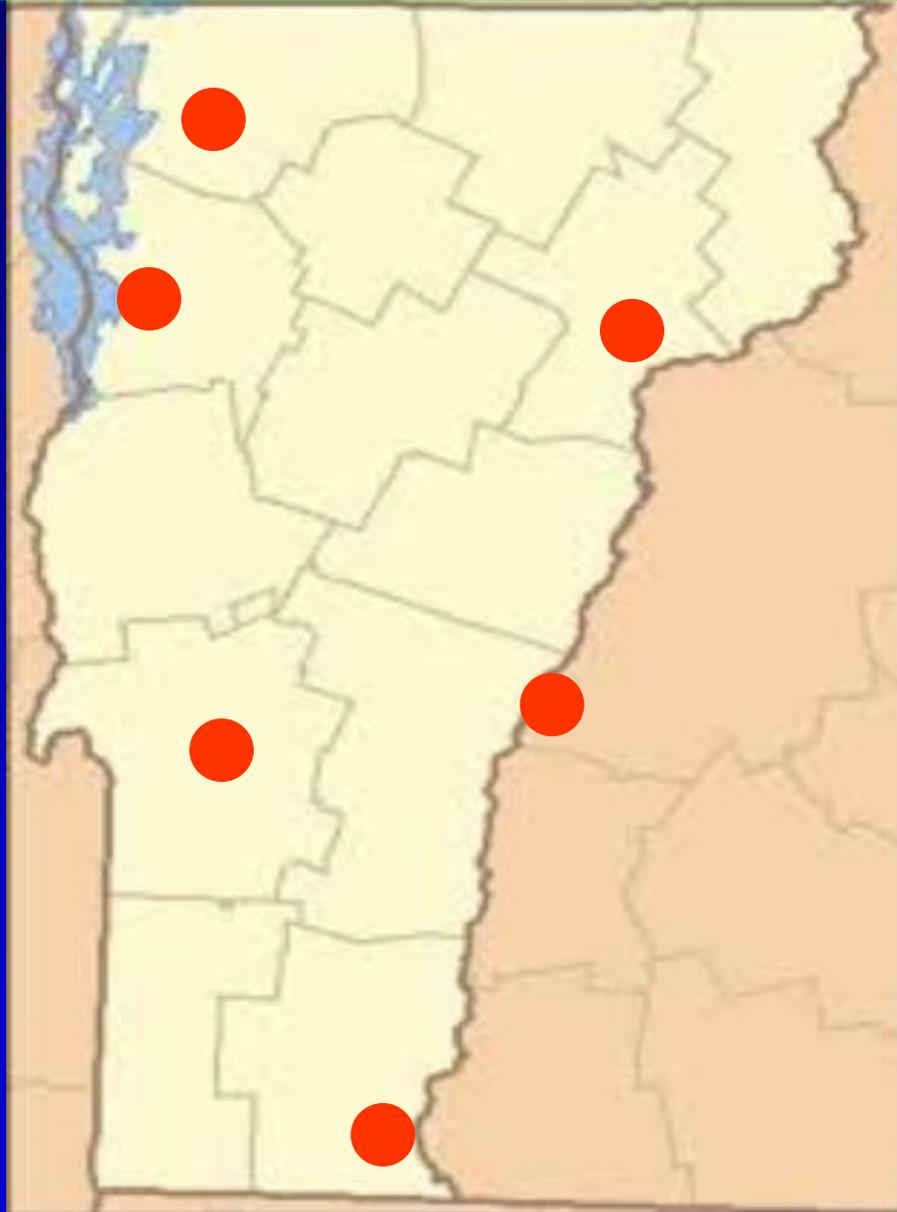
- ◆ Fosters sustainable and generalizable delivery and financing models that support and reward improvements in population health



# Funding and Sustainability

- ◆ Bernalillo: Set-aside portion of mill levy funds integrator
- ◆ Pueblo: Grant funded, contract work
- ◆ Lane: Global Medicaid payments, set-aside for prevention
- ◆ San Diego/Summit : County general funds, grants

# Map and List of Vermont Sites



# Vermont Sites

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- Rise Vermont: Franklin and Grand Isle Counties
- St. Johnsbury Collective Impact
- ECOS: Chittendon County
- Windsor Community Health partnership
- Upper Connecticut River Valley
- Brattleboro

# Integrators

- ◆ Franklin and Grand Isle Counties: Northwestern Medical Center
- ◆ St. Johnsbury: Northeastern Vermont Regional Hospital
- ◆ Burlington: Regional Planning Commission
- ◆ Windsor: Mt. Ascutney Hospital and Health Center
- ◆ Upper Connecticut River Valley: ReThink Health UCRV (TDI)
- ◆ Brattleboro: Brattleboro Memorial Hospital (planning)

# Priorities

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- ◆ Healthy lifestyles
- ◆ Access to mental, behavioral, social, and economic services
- ◆ Substance abuse treatment
- ◆ Poverty – housing, economic development, jobs
- ◆ Aging in Place

# Partners

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- ◆ Hospitals, FQHCs
- ◆ Public Health districts
- ◆ Social Services, AAA, other service providers
- ◆ Regional Planning
- ◆ Business community, media

# Strategies

- ◆ Individual and group health education
- ◆ Service referrals – working with CHTs
- ◆ Model organizational practices to promote healthy lifestyles
- ◆ Regional plans, local tobacco policies, state sugary beverages tax

# Funding

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- ◆ In-kind staff contributions
- ◆ Monetary contribution by hospital
- ◆ Grants

# Building Blocks in Vermont

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- ◆ Communities organizing around ACH concepts
- ◆ The right size for innovation
- ◆ Communities taking action to create healthy environments
- ◆ Vermont Blueprint for Health
- ◆ Hospital system leadership

# Issues for Reflection



# ACH: The Intersection of Two Paradigms

Healthcare and  
Service Providers



- ◆ Individual
- ◆ Responsive to needs

Community-Wide  
Prevention



- ◆ Community
- ◆ Prevents illness and injury in the first place

# Seeking Balance

Service  
delivery and  
integration



Community  
prevention

# Other Reflections

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- ◆ How to motivate ACH participation
  - ◆ Mission-Driven Participation
  - ◆ Funding-Driven Participation
- ◆ Power dynamics in the shifting healthcare marketplace
- ◆ Accountability mechanisms

# Opportunities to Consider



# Seed Funding for ACH Communities



# Ensuring a Strong Role for Community Prevention in the ACH

- ◆ Make the co-benefits for multi-sector partnership explicit
- ◆ Promulgate a comprehensive framework for population health
- ◆ Establish a set of core community level metrics for use by communities
- ◆ Cultivating leadership

# Other Opportunities

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- ◆ Develop practices to maximize synergy between service integration and community prevention efforts
  - ◆ Community-Centered Health Homes
- ◆ Create a set-aside for prevention
- ◆ Closing the loop

**CLOSING THE LOOP  
CAPTURING AND  
REINVESTING  
REVENUES AND SAVINGS  
TO ADVANCE HEALTH AND  
PREVENTION**

**Prevention Funding Mechanisms / Investments**

<ul style="list-style-type: none"> <li>• Prevention-related taxes and fees</li> <li>• Current health / other sector expenditures for community prevention</li> <li>• Social impact funds</li> </ul>	<ul style="list-style-type: none"> <li>• Government funding</li> <li>• Philanthropic investment</li> <li>• Community Benefit / Community Reinvestment Funds</li> </ul>
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**Local Pooled Prevention Fund**

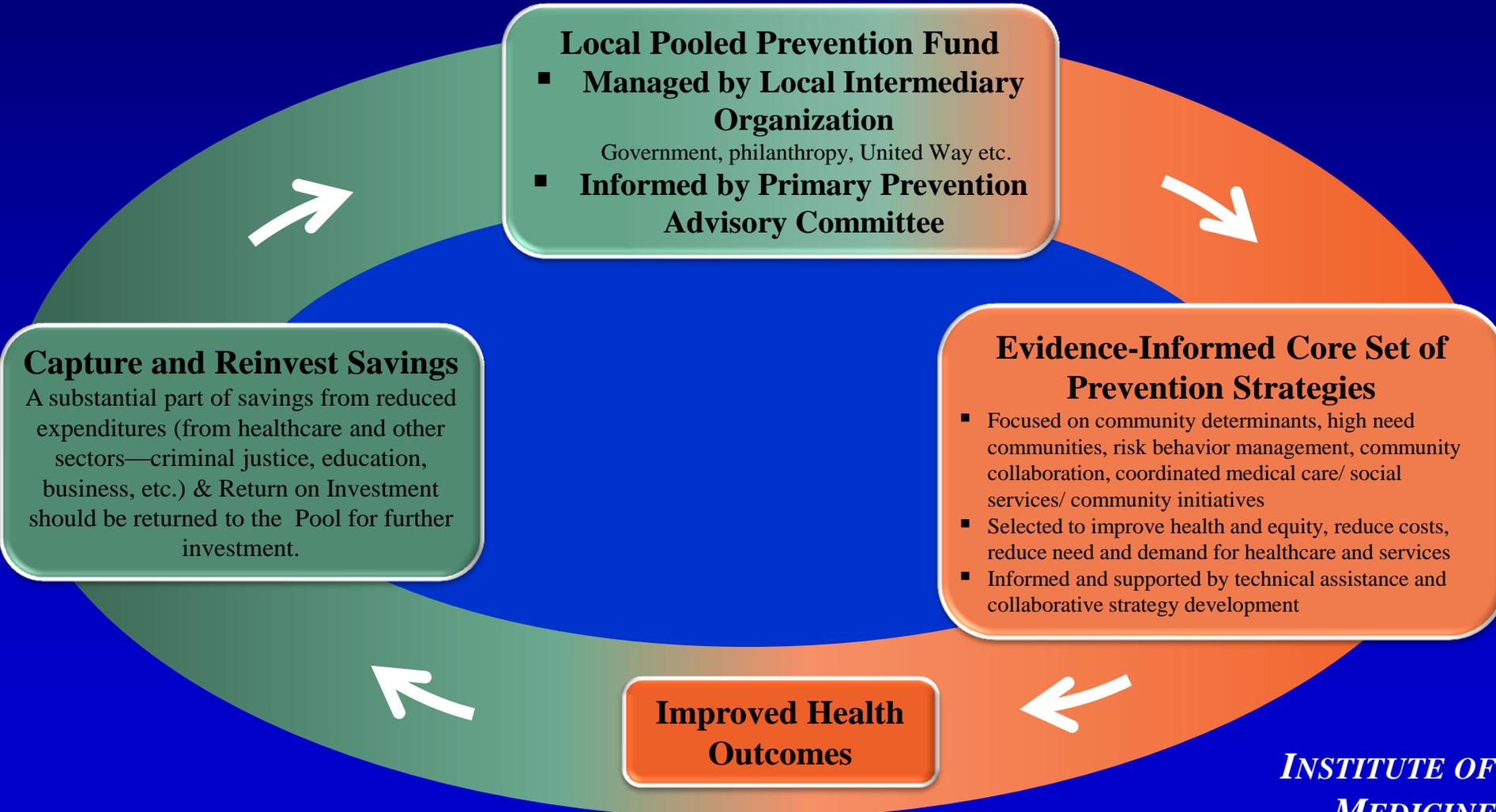
- **Managed by Local Intermediary Organization**  
Government, philanthropy, United Way etc.
- **Informed by Primary Prevention Advisory Committee**

**Capture and Reinvest Savings**  
A substantial part of savings from reduced expenditures (from healthcare and other sectors—criminal justice, education, business, etc.) & Return on Investment should be returned to the Pool for further investment.

