Robert Wood Johnson Foundation

nrhi Network for Regional Healthcare Improvement

AcademyHealth

# Fostering Collaboration to Support a Culture of Health:
## Update from Five Communities

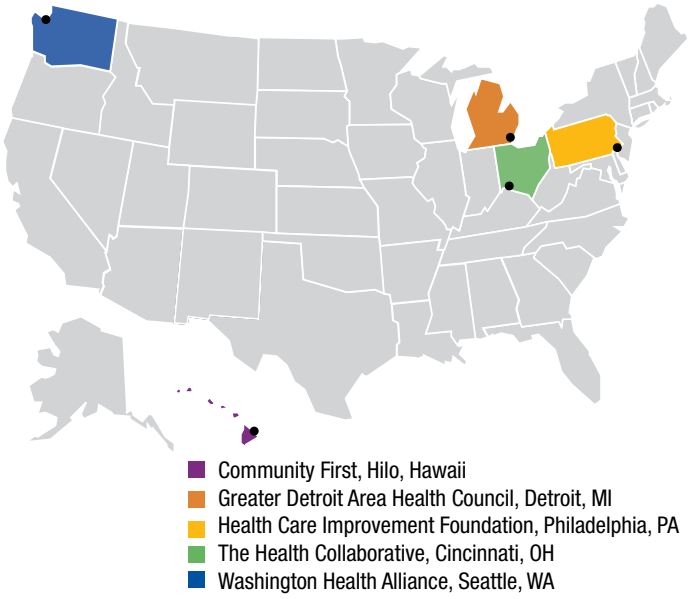
With support from the Robert Wood Johnson Foundation, AcademyHealth launched the Payment Reform for Population Health initiative in 2016 to explore improving community-wide health through the transformation of the health care payment system. As part of their efforts to identify the opportunities and challenges associated with linking payment reform to population health, AcademyHealth contracted with the Network for Regional Healthcare Improvement to build on discussions from the AcademyHealth / NRHI co-hosted workshop held in Austin, Texas in January 2017, and continue engagement activities to facilitate shared learnings among the five regional collaboratives and their communities.

**To learn more about the Payment Reform for Population Health initiative, visit www.academyhealth.org/p4ph**

Produced by the Network for Regional Healthcare Improvement for AcademyHealth. www.nrhi.org

# Introduction

On January 26-27, 2017 in Austin, Texas, AcademyHealth and the Network for Regional Healthcare Improvement (NRHI) hosted a two-day workshop called "Striving Toward a Culture of Health: How Does Care and Costs for Non-Medical Needs Get Factored into Alternative Payment Models?". This workshop convened five multi-sector teams led by regional health improvement collaboratives (i.e., regional collaboratives) participating in the workshop were from Hilo, HI; Detroit, MI; Cincinnati, OH; Philadelphia, PA; and Washington State. The workshop focused on four fundamental topics (i.e., cross-sector collaboration; metrics, data and evidence; care delivery requirements and incentives; and payment and financing) and related barriers that can influence the conditions and collaborations necessary to support non-clinical community-wide population health services.




To continue engagement and help support the communities to move forward, NRHI facilitated a series of virtual meetings ***(see Appendix)*** periodically throughout the year, each focusing discussions on one of the four topic themes.

Each of these four topic areas is central to the complex goal of transforming the health care delivery system, where there is a transition from a fee-for-service payment system that squanders 30 cents of every medical dollar on unneeded care and waste to a value-based payment system that reimburses based on the quality and cost efficiencies of services delivered that result in positive patient outcomes. It is expected that value-based payment models will incentivize the integration of clinical care with social services, thereby encouraging health plans and health care providers to strategically invest in addressing social determinants of health and pave a path towards eliminating costly inefficiencies while improving the health of populations. But making that transition requires nothing less than a paradigm shift, given that under the current payment system no one gets paid for providing clinical services when people are healthy.

The following issue brief summarizes lessons learned from a year of discussions involving numerous stakeholders with varied perspectives working to advance a culture of health in their communities. This overview provides a snapshot of where each regional collaborative and their own communities are now and what they must consider going into the future.

# Cross-Sector Collaboration

## Trusted Convener and Governance

Transitioning to a culture of health is a monumental challenge that requires a coordinated effort across many organizations and community members. Given that, two needs emerge as obvious priorities: 1) the need for a trusted convener able to assemble the appropriate stakeholder groups required for collaboration on key initiatives; and 2) the need for a governance structure that determines the respective roles for each partner and how collective decisions are to be made.

