FRAMEWORK FOR ENGAGING REFERENCE COMMUNITIES

Collaboratives: Context

The United States has among the highest rates of chronic disease, and a below-average life expectancy, compared with other OECD countries. The US achieves this health status, despite spending 18% of the GDP on healthcare, nearly twice that of other OECD countries. Conversely, the US spends only 1% to 2% on prevention, and substantially less than other countries on the social, behavioral, and environmental factors that contribute to poor health.

In Connecticut and nationally, local stakeholders are increasingly developing multisector regional collaboratives to improve community health. Typically, such collaboratives include public health agencies, health care systems, and other sectors such as education, housing, transit, and social services. These types of multi-sector networks show promise in reducing preventable deaths[i]. However, despite the enormous efforts within communities to create impact and address social determinants of health, health improvement remains difficult to achieve due to the complexity of factors involved.[ii] Chief among them is the lack of funding to carry out initiatives of meaningful scope and scale.

Healthcare Payment Models: Their Promises and Limitations

Our disproportionate investment in healthcare is perhaps in part the result of more than fifty years of fee-for-service reimbursement, which pays providers for how much they do, not for the value of the services they provide. Today's alternative payment models such as the Medicare Shared Savings Program, are beginning to correct the problems of fee-for-service reimbursement by shifting the focus from volume to value. These new models reward providers for providing high quality, cost-effective care for patients with acute or chronic healthcare problems (or conversely, penalize providers who fail to do so). Because of these new financial rewards and penalties, there has been a great deal of innovation and investment focused on providing better healthcare at lower cost.

Unfortunately, these new payment models do not reward providers for preventing new health problems from occurring. As a result, it remains difficult to get healthcare systems to focus on reducing health risk by addressing root cause contributors to health problems, whether social, behavioral, environmental, or genetic. Even if healthcare payment models rewarded prevention, the healthcare sector alone is limited in its ability to address the social, behavioral, and environmental factors that contribute to poor health.

Payment Reform to Support Collaborative Efforts

A payment reform is needed that rewards prevention and all of the sectors of a community that contribute to prevention outcomes. Providing for a return on investments in prevention would make it easier to garner the investments needed to carry out *collective, place-based primary and secondary prevention efforts*.

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[i] Zahner SJ, et. al. The mobilizing action toward community health partnership study: multisector partnerships in US counties with improving health metrics. Prev Chronic Dis. 2014; 10:E05.

[ii] IOM. U.S. Health in International Perspective: shorter lives, poorer health. Washington (DC): National Academies Press; 2013.

Health Enhancement Community (HEC) Demonstration

Through the HEC initiative, the State is proposing to undertake a multi-payer demonstration with Medicare, Medicaid and commercial health plans. Under this demonstration, payers would agree to share savings associated with a reduction in health problems (and associated healthcare costs) that result from primary and secondary prevention.

The State is proposing to designate multi-sector collaboratives as HECs to assume accountability for reducing the incidence and prevalence of acute and chronic illness and injury. Each HEC would govern shared assets and pooled prevention investment funds. HECs would coordinate the strategies of multi-sector partners who agree to make prevention aligned investments.

> For example, an HEC proposes to invest in a set of prevention strategies to reduce the incidence and prevalence of falls among the elderly over 5 or 10 years. If the HEC is able to reduce the rate of falls incrementally over 10 years, they could receive a portion of the cost savings. This money could then be re-invested in subsequent prevention efforts.

How Reference Communities will be Engaged Once Selected

Reference communities, represented by an existing collaborative, will be asked to imagine that they are going to enter a demonstration with the State and federal government. As part of this demonstration, they would assume overall responsibility for managing a cross-sector partnership to achieve mutually shared goals and objectives. The State and Reference Communities will examine a series of topics and associated questions relevant to this type of demonstration. These topics are captured in the table below. This engagement will occur through meetings, webinars, workshops, review of existing materials, or other means. The reference community will assist the state in gathering needed materials, ensuring that a broad array of stakeholders--including members of the community--are heard, and actively participating in discussions.

Planning Parameters:

- *Prevention focused:* Proposed strategies must focus on root-cause preventive interventions rather than treatment. An initiative that focuses on preventing avoidable ED or hospital visits for patients with COPD would be out-of-scope. However, upstream interventions targeting environmental causes of COPD would be in-scope.