**Evidence-Informed Core Set of Prevention Strategies**

- Focused on community determinants, high need communities, risk behavior management, community collaboration, coordinated medical care/ social services/ community initiatives
- Selected to improve health and equity, reduce costs, reduce need and demand for healthcare and services
- Informed and supported by technical assistance and collaborative strategy development

**Improved Health Outcomes**



# Prevention Institute

Prevention  
and  
equity | at the center of community well-being

Questions, Comments? Contact us:

[leslie@preventioninstitute.org](mailto:leslie@preventioninstitute.org)

[william@preventioninstitute.org](mailto:william@preventioninstitute.org)

[www.preventioninstitute.org](http://www.preventioninstitute.org)



**221 Oak Street  
Oakland, CA 94607**

Attachment 3b  
Prevention Institute  
National Accountable  
Communities for Health Profiles

PREVENTION INSTITUTE

# National ACH Profiles

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Draft Copy

6/9/2015

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# Pueblo Triple Aim Coalition

## SNAPSHOT

Name of initiative	Pueblo Triple Aim Coalition
Location	Pueblo County, Colorado (pop. 161,451)
Leadership Structure	The collaboration is coordinated by the Pueblo Triple Aim Corporation, a 501(c)(3) governed by a board of directors that includes CEO-level representation from the various organizations that sit on the collaborative. These include the health department, local hospital systems and FQHCs, Colorado State University Pueblo, and groups like Pueblo United Way, Pueblo Latino Chamber of Commerce, and Pueblo Economic Development Corporation. The CEOs on the board and the organizations they represent are guided by the Pueblo Triple Aim Corporation's bylaws.
Partnership structure	The Pueblo Triple Aim Coalition serves as a neutral convener bringing county stakeholders to the table. Its board creates the policy and governance decisions for the coalition. The coalition is also supported by the Pueblo Triple Aim Steering Committee, which serves in an advisory capacity and represents more grassroots-level participation. Ad-hoc committees are also formed to work on specific issue areas.
Number of staff	2.5 FTE
Stated goal	To make Pueblo County the healthiest county in Colorado based on county health rankings.
Population served	The entire population of Pueblo County, Colorado.
Issues addressed	Obesity, teen and unintended pregnancy, tobacco, and emergency department use and hospital readmissions.
Scope of services	The Pueblo Triple Aim Coalition works across a spectrum of strategies to implement their plan. They strengthen individual knowledge and skills through activities such as training young parents to talk to high school and college-age youth about parenthood, for example, while also working on policy and systems change work such as improving zoning laws to encourage cycling and pushing for a Health in All Policies ordinance to ensure that health impacts are taken into consideration in all major policy decisions.
Link to other healthcare payment or delivery reform	The Pueblo Triple Aim Coalition works with the regional Medicaid ACO on a variety of efforts in care coordination,

efforts	readmissions, and Emergency Department use.
Policy changes	The collaboration has yielded new policies on zoning and land use to promote active living.
Funding sources/ budget	The Pueblo Triple Aim Coalition is largely supported through philanthropic grant funds, though it also works on a contractual basis to help local and state entities perform assessment, planning, and data analysis.
Key reported successes	Improved partnership process, reductions in teen pregnancy, policy change on the county level.
Notable Feature	The Pueblo Triple Aim Coalition serves as an interesting example of how partners representing hospitals, FQHCs, the public health department, and other key players can create an external coordinating organization to serve as a neutral convener of collaborative work, conduct data collection and analysis, lead all activities in the community directed at achieving the Triple Aim, and provide a governance structure for the collaborative. Also notable is the specific inclusion of changes to county policy in the collaborative’s work plan.

**PROFILE**

Background

The convergence of several factors in Pueblo County, Colorado led to the creation of the Pueblo Triple Aim Coalition. Pueblo County had been recognized for some time as a hot spot for collaboration in the health field. In 2010, a number of organizations, including Kaiser Permanente’s new medical offices, began investigating the frameworks of collective impact and ReThink Health. At the same time, the Institute for Healthcare Improvement was seeking local partners to advance the Triple Aim Framework. Finally, the passage of the Affordable Care Act meant that local hospitals would be required to conduct community health needs assessments, in addition to the needs assessment that the county health department was required to carry out under state law.

The environment was ripe for collaboration, and several local groups had already achieved some collaborative successes, including the passage of the toughest tobacco ordinance in Colorado, which prohibits smoking in enclosed public places and places of employment. It was determined that an independent “neutral convener” should be formed to facilitate the future partnership. The Pueblo Triple Aim Corporation was founded as a 501(c)(3) specifically to serve as the coordinating organization for collaborative efforts intended to improve the health of Pueblo County, and was assigned four tasks: (1) Serve as the neutral convener of coalition work; (2) conduct data collection and analysis; (3) Lead all activities in the community directed at achieving the Triple Aim; and (4) provide a governance structure for the collaborative.

When the Pueblo Triple Aim Coalition was founded, according to County Health Rankings, Pueblo County ranked in the bottom five of all 64 counties in Colorado with regards to behaviors directly impacting health, including nutrition, physical activity, tobacco usage, and sexual activity. The Pueblo Triple Aim Coalition was specifically created to improve these metrics.

### Population Served

The Pueblo Triple Aim Coalition seeks to improve the health of the entire population of Pueblo County, Colorado. Its stated aim is “to make Pueblo County the healthiest county in Colorado based on county health rankings.” Much of its work is dedicated to improving health equity in the county.

### Partnership Structure

Pueblo Triple Aim Corporation is the coordinating organization for the collaborative, and is staffed by 2.5 full-time equivalent employees. The Pueblo Triple Aim Corporation’s governing board is comprised of CEO-level representatives from the various organizations that sit on the collaborative. These include the health department, local hospital systems and FQHCs, Colorado State University Pueblo, and groups like Pueblo United Way, Pueblo Latino Chamber of Commerce, and Pueblo Economic Development Corporation. The CEOs on the board and the collaborating organizations they represent are guided by the Pueblo Triple Aim Corporation’s bylaws, and they make formal commitments on behalf of their organizations. Of the nine seats on the board, five are specifically reserved for the CEOs of each of the two local hospitals, the county Public Health Director, the CEO of the local federally qualified health center, and the State Director of Kaiser Permanente.

The coalition is also supported by the Pueblo Triple Aim Steering Committee, which serves in an advisory capacity and represents more grassroots-level participation. Ad-hoc committees are also formed to work on specific issue areas. Some of the groups that make up the ad-hoc committees include groups that exist outside of the realm of the Triple Aim effort.

### Planning

The Pueblo Triple Aim Coalition’s work is largely guided through a Community Health Improvement Plan that was developed with the participation of all the coalition members, particularly the Pueblo City-County Health Department. This plan began with a health needs assessment conducted by the Pueblo City-County Health Department. Members of the coalition described the assessment process as “highly collaborative,” with regards to both the organizations doing the assessing, and overall community involvement. The assessment involved the analysis of 200 indicators and the collection of detailed information on 60 indicators. During the analysis process, community members provided feedback on the data produced and contributed their perspective on what the status of health was in the county. A Community Health Assessment Steering Committee was established to engage in a formal weighting process to identify key areas of strength and concern within Pueblo County. This committee was composed of representatives from the Pueblo County hospitals, community-based organizations, and other key stakeholders. At the end of the assessment process, four issues were identified as community priorities: (1) Obesity prevention; (2) Teen and unintended pregnancy prevention; (3) tobacco prevention; and (4) Improvements in emergency department use and hospital readmissions. The Pueblo Triple Aim Coalition adopted these as its primary issues.

Following the assessment, the Pueblo City-County Health Department worked with the collaborative to develop a planning process for creating strategies to address the identified community needs. The same collaborative that developed the Community Health Assessment divided into work teams to write a Community Health Improvement Plan. Taking a collective impact approach, work teams involved organizations in the process by directly engaging them in the implementation of the plan. The plan detailed goals, objectives, and specific activities that the organizations involved have committed to. It was ultimately approved by both the Pueblo Triple Aim Steering Committee and the Pueblo Triple Aim Corporation Board of Directors.

These plans were then ushered to the implementation phase for actualizing the strategies and objectives outlined in the Community Health Improvement Plan. The work team members and representatives of different organizations involved united to support a variety of identified issues and signed written commitments to complete specific tasks.

### Implementation

The Pueblo Triple Aim Coalition works across a spectrum of strategies to implement their plan. They strengthen individual knowledge and skills through activities such as training young parents to talk to high school and college-age youth about parenthood, and providing outreach on reproductive health and health services to Spanish-speaking populations. They promote community education by conducting community outreach campaigns to increase knowledge about healthy choices for reproductive health care, and identify gaps in the community where parenting groups are needed. To educate providers, they conduct focus groups with high- and low-risk individuals and community members to identify barriers and solutions to accessing medical care and health information, and provide outreach to elected officials, community leaders, and medical providers informing them of the results of the focus groups. The Pueblo Triple Aim Coalition fosters coalitions and networks through its partnership structure consisting of a variety of county stakeholders, as well as its collaboration with Pueblo County agencies and organizations that currently work on Positive Youth Development to maximize resources. To work towards changing organizational practices, the coalition works with school districts to implement policies in accordance with state laws on reproductive education, and to implement comprehensive reproductive and health education in schools. Finally, to influence policy and legislation, the coalition has worked improve zoning laws to encourage cycling, and are working with the Pueblo City Manager to implement a Health in All Policies ordinance to ensure that health impacts are taken into consideration in all major policy decisions.