As the organizing entities, regional collaboratives serve as trusted conveners that foster collaboration, facilitate community-wide population health interventions, and help to align goals across partnerships. Since the success of community-wide population health interventions hinges on the strengths of the partnerships behind them, it is critical that conveners can inspire confidence, identify shared interests, assess capacity needs, and resolve tensions and internal disputes. They must also identify sustainable financing sources both for their own operations, and for potential population health-focused services or activities. Similarly, governance structures must assure that responsibilities among each of the participating groups are equitably distributed to avoid mistrust and misaligned interests that could doom an intervention to failure.

During a two-day workshop and a series of virtual meetings in 2017, AcademyHealth, NRHI, and its partner regional collaboratives discussed issues to consider when identifying a trusted convener and establishing a governance structure. Below are examples of how these regional collaboratives have fostered partnerships, coordinated interventions and aligned goals to ensure the needs of the community were being met.

- The Health Care Improvement Foundation (HCIF) of Philadelphia has recognized the need for broad-based buy-in from community stakeholders, insurance companies, and local public health systems to identify and address food insecurity in Greater Philadelphia. HCIF has worked to assure that key stakeholders and referral partners including the United Way, local anti-hunger organizations, and groups providing public benefit enrollment assistance will serve on the receiving end of the warm handoffs from healthcare providers to ensure referrals are being completed. HCIF has confronted challenges of identifying who amongst the community participants is responsible for addressing these social needs. They have faced questions of who should fund and who should receive payment for providing resources or navigation support to meet social needs. HCIF has found that having a forum to discuss these issues across organizations has begun to help resolve these questions.

- Meanwhile, the Greater Detroit Area Health Council (GDAHC) has grappled with how to integrate population health goals into revitalization programs for low-income neighborhoods. Since health concerns are not traditional drivers in urban economic revitalization, the GDAHC has had to persevere in its efforts to make these health concerns a priority for those working on both economic revitalization and healthcare. GDAHC has found that funders, community organizations, and other groups can change strategies suddenly, creating frustrating challenges. In these cases, it is the convener's job to navigate complex relationships with grace and flexibility—to keep bringing participants back to the table, so they can continue to move forward on population health.

As illustrated in the examples above, it is important that conveners and the governance structures they oversee:

- Solicit input from all participating groups to increase engagement;

- Notify partners of pending decisions in advance to foster good will and consensus and set programmatic, achievable goals that collaborators can rally around enthusiastically; and

- Need to earn trust, obtain buy-in from collaborators, coordinate transparent processes that foster a sense of inclusion among partners, and identify the barriers they face, as well as areas for improvement.

*Learning Collaborative*: *Governance Issues for Sustaining Provider and Community Organization Participation in Population Health.* Issues related to the need for a trusted convener was the topic of an NRHI/AcademyHealth-sponsored learning collaborative held on September, 25, 2017. Participants heard from Ted Rooney, a long time participant in Maine's health improvement efforts and former project leader for Aligning Forces for Quality, a national initiative of the Robert Wood Johnson Foundation, sponsored by Maine Quality Counts in Maine. He noted that the growing baby boom generation presents a burgeoning population with chronic illnesses, many who cannot afford to meet basic needs, and likely do not have sufficient access to social services. Yet, Rooney insisted this same aging population presents a compelling opportunity for regional collaboratives to convene key healthcare and social service organizations to align their services to meet the multiple needs of the chronically-ill elderly. Rooney added that while financial transfers between the two sectors might be temporarily delayed by a lack of shared metrics, regional collaboratives can facilitate efforts to incorporate functional status and quality of life measures into value-based payment models, thus promoting their integration over time.

*Still, how should regional collaboratives that originally formed in response to community healthcare needs adjust their governance structures to accommodate new social services partners with whom they are not as familiar?* Healthcare and social services have similar missions and provide for complementary needs, yet they do not always interact in effective or compatible ways. And, since they do not share a similar language, mindsets, and frames of reference, it can be difficult to bridge the two worlds. Clinical care in particular is replete with acronyms that social service organizations might never have heard before. Similarly, healthcare partners often are not familiar with the jargon, acronyms, policy issues and financing structures of other sectors (e.g., housing, education). Moreover, social services struggle constantly with inadequate funding, while healthcare providers are still paid mostly on a fee-for-service basis. At the same time, large healthcare organizations routinely get requests to help pay for social service initiatives, without being offered a clear explanation of potential returns on investment or the evidence that a particular intervention will be successful.