- *Multi-sector:* Strategies must involve multiple sectors such as the business, municipal, educational, social service, public health, healthcare, and others.

- *Impact within 10 years:* The health and economic benefits must accrue within 10 years. For example, strategies to improve access to healthy food among school age children are likely to show some level of progress within a 10 year period.

- *Address factors within a community's influence:* Although state and federal policies and macro-economic trends impact the health of communities, HEC strategies should focus on local initiatives that the cross-sector collaborative can feasibly achieve.

Table: Reference Community Engagement Framework

The following interrelated topics and questions will guide the engagement process. The State and the reference communities will work together to examine these topics and answer the questions. The answers will inform the development of implementation plans for each reference community and for the HEC initiative overall. To support this process, the State will provide funds, tools, consultant support, and subject matter experts (SMEs). The State is using the Collective Impact Model[iii] as an overall approach to this process.

Topic	**Questions that will be answered in partnership between the reference communities and the State** ***If your Collaborative were to enter into this demonstration…***	**What will enable us to answer that question?**	**After we answer the questions, what will we p**
Community Overview	What do we need to know about your community to provide context for this work?	Data and information collected and presented by the Collaborative on community characteristics and current and prior efforts, including from community health needs assessments, focus groups, listening sessions, surveys, etc. Data and information provided by the State and consultants on community characteristics. Examples from SMEs	Synthesis of key community characteristics and current and prior efforts
Health Improvement Priorities	What are the biggest health problems that you would prioritize for the next 3, 5, and 10 years?	A process to assess and pick priorities using criteria such as: • Is the problem preventable? • How many people in your community are directly or indirectly effected? • Is problem or risks associated with the problem increasing? • Is there a readily available and timely data source with which to measure progress? • How bad are the health outcomes of the problem?	3-5 priorities by timeframe

[iii] The Collective Impact Model has five key elements: 1) All participants have a common agenda for change, including a shared understanding of the problem and a joint approach to solving it through agreed upon actions; 2) collecting data and measuring results consistently across all the participants ensures shared measurement for alignment and accountability; 3) a plan of action that outlines and coordinates mutually reinforcing activities for each participant; 4) open and continuous communication is needed across the many players to build trust, assure mutual objectives, and create common motivation; 5) backbone organization(s) with staff and specific set of skills to serve the entire initiative and coordinate participating organizations and agencies.

		• How costly are the poor outcomes and who pays those costs? • Can improvements be quantified in terms of benefits to community collaborators individually or for the community? • Are their evidence-informed strategies that show good outcomes or promise of good outcomes? • Can our collaborative can do something to improve outcomes and reduce costs? • Can make significant improvements in 3, 5, and 10 years? • Are their existing resources available to support solutions? • How likely is it that we can sustain solutions with existing resources? • How likely is it that we can sustain solutions with new lasting resources? • What interests community members the most? Data and information from the Collaboratives, the State, and consultants from community needs assessments, Community Health Improvement Plans, Department of Population Health data (BRFSS), national reports (e.g., 500 cities report), All-Payer Claims Database, etc. New data and information from community focus groups, listening sessions, surveys, etc.	
Root Causes	What are the biggest drivers of the above health problems in your community?	Data and information from the Collaboratives, the State, and consultants from community needs assessments, Community Health Improvement Plans, Department of Population Health data (BRFSS), Quality Improvement tools, local reports, curated evidence-based literature (from State, local health departments, and SMEs) New data and information from community focus groups, listening sessions, etc.	1-3 root causes per priority
Health Improvement Strategies	What are the evidence-informed strategies that would be undertaken to address the root causes?	Community Health Improvement Plans, existing local initiatives, curated resources/options (from the State and SMEs) New information from community focus groups, listening sessions, etc.	2-3 strategies per root cause