### Funding and Sustainability

Pueblo Triple Aim Corporation's current budget is supported primarily through grant funding offered by the Colorado Health Foundation. The individual organizations in the collaborative it coordinates have a more diverse portfolio of funding sources, and they contribute in-kind staff time to Pueblo Triple Aim Corporation's efforts. Pueblo Triple Aim Corporation also works on a contractual basis to help local and state entities perform assessment, planning, and data analysis, which supplements their funding. Beginning in June of 2015, in an effort to further diversify its funding, Pueblo Triple Aim Corporation is entering talks with state and local officials to develop processes to capture savings, including Medicaid savings from reductions in teen pregnancies, and state tobacco tax revenues tied to decreased smoking in the county.

## Community Resident Engagement

Pueblo Triple Aim Corporation and its associated collaborative efforts involve the community in several ways. The collaborative developed a community advisory team that represents populations most affected by obesity. The initial members were recruited by Pueblo City-County Health Department Employees; ongoing membership recruitment has been taken over by the team itself. The members of this team advise the coalition work on an ongoing basis. The collaborative also works to build community resident engagement by hosting Community Engagement Nights to collect community-driven data. Regular meetings are also scheduled to involve community stakeholders and discuss progress, hurdles, and identify new strategies.

Additionally, to build partnership and expand buy-in, the collaborative hosts meetings with faith-based community organizations, schools, clinics, hospitals, at-risk families and prevention groups. In doing so, they work to build community alliances, strengthen partnerships and identify champions.

## Data Sharing Capability

The Pueblo Triple Aim Coalition has established a common measurement tool to ensure that all participating organizations and individuals are tracking their progress in the same way so that data can be accurately compared. The coalition uses a management software called ClearPoint to organize and track the activities and objectives of the individuals and organizations participating as well as the community overall. For example, they track both teen pregnancy rates in the county and the progress they are making in their plan to reduce teen pregnancy rates. On the community level, they track years of potential life lost (YPLL), uninsured rates, and residents reporting fair or poor health.

## Accountability

The Pueblo Triple Aim Coalition measures numerous data points that they use to evaluate themselves. There is no formal accountability structure in place with incentives or disincentives. In June of 2015 they will begin discussions with state and local officials to develop processes to capture savings, which has the potential to build more accountability into their work.

To evaluate their progress, the Pueblo Triple Aim Coalition uses multiple measures related to teen pregnancy. Measures include teen pregnancy rates, the number of teens receiving mentoring from adults, and the number of adults and organizations offering mentoring.

## Successes and Challenges

Additionally, the coalition has achieved multiple successes related to county policy change and community improvement. Reported successes include establishing a strong network of community partnerships, engaging leaders in making health a priority, creating a stricter tobacco ordinance, helping organizations come up with their own health assessments based on community data, promoting improved health education in schools, creating new policies on zoning and land use to promote active living, reducing teen pregnancy, and identifying savings.

Reported challenges include engaging the business community, K-12 education, the public and private insurance community and the faith community; improving a short-term mentality around change; addressing the issue of “we don’t know what we don’t know”; and “finding the right place to “plug in.”

### Lessons Learned for Implementing Accountable Communities for Health

Pueblo Triple Aim Coalition staff have pointed to the time and patience needed to build strong partnerships as being important in implementing Accountable Communities for Health. Viewing challenges through the lens of each participating organization was described as an important approach to this process. Additionally, Pueblo Triple Aim Corporation Managing Director Matt Guy explained that the best way that the state could help implement an Accountable Community for Health is by providing funding for innovation, while allowing the community to set regulations and metrics. Ideally, seed money would be provided to hire two to four FTE core staff members.

# Live Well San Diego

## SNAPSHOT

Name of initiative	Live Well San Diego
Location	San Diego County, CA (pop. 3,211,000)
Coordinating organization	County of San Diego Health and Human Services Agency
Leadership structure	In 2010, the San Diego County Board of Supervisors adopted Live Well San Diego as the 10-year plan to improve the well-being of the county. In 2014, the Board took action to align its \$6 billion budget with Live Well San Diego as its long term vision for the region and for the operations of the County. Health and Human Services Agency coordinates the work at a county level and through its Regional Planning Areas.
Partnership structure	Live Well San Diego includes more than one hundred partnering entities working across the county. Each partner formally joins the collaborative effort by passing a resolution expressing their commitment to the Live Well San Diego vision and their willingness to share best practices. Partners meet regularly as Community Leadership Teams and at external collaboratives that exist to address specific issue areas.
Number of staff	At the county-level, nine FTE staff support partnership development, communication, and data. An additional three FTEs support the partnership component of the work in the North Counties Regions, one of five regions in the county.
Stated goal	To advance the health, safety and overall well-being of the whole county
Population served	The entire population of San Diego County
Issues addressed	Building better health (access to quality care; increased physical activity; healthy eating; stop tobacco use), living safely (residents are protected from crime and abuse; neighborhoods are safe to live work, and play; communities are resilient to disaster and emergencies), and thriving (built and natural environment; enrichment; prosperity, economy, and education)
Scope of services	Live Well San Diego addresses issues ranging from

	individual services and referrals to changes in the built environment and policy.
Link to other healthcare payment or delivery reform efforts	Many hospitals and clinics work in various capacities under the Live Well San Diego effort. The “Be There San Diego” initiative focuses on more effectively managing hypertension and preventing heart disease and stroke by building better service delivery systems through partnerships with medical groups, hospitals, clinics, and other healthcare providers and improving standard clinical care interventions to increase control of high blood pressure and high cholesterol. The San Diego Care Transitions Partnership established under CMMI’s Community-Based Care Transitions Program has linked the county and four health systems (13 hospitals) to provide comprehensive hospital- and community-based care transition support to medically and socially complex patients and has reduced the 30-day all-cause readmission rate and Medicare costs for more than 32,000 fee-for-service Medicare beneficiaries since it began in January 2013.
Policy changes	The initiative has worked to encourage localities to improve city pedestrian laws, school wellness policies, procurement policies, and other local policies.
Funding sources/ budget	Existing County resources from general funds; state and federal sources are leveraged to achieve desired results. For example, federal SNAP-Ed nutrition education and obesity prevention funds are used to support improvement in nutrition and physical activity policies and behaviors. These efforts have attracted additional support (e.g., CDC’s CPPW, CTG, and Prevention grants), state, and philanthropic sources.
Key reported successes	Deaths in San Diego attributable to cancer, heart disease and stroke, diabetes, and respiratory conditions have decreased. The partnership structure and work itself is reported as a critical success, creating a shared agenda and commitment to a common goal.
Notable features	Highly coordinated government collaboration; integration of health with safety and standard of living; robust communications systems.

## **PROFILE**

### Background

Live Well San Diego is built upon a strong history of partnership in San Diego County that stretches back to the county's Communities Putting Prevention to Work grant, the Community Transformation Grant, and many earlier efforts. In 2010, the San Diego County Board of Supervisors officially adopted Live Well San Diego as the county's 10-year plan to advance the health, safety, and overall well-being of the county.

San Diego County has a population of over three million people and a geographic area approximately the size of Connecticut. To best serve this large and diverse area, the county Health and Human Services Agency is divided into five Regional Planning Areas (there are technically six areas, but – for the purposes of Live Well San Diego – the North Coastal and North Inland regions are generally treated as one region, known as the North County Regions). As the initiative launched in 2010, these service regions began involving themselves in comprehensive community planning processes. This produced Community Health Needs Assessments, which in turn informed the Live Well San Diego Community Health Improvement Plans. Both the needs assessments and the plans operate on a regional level.

Live Well San Diego first involved county Health and Human Services Agency staff at all levels in the “Building Better Health” component. It then expanded to the other four branches of county government with the addition of the “Living Safely” component in 2012 and “Thriving” in 2014. Community partners first joined in 2013 and now number more than one hundred. Health and Human Services Agency has provided the critical coordinating role, developing partnerships with agencies, organizations, and businesses across the county.

### Population Served

Live Well San Diego aims to improve the health of the entire geographic population of San Diego County, California. San Diego County is currently home to 3,211,000 residents. This profile uses the North County Regions as an example of the regional work taking place in San Diego; the North County Regions has a population of approximately one million, one-third of the county total.

### Partnership Structure

San Diego County Health and Human Services Agency serves as the coordinating organization for Live Well San Diego on both the county level and the regional level. It should be considered an “internal” coordinating organization; it provides a wealth of services within the county beyond its facilitating role, including public health, behavioral health, aging and independent services, children's services, and others. Health and Human Services Agency sponsors the “Building Better Health” agenda; the County's Public Safety Group sponsors the “Living Safely” agenda and the Land Use and Environment and Community Services Groups co-sponsor the “Thriving” agenda.

The list of partner organizations outside of county government now numbers more than one hundred, including hospitals and clinics, school districts, the military, social service organizations, community-based organizations, the business community, and faith-based organizations.

Much of the partnership collaboration occurs on a regional level. In the North County Regions, partners convene at monthly Community Leadership Team meetings. The Community Leadership Team includes key representatives from throughout the North County Regions, where the stakeholders use the regional Community Health Improvement Plan as a guiding document to identify common goals and ways to collaboratively move forward to achieve the regional goals. Data provided by the county helps inform this work by allowing the teams to identify priority areas for intervention and track their progress. In addition to the Community Leadership Team meetings, existing workgroups and coalitions within the region address specific issues (e.g., preventing violence). These efforts are also considered part of Live Well San Diego.

No formal governance structure or memoranda of understanding bind the various partners in the collaborative. However, organizations that wish to join Live Well San Diego as recognized partners do go through a process that involves their governing board passing a resolution expressing their commitment to the Live Well San Diego vision and their willingness to share best practices. This is to build organizational buy-in amongst the partner organizations, rather than potentially relying upon a single champion within the partnering organization to maintain the collaboration.