Social service providers can assist trusted conveners in collecting additional meaningful data and help to align measures. Social service agencies typically gather transactional data, such as numbers of meals delivered, or rides provided, rather than data to measure progress towards outcomes, such as reducing emergency room visits, which the healthcare systems would value.

Rooney's view is that social service collaborators must have a seat at the table and be invited repeatedly to meetings, to engage in dialogue and share experiences. That way, health care providers can be oriented to look more closely at their patients' social needs and how they might be addressed. And with healthcare payments becoming increasingly tied to patient outcomes that may be impacted by social services, the need for both sides to learn more about each other has never been greater.

Given these and other issues, the trusted convener has a pivotal role in bridging these sectors and fostering these partnerships to ensure there is equal representation, shared buy-in and a clear understanding of the initiative's objectives to improve the health and well-being of their community.

## Metrics, Data and Evidence

### Measuring, Sharing, and Building Infrastructure

Productive collaborations in population health could not succeed without data sharing and consensus on metrics to measure progress and outcomes. But even as healthcare organizations forge partnerships with social service providers, they struggle with how to share data and use it effectively to solve community-wide problems. Healthcare and social service providers may not easily understand each other, and identifying who among them should receive, analyze, house, and report data is an important priority. It is absolutely essential that healthcare and social service providers build trust when it comes to sharing confidential data, in order to reduce fears that control over information will be lost, or that data will be used in unanticipated ways. regional collaboratives can help healthcare and social service sectors establish that trust by promoting common definitions, governance structures, technical interoperability, and an infrastructure for launching new initiatives that scale up to ever-larger populations. Collecting and analyzing data is a costly enterprise and without addressing governance concerns, partners may be reluctant to reveal their initial financial outlays.

*Learning Collaborative*: *Data and Information Sharing that Can Impact Population Health.* During a virtual meeting hosted on June 26, 2017 by AcademyHealth and NRHI, the following regional collaboratives described their own efforts to improve data and information sharing, and to develop population metrics for alternative payment models. A message that came through loud and clear was that collaborators should start with the data they have, and aim for short-term wins that reassure investors looking for accountability and positive results.

- The Center for Improving Value in Healthcare (CIVHC) is working with other local stakeholders to develop a consistent system for tracking social determinants of health (SDOH) in Colorado. CIVHC's role in that effort has been to explore various opportunities for data integration, starting with vital statistics and claims data. At the same time, CIVHC is assessing the statewide data landscape, in a search for information gaps that need to be filled. Its initial focus has been on individual-level data obtained from health care payment records, which are more broadly available. While this information does not address all questions related to the social determinants of health, CIVHC is using this information to align healthcare providers and social service organizations around shared opportunities to improve population health and discuss additional data that could be collected for the future.

- The Seattle-based Washington Health Alliance (WHA) is working on efforts stemming from the state's recent Medicaid Transformation Waiver. Washington already had a 4-year, $65 million State Innovation Model grant, under which the state established nine Accountable Communities of Health (ACHs). ACHs are regional collaboratives that have state support through funding, legislative authorization and access to data that is used to improve the health of populations. ACHs are now submitting plans detailing how they will improve population health by focusing on high priority needs, such as diabetes, child care, opioid addiction, housing, social supports, and reducing avoidable ER visits through better coordinated care. In addition, the ACHs also have set goals to build capacity for integrating behavioral health with primary care, and to position the healthcare delivery system to perform better under value-based purchasing.

  ACHs and local health jurisdictions in Washington often wish for more data than they have. State officials have responded by creating an online "dashboard" that integrates measures from multiple sources, including Medicaid claims and enrollment data, immunization data, and survey information. However, the greatest desire is for more granular data that uses geocoding and other census-level information to map specific health conditions to different parts of the state. That "small-cell" data identifies opportunities and disparities in care, but it also has the potential to expose individuals, and thus raises challenging privacy concerns.