Target Population	What are the populations that you will target your strategies to achieve the expected outcomes	Community Health Improvement Plans, existing local initiatives, curated resources/options (from the State and SMEs) New information from community focus groups, listening sessions, etc.	Target populations per strategy
Activities	What are the activities that would support each strategy?	Community Health Improvement Plans, existing local initiatives, curated resources/options (from the State and SMEs)	2-3 activities per strategy
Existing Resources	What existing resources (e.g., funds, reimbursement, staff, infrastructure, etc.) could be leveraged to support implementing and sustaining the HEC infrastructure, strategies, and activities?	Scan of community resources and assets by organizations and source (municipal, state, private, etc.) Examples from other states (from State and SMEs)	Resource plan
Implementation Funds	How would the upfront funds be raised to implement the proposed HEC infrastructure, strategies, and activities?	Scan potential or committed implementation funds by source Examples from other states (from State and SMEs)	Financing plan for raising funds to support implementation
Sustainable Financing	What additional financial vehicles will be explored to sustain this effort?	Financing scope, including details of what will need to be sustained long term Scan of community sustainable financing options by source (municipal, state, private, etc.), including opportunities to braid or blend resources Examples from other initiatives (from State and SMEs) (e.g., social impact bonds, wellness trust)? Ability to quantify costs and benefits to inform potential investments from both public and private payers.	Financing plan for raising sustainable financing
Accountability Management	How will strategies and activities be coordinated, managed, and monitored?	Management resources that leverage existing Collaborative infrastructure Examples from other initiatives and states (from State and SMEs)	Accountability framework and management plan
Tracking Progress	Which process and outcome measures would you track?	Current indicators being tracked Examples from other initiatives and states (from State and SMEs)	2-3 process measure per activity; 1-2

			outcome measures per priority
Data and Qualitative Information	What data and qualitative information would you need to manage each activity and track progress and performance? *Note that data must be granular enough to assess progress on activities* What barriers will have to be overcome to sharing data?	Current local and state data assets Data from other sources (Data Haven, BRFSS, etc.) Information from community focus groups, listening sessions, surveys, etc. Examples from other initiatives and states (from State and SMEs)	Summary of activity specific data needs and potential solutions to overcome barriers
Key Partners	Which organizations would be responsible for what aspect of implementation? Which stakeholders, sectors, and organizations would need to be represented on the Collaborative and in what way?	Assessment of existing Collaborative engagement Examples from other initiatives and states (from State and SMEs)	Engagement plan describing which stakeholders would be involved and how
Partner Commitment	How will responsibility be shared? What would be needed to maintain commitment and engagement?	Local examples Matching strategies, activities, and other roles to specific partners Examples from other initiatives and states (from State and SMEs)	Proposed principles and strategies of commitment; agreement template
Community engagement	How would you engage community residents? How would you communicate progress?	Community focus groups, listening sessions, town hall meetings, and current communication methods	Engagement and communication plan

Partners Capacity	What additional capacity would be needed among partners to support implementation and HEC operations?	Assessment of current capacity vs. anticipated demand Existing capacity-building resources and infrastructure	Partner capacity plan
Geographic Size	How large or small would the catchment area of the Collaborative have to be to make an impact and garner investments while still being able to manage the effort?	Granular data and information (from Collaborative and State) Assessment of partners, local assets, and current service areas demarcations	Outline of sufficient geographic boundaries
Collaborative Capacity	What is the additional capacity does the Collaborative need to coordinate and manage the HEC, implementation of strategies and activities, and funds administered by the Collaborative?	Assessment of gaps current capacity Examples from other initiatives and states (from State and SMEs)	Summary of capacity needed, including FTEs and roles
Governance	Would your governance model need to change? If so, how (e.g., nonprofit status)? Who would be the organization leading the effort (the backbone organization)?	Assessment of current governance structure Examples from other initiatives and states (from State and SMEs)	Governance model, proposed changes, and backbone organization
Funds Distribution	How would the Collaborative govern and distribute the implementation funds? What principles should govern the distribution of sustainable financing?	Assessment of current fund distribution methods Examples from other initiatives and states (from State and SMEs)	Funds distribution model
Authority	Is the authority that currently exists within the Collaborative and among the partners sufficient to enable implementation? Is state designation needed?	Assessment of current authority Examples from other initiatives and states (from State and SMEs)	Summary of authority levers

Feasibility and Risks	How feasible is it for your region to do this? What are the risks and considerations that should be considered?	Assessment of part successes, barriers, and risks Examples from other initiatives and states (from State and SMEs)	Summary of risks, mitigation strategies, and feasibly analysis
Other Considerations and New Ideas	What would you do differently from what you are doing now that was not captured in the above? What are new ideas that the State should consider in relation to this demonstration?	TBD	TBD