### Planning

Live Well San Diego's guiding strategic framework is a pyramid model outlining "ten indicators that measure progress in achieving the vision for healthy, safe, and thriving communities; five areas of influence that capture overall well-being; four strategies that encompass a comprehensive approach; three components to be rolled out over the long-term initiative; and one vision of a healthy, safe, and thriving San Diego County."

This strategic framework is reflected in San Diego County's Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP), both of which were conducted through extensive regional and county processes. San Diego County developed both its CHA and CHIP through a community health improvement planning model adapted from the National Association of County and City Health Officials and the Centers for Disease Control and Prevention, called Mobilizing for Action through Planning and Partnerships (MAPP). Because of the size and diversity of the county, each region participates in its own CHA and CHIP processes. Health and Human Services Agency Community Health Statistics staff provide data on demographics, community health indicators, and additional countywide and regional health data to the five regional Community Leadership Teams through the development stages. Final documents are produced by Health and Human Services Agency, which weaves the regional CHAs and CHIPs into complete, county-wide documents.

In the North County Regions, the CHIP was developed through quarterly community forums over a two-year period that brought community partners together to discuss priority health issues. Surveys and assessments were also used to inform this process. North County Community Leadership Team members used the MAPP planning model in bimonthly meetings to help determine priority areas. Under the Building Better Health component of Live Well San Diego, three priority areas were selected: (1) Physical Activity; (2) Nutrition; and (3) Behavioral Health. Success in each priority area is linked to objectives and performance measures, some of which relate to policy, systems, and environmental change and others that relate to individual behaviors. For example, in the Physical Activity priority area, one of the objectives is to “Increase the number of community stakeholders that adopted Live Well San Diego to utilize joint use policies by December 2018,” using “number of schools with joint use agreements” as the performance measure. In the Behavioral Health priority area, one of the objectives is to “Increase the percentage of residents who needed a mental health service and who sought out a service by 1% by December 2018,” using data from the California Health Interview Survey as the performance measure.



### Implementation

Live Well San Diego has three key components and four basic strategies that guide efforts to achieve its vision of a healthy, safe, and thriving county. The “Building Better Health” component includes the development of better service delivery systems through strong partnerships with hospitals, clinics, and other healthcare providers. As an example, Be There San Diego – an initiative of local medical groups, hospitals, health plans, Naval Medical Center San Diego, community clinics, the local medical society, and the county – has a shared goal to make San Diego the nation’s first heart attack and stroke-free zone. The collaboration has established

regional standards of care and treatment protocols for more effectively managing hypertension and preventing heart disease and stroke and has designed technology-supported tools to assist physicians in managing the health of their whole practice population and helping patients manage their own health outcomes.

In the North County Regions, Palomar Hospital has a community liaison who sits on the Community Leadership Team and works to address community health issues through such efforts as diabetes screenings at schools and health education programming for students and families.

Live Well San Diego works to provide county residents with individual knowledge and skills to support healthy behaviors. For example, the 5-2-0 messaging campaign aims to increase knowledge about childhood obesity prevention by recommending to children five servings of fruits and vegetables daily, two hours of exercise per week, only one hour of non-instructional screen time daily, and zero sugary beverages daily. The message is disseminated through schools, community fairs, brochures, and posters. Live Well San Diego also works to educate providers of medical and other services on prevention. For example, over 600 county employees received violence prevention training through the Risk Awareness, Violence Prevention and Crisis Response Training.

Changing organizational practices is another area where Live Well San Diego is active. In North County Regions, the partnership works closely with school districts to update their wellness policies to better support health, as well as creating specific organizational policies to support safe routes to schools. Live Well San Diego also promotes policy change. In North County Regions, members of the Community Leadership Team, partner organizations, and local resident leaders have worked with cities to improve pedestrian safety laws to encourage active transportation. For example, this collaborative work in one North County city resulted in an agreement by city staff to update their crosswalk policies, which date back to the mid-1970s, as well as create new sidewalks at a critical intersection near two local schools.

### Funding and Sustainability

Live Well San Diego is primarily funded by leveraging and optimizing existing resources – county general funds, state, and federal support. Because Live Well San Diego has been so successfully integrated into the overall mission of the county, it provides a basis for coordinating efforts that serve the same clients, working with community partners, and attracting new funding sources from government and foundations. The Affordable Care Act has been a major source of such resources, from CDC's CTG and Prevention grants to the CMMI award to the San Diego Care Transition Partnership and to Medicaid funding for increased community outreach to enroll the newly eligible childless adult population. Health and Human Services Agency's role as coordinating organization is funded through its annual county budget.

### Community Resident Engagement

The Community Health Assessment and Community Health Improvement Plan that guide Live Well San Diego were both developed with broad community participation through the Mobilizing for Action through Planning and Partnerships (MAPP). In the North County Regions,

the collaborative work that takes place in the Community Leadership Team meetings is informed by community partners, which are largely organizations that aim to represent residents.

Data Sharing Capability

At the county-level, the Community Health Statistics Unit and the Office of Business Intelligence are responsible for gathering, analyzing, managing, and improving data. The Community Health Statistics Units provides health statistics that describe health behaviors, diseases, and injuries for specific populations, health trends and comparisons to national targets, as well as linking to available local, state and national statistics. The Office of Business Intelligence provides information, risk analysis, and predictive analytics to support Live Well San Diego, identifying opportunities for service integration through the use of data reporting and business process analysis. The Office of Business Intelligence employs tools such as integrated dashboards, data visualization, data mining, and predictive analytics.

These data are provided from the county to the regions to support regional planning and implementation of activities.

Evaluation

Live Well San Diego relies upon a shared measurement system to collectively focus its activities and track the progress of its collaborative effort. With input from local, state, and national experts, Health and Human Services Agency developed the Live Well San Diego Indicator framework to highlight the top ten indicators and allow for progress assessment. The framework encompasses the range of factors that impact how individuals live and recognizes the influence of social and environmental factors on overall health and wellbeing. By drawing a link between living condition and overall health, the Live Well San Diego Indicator Framework includes measures for assessing health outcomes as well as those that address social determinants of health.

Live Well San Diego top ten indicators and associated measures:

INDICATOR	MEASURE
<b>HEALTH - Enjoying good health and expecting to live a full life</b>	
Life Expectancy	Measure of length of life expected at birth and describes overall health status
Quality of Life	Percent of population that is sufficiently healthy to be able to live independently
<b>KNOWLEDGE - Learning throughout the lifespan</b>	
Education: High School Diploma or Equivalent	Percent of population with at least a High School Diploma or equivalent
<b>STANDARD OF LIVING - Having enough resources for a quality life</b>	
Unemployment Rate	Percent of the total labor force that is unemployed
Income: Spending Less Than 1/3 of Income on Housing	Percent of population spending less than 1/3 of household income on housing
<b>COMMUNITY - Living in a clean and safe neighborhood</b>	

Security: Crime Rate	Number of crimes per 100,000 people
Physical Environment: Air Quality	Percent of days that air quality was rated as unhealthy
Built Environment: Distance To Park	Percent of population living within a half mile of a park
<b>SOCIAL - Helping each other to live well</b>	
Vulnerable Populations: Food Insecurity	Percent of population with income of 200 percent of poverty or less, who have experienced food insecurity
Community Involvement: Volunteerism	Percent of population who volunteer

### Successes and Challenges

The sheer size and magnitude of Live Well San Diego is identified as a challenge of this effort. Despite the obstacles put forward by creating a program to serve a diverse county of more than three million, the leadership of Live Well San Diego takes great pride in “the momentum that has been created where partners are recruiting partners, embracing the goals and vision, and organizations genuinely want to be a part of Live Well San Diego.”

Another challenge was that, in the early stages of Live Well San Diego, the work advanced more quickly than the processes and infrastructure could keep pace with. Additionally, the ability to sustain meaningful regional engagement of the partners as they come on, and in the long term, is seen as a challenge.

### Lessons Learned for Implementing Accountable Communities for Health

Keep it simple. From messaging to measurement, “potent simplicity” is the rule. In reaching across political jurisdictions, disciplines, programs and geographic and cultural lines, it is necessary to communicate very clearly and simply the issues, the proposed solutions, the measurements and the opportunities to engage.

Keep it local. In a large, diverse region like San Diego County (which has a population of 3.2 million filled with complex societal dynamics, 18 incorporated cities, 18 tribal organizations and 43 school districts), information, engagement and action must occur at the sub-regional level in order to be effective and sustained. A one-size-fits-all approach to community health improvement does not always work.

Keep it real. Large population wellness initiatives require goal and resource alignment, changing the business culture to be more data-driven and evidence-based and addressing workforce wellness concurrent with population health—“walking the talk.” Initially, progress is slow and steady, but it accelerates with time.

# Live Healthy Summit County

## SNAPSHOT

Name of initiative	Live Healthy Summit County
Location	Summit County, OH (pop. 541,824)
Leadership structure	Coordinated by Summit County Public Health, overseen by an Executive Committee, and informed by a soon-to-be-merged Advisory Committee and Wellness Council that represent external organizations and the community
Partnership structure	Summit County Public Health coordinates efforts with external partners participating on a voluntary basis
Number of staff	Live Healthy Summit County is fairly well-integrated into Summit County Public Health, making it difficult to determine the exact number of staff members involved. It is estimated that nine staff members, including the Assistant Director, are involved in the initiative.
Stated goal	Live Healthy Summit County seeks to strengthen the local community by promoting healthier lifestyles and reducing chronic diseases and health disparities.
Population served	The entire population of Summit County
Issues addressed	(1) Tobacco-free living; (2) active living and healthy eating; (3) high-impact quality clinical and other preventive services; (4) social and emotional wellness; and (5) healthy and safe physical environments.
Scope of services	From preventative services to policy and built environment change
Link to other healthcare payment or delivery reform efforts	Bidirectional referrals between the medical sector and public health
Policy changes	Currently advancing a Health in All Policies platform at the county level
Funding sources/ budget	Funding comes through grant opportunities for different areas of work that the county places under the umbrella of Live Healthy Summit County, as well as general fund dollars dedicated to the public health department.
Key reported successes	Process accomplishments include increased Wellness Council membership from 60 to 70 organizations; implementation of

	<p>software to track health and wellness programs, along with participation from the county’s four major health systems; a completed policy scan of the county; and the identification and adoption of key individual and population-wide indicators to evaluate progress.</p> <p>Outcome accomplishments include the adoption of smoke-free policies in public housing; changes in road structure to calm traffic along routes to school; launching a “green cart” program to create business opportunities for vendors to sell fruits and vegetables in food deserts; launching a program in collaboration with two large community health systems to implement enhanced quality of care protocols that support the control of high blood pressure and high cholesterol at 34 sites; and implementing The Million Hearts Project in Summit County, which included assisting local physician providers to develop a screening tool specific to their practices on assessing psychosocial supports that may be needed by hypertensive clients to maintain compliance in managing their hypertension diagnosis.</p>
<p>Notable Feature</p>	<p>Summit County was the genesis of the ACC/ACH concept. It has created a structure that involves the three largest regional healthcare systems on its Executive Committee. Additionally, its strategies work along the full spectrum of the socio-ecological model, and it is pursuing a Health in All Policies review for all county policies.</p>

**PROFILE**

Background

In 2012, the publication of “Healthier by Design: Creating Accountable Care Communities” garnered national attention for the Live Healthy Summit County initiative. Live Healthy Summit County is a community-level initiative that promotes healthier lifestyles among residents of Summit County, Ohio. The work began in 2008, when the Knight Foundation provided funding to create the Austen BioInnovation Institute in Akron (ABIA) with the support of the local university and hospitals. ABIA’s Center for Clinical and Community Health Improvement secured financial commitments from the hospitals to assess county health and document gaps in existing policies, environments, programs, and infrastructure.

In 2011, ABIA’s Center for Clinical and Community Health Improvement received a federal Community Transformation Grant (CTG) for capacity building to continue this work. With the support of CTG funds, ABIA organized a coalition of more than 70 community organizations with a range of missions to form the Summit Partners for Accountable Care Community Transformation (Summit PACCT). The coalition was designed to promote healthy lifestyles and reduce chronic disease prevalence and health disparities. However, sustainable funding for this

work proved elusive, and as the foundation funds and federal grant funds receded, stewardship of the project transferred to Summit County Public Health, the current coordinating organization for Live Healthy Summit County.

### Population Served

Live Healthy Summit County serves the entire geographic population of Summit County, Ohio. Summit County is currently home to 541,284 residents.

### Partnership Structure

Summit County Public Health (SCPH) serves as the coordinating organization for this effort and sponsors all Live Healthy Summit County activities. Approximately nine Summit County Public Health staff members are engaged in the initiative.

Live Healthy Summit County has an Executive Committee composed of executive-level representatives from 10 key institutions: three research universities, three health systems, one federally qualified health center, one payer, the Akron city government, and the Summit County government. In addition, an Advisory Committee and a Wellness Committee work to shape overarching strategy, goals, and collaboration. As of May 2015, these two committees are scheduled to merge into one. These committees work on an advisory basis – the collaboration and partnerships involved in Live Well Summit County do not involve a formal governance structure, memoranda of understanding between the various partners, or formal decision-making process.

Notable partners that serve on the various committees include Summit County Public Health, the three major hospitals within Summit County, the Akron Mayor's office, and county government agencies working on social services, housing, and transportation. Other key members of Live Healthy Summit County include substance abuse and mental health providers, the local national park, the United Way, the YMCA, several faith-based organizations, community service providers such as Asian Services in Action, and higher learning institutions such as the University of Akron and Kent State University.

### Planning and Implementation

Summit County is moving toward a model of shared community health assessment, but is challenged by legal requirements and timelines. For instance, the Affordable Care Act requires each of the three hospital systems that serves as a partner in the collaborative to conduct a community health assessment. Using data provided by sources like SCPH, each hospital conducted its own assessment and wrote an implementation process for the actualization of its plans. After analyzing themes that arose in each of their Community Health Assessments, two priority areas were identified and the three hospitals agreed to pursue a shared effort to address diabetes and prioritize Health in All Policies. As the coordinating organization, SCPH will continue to play a facilitating role throughout the development process of the second Community Health Assessment that the hospitals must produce in 2016.

Live Healthy Summit County strives to improve population health by achieving tobacco-free living, promoting active living and healthy eating, advancing high-impact quality clinical and other preventative services, supporting social and emotional wellness, and fostering healthy and

safe physical environments. Through its Million Hearts project, Live Healthy Summit County is improving the connection between community health resources and healthcare providers by utilizing a referral network to address issues related to social determinants of health.

The initiative also involves partners from a diverse realm of sectors and invites both service providers and higher level policy influencers into the network of members working together to serve the community in a wide range of capacities. At the health department, an organization that serves as a partner in the Live Healthy Summit County initiative, there is a system of care coordination in place to allow staff to call social service providers on their patients' behalf. The collaborative is also involved in educational and training activities. For example, through the Million Hearts Project, training was provided for physicians on how to interact with public health in their communities. As a result of this training physician officers were able to conduct blood pressure referrals for patients who seemed not to be compliant with their medication regimen or had other social needs. Physician office staff learned how to make referrals to public health and public health, in turn, learned how to make referrals back to physician offices.

The collaborative also works to change organizational practices as they were involved in getting local employers to introduce worksite wellness practices to their business model. Similarly, SCPH works to influence larger policies and legislation. A Health in All Policies work group was established under the Live Healthy Summit County initiative in an effort to integrate a health framework into all decisions made by county government. This group was able to complete a large community engagement phase of Health in All Policies, host a community event, and send out a survey to collect information about what the community thought should be included in the Health in All Policies charter and what policies would have the most effect on the community. The end goal is to develop a Health in All Policies charter for the county, which will then be presented to various governing bodies, both public and private, to garner support.

### Funding and Sustainability

Summit County Public Health works with approximately 80 organizations and holds open meetings to encourage community participation. The collaborative activities are funded by leveraging financial resources to support the initiative's priorities. Live Healthy Summit County is funded primarily through grants, which means that the availability of grant-funded opportunities often determines which activities are carried out. Outside of grants, the organization receives funding from the general fund. The overall budget amount ranges from \$900,000 to \$1,000,000, but the general revenue is about \$200,000. SCPH uses grant funding to offset the costs that remain after general revenue funds are spent. At this time, SCPH does not have any healthcare payment innovations in place to support the initiative, nor does it have any mechanisms in place for realized savings to be reinvested back into the effort.

### Community Resident Engagement

Live Healthy Summit County encourages community participation, particularly through its Health in All Policies work. The project has contracted with Project Ujima, an organization that specializes in community engagement and facilitated community dialogue.

Furthermore, SCPH has identified community engagement as an area for improvement. To this end, it distributed an online survey to the community, and received over 600 responses from community members. SCPH has also made plans to involve more community members on its

soon-to-be merged Advisory/Wellness Committee. The goal moving forward will be to generate broad input on the community health needs assessment in 2016.

### Data Sharing Capability

SCPH has implemented some data sharing practices to enable the distribution of relevant information. For example, it runs the Access to Care Program, which has collected years of data on diabetes and hypertension. Additionally, its Healthy Summit 2020 project tracks key quality of life indicators among Summit County residents over time. Data for Healthy Summit 2020 comes from a wide array of partners, mainly the large levy-funded agencies within the county and other government organizations.

School data is organized by the Summit Education Initiative, which receives data from almost every district (public and private) in the county and analyzes key readiness indicators to track educational progress over time. Furthermore, SCPH tracks data on school readiness and child development. Medicaid HMOs share data with SCPH on children that are behind on child visits. The Maternal Depression Project allows for screening in OB offices, and has established a system has been to connect at-risk patients with immediate referrals after the screenings are complete.

With all of these data tracking practices in place, SCPH hopes to build an equity database to help improve the quality of health disparity information gathered.

### Accountability

Beyond the Healthy Summit 2020 metrics, SCPH does not evaluate Live Healthy Summit County using one single framework. Evaluation measures for the initiative as a whole are closely tied to the Community Transformation Grant, and individual activities within the initiative are evaluated separately. Live Healthy Summit County does not currently have any accountability measures in place tied to financial incentives or disincentives.

### Successes and Challenges

Through the Community Transformation Grant experience, ABIA's Center for Clinical and Community Health Improvement was able to improve environmental and policy scans in the community. These improvements laid the foundation for current work. Today, Summit County reports that it can successfully demonstrate a new, emerging governance structure with public health at the hub of the wheel. It has engaged diverse, multi-sectorial community partners who are highly involved in both "upstream" and "downstream" strategies.

Even with this momentum, challenges still exist. Regional adult hospital systems are experiencing significant changes under national health reform, which has impacted their level of engagement at times. Additionally, Summit County still seeks a long-term financial model that can provide sustainable funding for Live Healthy Summit County.

### Lessons Learned for Implementing Accountable Communities for Health

SCPH staff and others involved in the initiative all pointed to the importance of communication to facilitate successful collaboration. James Hardy, Assistant Director of Community Health at SCPH, described this:

“It may seem like an over simplification, but communication really is key. It is necessary to have a lead organization whose responsibility includes ensuring communication pathways between activities and stakeholders. In a resource-rich environment like Summit County, funding hasn’t been the major challenge, but rather coordination of resources and activities has been the focus of our efforts in recent times. The extent to which you can ensure effective governance structures at the outset the more likely you’ll be to steer clear of such issues.”

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# Trillium Community Health Plan

## SNAPSHOT

Name of initiative	Trillium Community Health Plan
Location	Lane County, Oregon (pop. 356,212)
Leadership Structure	Trillium is governed by a board of 22 directors that includes senior Trillium employees, representatives from hospitals, primary care and specialty care physicians, county government, the county public health department, and others, as well as representatives from its Community Advisory Council and its Rural Community Advisory Council. As a Coordinated Care Organization, Trillium is ultimately accountable to the Oregon Health Authority.
Partnership structure	Trillium partners with its Community Advisory Council, its Rural Community Advisory Council, Lane County Public Health, and several other workgroups to invest in population health improvement efforts.
Number of staff	As the county Medicaid provider, Trillium has a number of employees providing the services of a medical payer. In addition, Trillium funds three prevention employees at Lane County Public Health through a financial set-aside, as well as an additional prevention FTE to interface with schools.
Stated goal	Trillium Community Health Plan is dedicated to transforming healthcare for Lane County's Medicaid beneficiaries into a system that makes substantial and sustainable advancement toward achieving the triple aim.
Population served	Trillium serves the approximately 92,000 Medicaid beneficiaries in Lane County, constituting 26 percent of the total population. In addition, specific collaborative prevention activities they have engaged in have been targeted at the broader population of Lane County.
Issues addressed	Medicaid services, healthcare and behavioral health integration, health equity, tobacco, obesity, substance abuse and behavioral health, access to health care.
Scope of services	Trillium pays for a range of medical services including doctor visits, prescriptions, medical equipment, hospital stays, dental care, mental health services, tobacco cessation, substance abuse treatment, vision, home healthcare, and transportation to healthcare appointments. In addition, Trillium's community

	<p>partnerships have brought tobacco prevention programs into schools, created interventions for pregnant mothers who smoke, and engaged in a range of other population health-focused activities.</p>
<p>Link to other healthcare payment or delivery reform efforts</p>	<p>Trillium is closely linked to healthcare payment and delivery reform efforts in Oregon, including (1) improving care coordination; (2) implementing alternative payment methods; (3) integrating physical, behavioral, and oral health; (4) increased efficiency through administrative simplification; (5) use of flexible services to improve care; and (6) spreading effective innovations and best practices.</p>
<p>Policy changes</p>	<p>Trillium endorsed a tobacco prevention policy that recently took effect in Lane County, which was backed by Lane County Public Health, the Community Advisory Council, and the Rural Community Advisory Council. While Lane County Public Health has embraced a policy, systems, and environmental approach to public health, Trillium has played less of a central role in these efforts thus far.</p>
<p>Funding sources/ budget</p>	<p>As a Coordinated Care Organization, Trillium receives a capitated per-member per-month budget from Oregon’s Medicaid program. Trillium has approximately 92,000 members as of April 2015. In addition, Trillium is eligible to receive incentivized funds from Oregon’s CCO Performance and Quality Pool for achieving key quality benchmarks. CCO collaborative prevention activities are funded through a specific per-member per-month set aside that Trillium provides from its global budget; those funds go to staffing and program support for Lane County Public Health.</p>
<p>Key reported successes</p>	<p>Successfully met key statewide quality metrics for service delivery, created a smoking cessation incentive program for pregnant women, trained 200 teachers in an evidence-based tobacco prevention program for seven-year-olds, integrated behavioral health providers and medical providers in eight different clinics in the county, supported the successful passage of a county cigarette regulation ordinance.</p>
<p>Notable Feature</p>	<p>Trillium serves as an example of successful integration between physical and behavioral health services. It is also quite notable that Trillium and Lane County have created a structure to invest Medicaid dollars in prevention activities that extend significantly beyond the scope of services that are normally billable (e.g., tobacco prevention programs in county schools).</p>

## PROFILE

### Background

Oregon Health Plan, the state's Medicaid program, underwent significant reform in 2012. Under a waiver from the federal government, Oregon embarked upon a program that allowed the state greater flexibility in how it spends its Medicaid dollars, with the provision that it must meet quality metrics while growing at a rate that is 2 percent slower than the rest of the United States. The state began implementing its new program through Coordinated Care Organizations (CCOs). These are local managed care entities, selected through a competitive process, that receive capitated budgets from the state to provide Medicaid beneficiaries with integrated physical, behavioral, and dental care.

In Lane County, Trillium Community Health Plan launched as the county's CCO in the summer of 2012. It took on the portfolios of both Lane Individual Practice Association, the local Medicaid managed care plan, and LaneCare, the division of the county Department of Health and Human Services responsible for behavioral health services. Trillium was also the recipient of Transformation Award funds from the state government – a one-time award that allowed them to launch the Shared Care Plan, which focuses on care coordination and quality, patient activation, and health information exchange work.

Lane County was also the site of an innovation in integration between service delivery and public health that has its roots in a collaboration between Lane County Public Health and Trillium's parent company through a United Way initiative called the 100% Access Coalition. The Lane County Public Health administrator and the CEO of Trillium sat on the Steering Committee and worked together to foster a community-wide initiative to increase the uninsured population's access to health care. When Trillium launched as a CCO, there was already a collaborative relationship between the two organizations. This led to an arrangement where Trillium dedicates a per-member per-month set aside of its funds to pay the salaries of three FTE Lane County Public Health Department employees and support their prevention programs. This collaboration is unique in the state of Oregon.

### Population Served

Trillium's primary population is the approximately 92,000 Medicaid beneficiaries in Lane County, who comprise about one quarter of the county population. By definition, this group is low-income. Trillium has also partnered with Lane County Public Health to engage in prevention activities that benefit the broader population of the county.

Lane County contains the small cities of Eugene, Springfield, and Cottage Grove, and is otherwise quite rural.

### Partnership Structure

Trillium has its roots in its founding partnership between Lane Individual Practice Association, the previous Medicaid managed care plan, and LaneCare, the division of the county Department of Health and Human Services that was responsible for behavioral health services. During the

merger process that founded Trillium as a CCO, internal planning teams from each organization met regularly to integrate their systems and ensure that Trillium would have a unified approach to referring to both physical healthcare and behavioral and mental health.

Trillium is governed by a board of 22 directors that includes senior Trillium employees, representatives from hospitals, primary care and specialty care physicians, county government, Lane County Public Health, and others, as well as representatives from its Community Advisory Council and its Rural Community Advisory Council. As a Coordinated Care Organization, Trillium is ultimately accountable to the Oregon Health Authority.

Under the CCO charter with the state, Trillium is also required to have a Community Advisory Council (CAC), a board of Trillium consumers and Lane County community members. The CAC is charged with engaging Trillium members and the community as a whole to advise and make recommendations to the Trillium Board on the strategic direction of the organization, ensure that Trillium remains responsive to consumer and community health needs, and advise on the design and priorities of Trillium in achieving the Triple Aim. Two CAC members serve as representatives on the Trillium Board, fulfilling a state requirement of the CCO. Lane County also has a Rural Community Advisory Council to more specifically represent the rural interests of the county.

Trillium also works collaboratively to advance prevention. Under a formal arrangement with the county, Trillium sets aside \$1.33 per member per month to underwrite staffing and program support for Lane County Public Health. The health priorities and strategies that are employed are selected through a prescribed partnership process. A Prevention Committee – made up mostly of CAC members but not solely – identifies a challenge that they would like to address. Lane County Public Health staff then provide information on which evidence-based programs could address that particular need. Based on this intelligence, the Prevention Committee creates a proposal that is then sent for feedback and approval to the CAC, the Rural Community Advisory Council, a Clinical Advisory Panel, and the Trillium Finance Committee. Once each of these committees has endorsed the proposal, it is then heard by the Trillium Board, which has the final authority to approve. Examples of prevention programs that have been approved in the past include a cash incentive smoking cessation program for pregnant women, a school-based tobacco prevention program for seven-year-olds, and a plan for Trillium membership cards to provide children with access to public pools.

Finally, Trillium works in a grant-making capacity to develop partnerships and increase coordination in Lane County. For example, through the Trillium Integration Incubator Project, Trillium funded eight clinics in the county to promote service integration by bringing physical health providers and behavioral health providers to the same location.

### Planning and Implementation

Trillium was required to submit a Transformation Plan to the Oregon Health Authority as part of its certification process for becoming a CCO. The Transformation Plan outlined initiatives that Trillium planned to roll out to fulfill state requirements. These are shown below.

### **Oregon Health Authority Initiatives for Transformation**

- 1) Developing and implementing a health care delivery model that integrates mental health and physical health care and addictions.
- 2) Continuing implementation and development of Patient-Centered Primary Care Home.
- 3) Implementing consistent alternative payment methodologies that align payment with health outcomes.
- 4) Preparing a strategy for developing a Community Health Assessment and adopting an annual Community Health Improvement Plan.
- 5) Developing electronic health records, health information exchange, and meaningful use.
- 6) Assuring communications, outreach, member engagement, and services are tailored to cultural, health literacy, and linguistic needs.
- 7) Assuring provider network and staff ability to meet cultural diverse needs of community.
- 8) Developing a quality improvement plan focused on eliminating racial, ethnic and linguistic disparities in access, quality of care, experience of care, and outcomes.

Trillium engaged in a Community Health Assessment (CHA) process and a Community Health Needs Assessment (CHIP) process in a collaborative that also included Lane County Public Health, the United Way of Lane County, and PeaceHealth, a non-profit hospital system with several medical centers in Lane County. The CHA looked across a range of data, both clinical and environmental, to assess the health of the county and identify strengths and challenges. After this process was complete, the collaborative then developed a CHIP that articulated a series of strategies to address the health challenges faced by Lane County. The collaborative identified five key areas of intervention:

- 1) Advance and Improve Health Equity
- 2) Prevent and Reduce Tobacco Use
- 3) Slow the Increase of Obesity
- 4) Prevent and Reduce Substance Abuse and Mental Illness
- 5) Improve Access to Health Care

Along with improvement strategies, the CHIP details performance measures, target benchmarks, and “responsible parties” for achieving its objectives. Trillium was among the group of organizations responsible for addressing the health priority related to preventing and reducing tobacco use. Trillium was involved in the strategy to increase the number of environments where

tobacco use is prohibited so that it included more city and community campuses, parks and recreational spaces, physical and mental health support centers and worksites. The plan for addressing this health priority includes improvement strategies, and specified target dates for outlined goals. Trillium CCO was also listed as a responsible party under the plan for addressing the health priority related to preventing and reducing substance abuse and mental illness. The outlines implementation strategies for this priority area include supporting the adoption and implementation of mental health-friendly workplace environments as a means to encourage mental health and reduce substance abuse. Additionally the team was responsible for strategizing ways to implement policies that work to restrict access to lethal means of self-harm and reduce the availability of alcohol and other drugs in the retail and social markets. Lastly, Trillium and the other organizations represented in the CHIP worked with healthcare and social service providers to improve support for providers as they adopt evidence-based and trauma-informed screening assessments and referral policies to improve services for mental health and substance abuse patients.

### Funding and Sustainability

As a CCO, Trillium receives a capitated per-member per-month budget from Oregon's Medicaid program, 36 percent of which comes from the state and 64 percent of which comes from the federal government. In 2015, that budget is approximately \$400 per member per month. Trillium has approximately 92,000 members as of April 2015. In addition, Trillium is eligible to receive incentivized funds from Oregon's CCO Performance and Quality Pool for achieving key quality benchmarks – in 2013 that equaled approximately \$5 million dollars. CCO collaborative prevention activities are funded through a specific per-member per-month set aside that Trillium provides from its global budget; those funds go to staffing and program support for Lane County Public Health.

The sustainability of these funds largely depends upon Trillium's ability to control costs while meeting quality measures, as well as the state's continued agreement with the federal government to allow the CCO model.

### Community Resident Engagement

The CAC and the Rural Community Advisory Council serve as the primary vehicles for Trillium's engagement with the community. Each of these councils – which have representatives on the Trillium Board – is designed to represent community residents and Trillium members. The CHA and the CHIP processes are also designed to involve the community.

### Data Sharing Capability

Trillium has in place a fairly well adopted electronic medical record system. In its Transformation Plan, Trillium reports that “approximately 90 percent of providers already have an EMR that meets meaningful use criteria. The small number of providers who do not use an EMR are not likely to convert as many plan to retire in the near future.”

Trillium is pursuing a robust Health Information Exchange (HIE) that will mobilize relevant healthcare information between users to offer more effective patient-centered care. This “smart HIE” will enable all healthcare-related providers in Lane County to have timely access to

relevant, actionable information about Trillium members for coordination and delivery of integrated patient-centered care, and assist members in self-managing their care through electronic connections with their care teams, as well as available healthcare data that is presented in an easily understood format.

### Accountability

The state evaluates Trillium's success according to 17 measures. These range from clinical (controlling high blood pressure) to screening tests (colorectal cancer screening) to administrative (Patient-Centered Primary Care Home enrollment). Trillium is provided with financial incentives when it meets key benchmarks. It was awarded approximately \$5 million – equaling the largest award for the state's 16 CCOs – for meeting benchmarks related to diabetes, depression, and Patient-Centered Primary Care Homes in 2013.

The CHIP also has evaluation measures built into it, such as “Increase the number of cities in Lane County that adopt and implement tobacco-free campus policies” from a baseline of zero and ensure that “all school districts in Lane County are on track to meet minimum PE requirements” according to state data.

### Successes and Challenges

The cross-sectoral work between Trillium and Lane County Public Health is reported to have been both “challenging” and “transformational.” Though differing cultures were described as an initial obstacle, Public Health staff report that they are challenged to think in much more concrete financial terms about issues such as hospital readmissions, while Trillium staff are becoming more familiar with the public health approach.

### Lessons Learned for Implementing Accountable Communities for Health

Staff involved in the collaboration between Trillium and Lane County Public Health offer the following advice:

“Be very clear on your processes, and make sure that the entities involved are clear on process and comfortable with it.”

“Understand the different perspectives. Public health and insurance companies have very different views. You need to understand each other to move the agenda forward.”

# Pathways to a Healthy Bernalillo County

## SNAPSHOT

Name of initiative	Pathways to a Healthy Bernalillo County
Location	Bernalillo County, New Mexico (pop. 674,221)
Leadership structure	The Office for Community Health of the University of New Mexico Health Sciences Center staffs Pathways to a Healthy Bernalillo County, the “Hub” of the effort. The Program Manager is an employee of UNM Health Services Center, and oversees all programmatic aspects of Pathways and reports to the CEO of UNM Hospital (funding source), UNMH Board of Trustees, Health, and Pathways Community Advisory Group. The Program Manager is supervised by the Director of the Office of Community Health Worker Initiatives, which is under the Office of Community Health in the Health Sciences Center. Provides technical support and coordinates standing monthly meetings or training for the navigators, assist the partner organizations, and evaluate the program. Navigators are employees of their respective organizations, who are contracted by the program.
Partnership structure	The collaborative is coordinated by the central hub that contracts with various partner organizations, selected through a competitive RFP process, to provide services known as “pathways” to the clients.
Number of staff	The Hub is allocated a 1.0 FTE, staffed by a full-time Program Manager, and 0.2 FTE in administrative support. The “pathways” organizations have their own, separate staffing, and employ community health workers, called navigators, to carry out HUB activities.
Stated goal	Through a comprehensive participatory planning process, the community participants identified the four primary goals of the program as: (1) People in Bernalillo County will self-report better health; (2) People in Bernalillo County will have a healthcare home; (3) Health and social service networks in Bernalillo County will be strengthened and user-friendly; (4) Advocacy and collaboration will lead to improved health systems.
Population served	The entire population of Bernalillo County, with a broad focus on low income, uninsured adults. Serves between 350-400 residents at any point in time.

Issues addressed	Access to healthcare, housing, education, social isolation, and systemic barriers inhibiting access to all of the above.
Scope of services	Medical care, behavioral health, employment, social services, establishing health homes.
Link to other healthcare payment or delivery reform efforts	<p>HUB Pathways leverages Community Health Navigators (CHNs) to identify and connect vulnerable County residents to community-based and social service resources based on their individual unmet need(s).</p> <p>The HUB Model is “service-oriented”, in that a bulk of the effort is in identifying and connecting clients to participating pathways resources, and establishing a health care home. In addition to working with individual clients, standing monthly community meetings with all navigators and 5-10 additional interested community partners provide a platform for Community Health Navigators and other community collaborators to offer social service administrators feedback on service access barriers that clients face. Meetings are organized by the Program Manager, but each agenda is decided upon in the prior meeting with input from the navigators. This feedback, in turn, has motivated improved processes and policies to make services more efficient and accessible (e.g. I.D. cards)</p>
Policy changes	Because Pathways to a Healthy Bernalillo County is a service organization, policy change is not a big part of their work. That said, political and organizational leaders are often brought to monthly meetings so that navigators may share their thoughts on systemic barriers. Navigators have been able to bring up repeated barriers to organizational leaders in order to change organizational practices.
Funding sources/budget	Funded through a county mill levy tax. Slightly less than 1% of the tax, approximately \$800,000 each year, is dedicated to funding Pathways to a Healthy Bernalillo County. The tax is renewed every eight years (next cycle starts in 2017). The “pathways” partner organizations are guaranteed 30% of their funding from the Hub to cover administrative costs; the other 70% is based upon the incentive structure paid to the partner organizations for successfully achieving outcomes for the clients served.
Key reported successes	<p>76% of Pathways clients report better health at the time they complete their participation in the program.</p> <p>20% of participants (630 individuals) have established a healthcare home.</p> <p>Strengthened processes and procedures related to services</p>

	<p>provided through community-based and social service (e.g. County) networks.</p> <p>The quality assurance manual developed by the program has been distributed and shared with interested individuals from across the country.</p>
Notable feature	<p>Pathways to a Healthy Bernalillo County uses a dedicated, tax-based funding structure, which promotes sustainability.</p> <p>It is also significant that the majority of the “pathways” funding is spent on payment incentives paid to community partners, and is dependent upon their ability to successfully achieve specific outcomes.</p>

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## PROFILE

### Background

In December 2005 the University of New Mexico (UNM) Health Sciences Center, at the request of the Governor, held a statewide summit to discuss its public mission and address concerns about the costs of uncompensated care for indigent residents. The Health Sciences Center leadership, including UNM Hospital, were receiving a lot of pressure from a large community group, Community Coalition for Healthcare Access (CCHA), to be more transparent and accountable for the more than \$80 million (at the time) that they received each year through the County mill levy fund. CCHA consists of leaders from non-profits, frontline community members, and health workers. CCHA combined efforts with the All Indian Pueblo Council (AIPC), who had been challenging the hospital for not fulfilling their agreement in the 1952 Treaty. After the summit, County stakeholders and the public taxpayers wanted to detail a strategy for fostering financial accountability. The County Commission convinced the UNM Hospital (UNMH) to commit a small portion (~1%) of the mill-levy tax to support a program that would “improve access for the underserved of the County in collaboration with community resources”. No less than \$800,000 per year for an eight-year period (duration of mill-levy funding) was committed for this newly created Pathways Program.

Early in the program’s tenure, office leaders became aware of the Pathways Model developed by Dr. Mark Redding and Dr. Sarah Redding, and were attracted to its emphasis on leveraging community health workers (CHNs) and its ability to track each client’s needs and progress to accessing appropriate “pathways” to services offered through participating health and social service agencies and community-based organizations. Program leaders felt that a similar approach could help at-risk county residents, including those with limited English proficiency, Native Americans living on and off reservations, returning citizens, immigrants, and other at-risk populations.

Following a community workshop by Dr. Redding in October 2007, a workgroup was formed to define the program’s mission and to explore the Pathways Model for use in Bernalillo County. The work group included representatives from community-based social service organizations, the New Mexico Department of Health, the University of New Mexico Health Sciences Center, the University of New Mexico Hospital, the Bernalillo County Community Health Council, community advocates, and others. Additional planning took place at a “kickoff” community meeting in September 2008 and at five half-day planning meetings with community-based organizations. In November 2008, passage of a mill-levy bond issue ensured that funding would be available through 2017. The workgroup then developed specific community outcomes as programmatic goals.

### Population served

While the overarching mission of Pathways to a Healthy Bernalillo County is to improve the health of the entire county, the program focuses on low-income, uninsured adults with risk factors including multiple or complex unmet needs, self-reporting fair to poor health, lacking stable employment, feeling unhealthy, being unemployed, having had at least one ED visit during the previous year, being homeless and not receiving services, or averaging fewer than two full meals per day.

The target population also includes individuals parenting young children; urban off-reservation Native Americans not connected to community resources; formerly incarcerated people experiencing difficulty obtaining employment and stable housing, among other needs; and undocumented immigrants or residents with limited-English proficiency.

Clients are identified and referred through a variety of sources, including friends and family members (who referred nearly 30 percent of clients in the program's first 4 years), community health navigators, and interagency referrals.

The program's goals and priorities were jointly set by community representatives and HUB staff, and include:

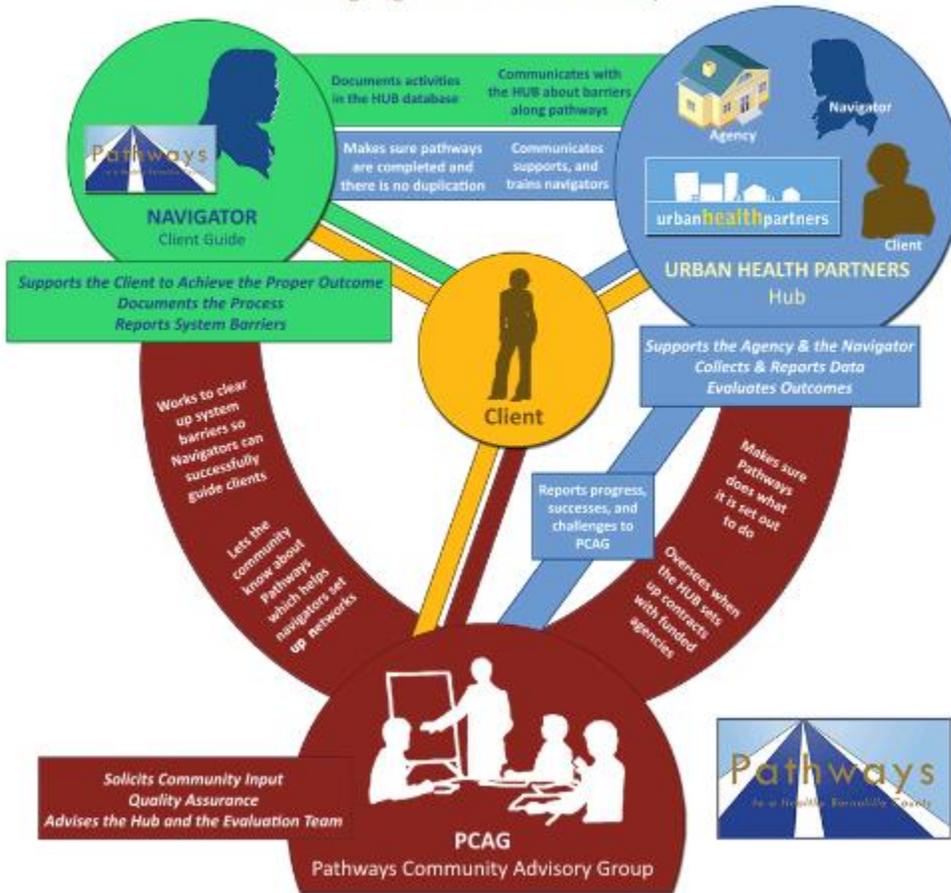
- (1) People in Bernalillo County will self-report better health;
- (2) People in Bernalillo County will have a healthcare home;
- (3) Health and social service networks in Bernalillo County will be strengthened and user-friendly;
- (4) Advocacy and collaboration will lead to improved health systems.

#### Partnership Structure

1.2 FTE staff in the Hub provide technical support and coordinate standing monthly meetings or training for the navigators, assist the partner organizations, and evaluate the program.

The Office for Community Health organizes an RFP process to identify the community organizations that house the community health navigators; the selected organizations are referred to as community partners, each has a minimum of one (1.0 FTE) community health worker engaged in the pathways program. The Pathways Community Advisory Group, comprised of non-UNM community representatives (i.e. Bernalillo County, NM Dept. of Health, Albuquerque Area Indian Health Board, Presbyterian Healthcare Services, private consultants, New Mexico Health Connections, the NM Community Health Workers Association, etc.) meets quarterly and serves the Hub in an advisory capacity, plays a major role in the development and review of the Request for Proposals, advocates on systems issues, and serves as a "sounding board" for the Hub. Funding for Pathways is written into both a Memorandum of Understanding (MOU) that the Bernalillo County Commission has with UNM Hospital, and in an MOU between the Hub's office and UNMH.

## Three Pathways Components Working Together to Serve Pathways Clients



### Planning and Implementation

Twenty community health workers, called navigators, are employed by community partner organizations to assess the immediate needs of the person referred, determine whether the individual would be an appropriate candidate for Pathways participation (i.e., has multiple needs), and then conduct an approximate 45-minute risk score assessment. The navigators obtain written consent from the individual prior to collecting any information, including the risk score instrument, and for individuals deemed eligible, the navigator obtains consent before enrolling them in the program.

The navigator works to build the client's trust in the system of care, coordinates the services provided by participating community agencies, reports any system barriers encountered, and documents all activities in the program's database.

### Funding and Sustainability

Pathways to a Healthy Bernalillo County is funded through a county mill levy tax. Slightly less than 1 percent of the tax, approximately \$800,000 each year, is dedicated to funding Pathways to a Healthy Bernalillo County. The tax is renewed every eight years (next cycle starts in 2017).

The “pathways” partner organizations are guaranteed 30 percent of their funding from the Hub to cover administrative costs; the other 70 percent is based upon the incentive structure paid to the partner organizations for successfully achieving outcomes for the clients served.

The pathways are paid through financial incentives, and payments are based on milestones. The partner organizations receive incentive-based payments at three stages:

- a) After the initial risk assessment/enrollment in the program;
- b) After confirmation that the client has received some level of necessary services, and
- c) After verification that pathways have been completed.

Each partner organization can be reimbursed for up to three completed pathways per individual, with the total payment limited to \$1,550 per client<sup>1</sup>. Incentive payments are weighted based on the average time it takes clients to complete a pathway. Examples of outcomes associated with a completed pathway include the following<sup>2</sup>:

- Behavioral health: The client has appropriate health coverage or a financial assistance program in place to establish a behavioral healthcare home and has seen a behavioral health specialist a minimum of three times. The client reports that he or she is no longer experiencing the negative symptoms that previously interfered with his or her quality of life.
- Employment: The client has found consistent source(s) of steady income and is gainfully employed over a period of 3 months.
- Food security: The client has achieved food security, including access to at least two hot meals per day during the last 3 months.
- Healthcare home: The navigator confirms that the client has seen a provider a minimum of two times and that client has established a comfortable relationship with the provider (CAHPS survey), has confidence in asking questions (CTM survey), is treated respectfully (CAHPS survey), has received whole-person care, and understands follow-up treatment plan (CTM survey), if applicable.

### Community Resident Engagement

Pathways interfaces with the community largely through its navigators, who are closely connected to grassroots efforts themselves. Additionally, community members are welcome to attend monthly meetings with navigators, and most community members attending meetings are “grass tops.” There has been outreach to grassroots organizers, but the program has faced challenges in getting additional community involvement at meetings.

### Data Sharing Capability

A database maintained by the hub allows navigators to avoid duplication of services, confirm that care pathways have been completed, and collect data for reporting purposes.<sup>3</sup>

### Accountability

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<sup>1</sup> The program is based on a capitated-plus payment structure per referred client.

<sup>2</sup> To Note: Partners are incentivized based on both process outcomes AND “health/care outcomes” (e.g. clinical quality, community health). Outcomes are NOT based on cost or healthcare cost proxies (e.g. readmission rates)

<sup>3</sup> Integrator maintains internal database with updates from CHNs. Thus, no data “sharing” activities between partners occurs. Instead, HUB reports out to partners and community based on outcomes reported to the Hub.

Pathways are held accountable for their work through their pay structure, where they receive incentivized payments based on their ability to achieve milestones. Incentive payments for each pathway are weighted differently, and depend on the amount of time and effort that is required to complete each. The average time period that a CHN works with their clients and completes 3 pathways is eight to nine months, but in some cases, particularly with the housing pathway, it can be well more than a year. This structure initially created a potential for CHNs to favor, and actively enroll, clients in certain “low hanging fruit” pathways, while avoiding those that were harder to complete (e.g. have more administrative hurdles). For example, one outcome measure of the housing pathway - “client has stable housing for greater than 3 months.” - is required for clients to complete before CHNs can receive a final incentive payment. However, many clients do not have State-issued I.D.s, which is a requirement to apply for public housing. State-issued I.D.’s can take up to 6 months to process, while public housing wait lists can be one year or more. Thus, the 18-month timeframe was often too short to successfully complete the housing pathway.

Aligning evaluation measures (especially those tied to incentive-based payments) with administrative timelines, processes and procedures, will promote “buy-in” (among CHNs) and ensure that outcomes-based incentive rewards are achievable.

### Successes and Challenges

The most recent long-term evaluation of Pathways to a Healthy Bernalillo County measured outcomes from 2009-2013. Key data held up by the HUB as successes include:

- 2,129 individuals participated in the program during the four-year reporting period
- 3,058 separate pathways were successfully completed
- 92 percent of participants assessed during exit interviews reported being either “completely satisfied,” “mostly satisfied,” or “satisfied” with the help that they received
- 86 percent reported that what they did with the navigator on specific pathways will continue to help them
- 84 percent have been able to help others with information and resources/services that they had learned about from participation in Pathways.
- 76 percent reported having a better understanding of how to access health and social services as a result of their participation in Pathways
- 70 percent reported that their overall health has either “greatly improved” or “improved” since they began participating in the program
- 68 percent of participants remained active participants in the program available for follow-up, a figure the Hub prides itself on given the transient nature of the population served.

One challenge faced by Pathways to a Healthy Bernalillo County has been the evaluation of long-term outcomes. This struggle has occurred both due to the lack of funding put towards program evaluation (when the focus is on putting funding back into the community), as well as challenges in contacting participants to conduct a six month follow-up when many of them have relocated and/or changed their contact information. An exit interview has now been instituted asking participants to update their contact information and to provide information about their experiences, but data supporting the long-term efficacy of the program has not yet been collected.

An additional challenge posed by the Pathways model is that its reach – both in terms of how many participants it is able to enroll and how many services it is able to provide – is limited by its funding constraints.

The Bernalillo County program experienced an unexpectedly high turnover rate among its navigators during the first 2 years, primarily because navigators found better paying positions elsewhere. In response, program leaders have taken steps to improve retention rates. One example includes the development of a training program for new navigators. In spring 2013, the program provided a 2-day nationally certified training on mental health/first aid and another mini-workshop on time management/organizational skills. Additionally, it is required in the most recent RFP that the organizations must pay their navigators no less than \$14/hour. Standing monthly navigator meetings are held to address topics of interest, learn about additional community resources, provide mini-workshops, and allow the navigators to mingle, network, and support one another, and the program manager regularly informs the navigators about opportunities for continuing education and encourages their employers to support them in these efforts. The program contracted with a consultant to develop training materials on service coordination and advocacy skills, community knowledge, and assessment as part of the statewide efforts to establish a voluntary Community Health Worker Certification Program (Updated December 2014).

#### Lessons Learned from Implementing Accountable Communities for Health

Ongoing support from the community can be maintained by hosting an annual Report-to-the-Community, providing leadership opportunities for the Navigators, working with a community advisory board, and issuing annual public reports