- The Health Collaborative (THC), meanwhile, through its Gen-H initiative, has united providers, civic leaders, health plans, employers, and community groups around population health goals in Cincinnati and northern Kentucky by establishing a process for sharing data. And with a recent $4.5 million Centers for Medicare and Medicaid Services (CMS) contract, THC also uses data to accelerate efforts related to the state's Comprehensive Primary Care Initiative, through which CMS collaborates with commercial and state government-sponsored health programs to offer population-based care management fees and shared savings opportunities in population health. THC is creating a technology platform to support the effort. Specifically, it is developing a process for capturing

data using the National Academy of Medicine's Accountable Health Communities screening tool—a screening questionnaire focused on an individual's housing, food, transportation, utility, and personal safety needs—which can then be uploaded into electronic health records for closed-loop referrals from clinical providers to social service teams. The screening tool has ten questions in all—and THC is capturing those data elements consistently across 60 different communities, and hopes to screen 100,000 patients during the next four years.

- Finally, the Healthcare Improvement Foundation (HCIF) is under contract with the Hospital and Health System Association of Pennsylvania to work with its collaborators on a screening tool for food insecurity that can be administered in clinical settings. Food insecurity was selected over other potential health improvement opportunities after a long iterative process with stakeholders that considered feasibility, available resources, and potential impact. Workflows to handle the associated referrals are now in pilot testing stages. One pilot works with the local United Way 211 system for emergency needs. Another pilot works with a community organization called the Coalition Against Hunger, which helps local residents apply for food stamps. A third project works with the Benefits Data Trust, which connects individuals with public benefits they likely qualify for but may not be aware of. Collaborators are now in agreement on what the screening tool should look like. It is anticipated that, with time, it will generate referrals that address hunger needs, and by extension, improve community-wide population health.

These efforts above exemplify the valuable role regional collaboratives play - from facilitating data sharing and measure alignment to the building of infrastructure and deploying of standardized screening tools – all to ensure consistent data capture in order to assess program performance and confirm their collective population health goals.

# Care Delivery Requirements and Incentives

## Transforming Care Delivery

Transitioning successfully towards a culture of health requires that clinical and non-clinical care systems engage effectively to reach consensus on goals and strategies to improve the wellbeing of populations. Entities that might not have worked together before must now collaborate in new ways, and deliver integrated services spanning both clinical and social service organizations. Multi-sector collaborations in population health face many uncertainties over how best to deliver such social services: *Who provides these services and how should they be delivered to target populations? What sorts of clinical and non-clinical care delivery interventions should the collaborative partners undertake and how will they measure outcomes?*

During a series of meetings in 2017, representatives from AcademyHealth, NRHI, and their regional partners addressed these and other questions. Participants agreed on several principles, including that collaborators should decide in advance how to allocate responsibility and accountability, and recognize harmful power dynamics that could derail their interventions. They were also encouraged to commit and remain at the table to represent the full voice of the community, and ensure that the organizations they choose to work with can deliver high-quality services.

*Learning Collaborative*: *Engaging Care System and Communities in Care Improvement Strategies that Impact Population Health*. An NRHI/AcademyHealth-sponsored learning collaborative call held on August 29, 2017 focused on how collaborations between health care systems and community based organizations can improve care delivery and positively impact a community's overall health. Several regional collaboratives described how they are making progress in aligning clinical and social service sectors around care delivery:

- Awarded a $4.51 million Accountable Health Communities (AHC) grant from CMS, the Cincinnati-based Health Collaborative (THC), in partnership with United Way of Greater Cincinnati, is establishing a sustainable model to connect clinical care with social services delivery in eight counties throughout Southwest Ohio. For its part, THC is now developing an integrated data sharing platform with participation from more than 30 partners, including Federally Qualified Health Centers, health systems, community agencies, and other organizations.

- The Health Care Improvement Foundation (HCIF) has organized seven healthcare systems around a project to address the widespread problem of food insecurity in greater Philadelphia. A hunger screening tool is being implemented and used in multiple settings, including primary care offices, hospitals, OB-GYN offices, emergency rooms, and conducted via phone from call centers. In combination, HCIF has developed multiple referral pathways to connect vulnerable people with critical social services to address their nutritional needs.

- The Seattle-based Washington Health Alliance (WHA) is working on training programs designed to help medical practices integrate behavioral health and clinical care, which often involves community-based services, and move successfully towards value-based purchasing. These trainings support the Healthier Washington Practice Transformation Support Hub, which is supplying healthcare providers in Washington with tools and resources they need to make effective referrals to community-based social service organizations.

To underscore the value in engaging those in the clinical setting to help coordinate patient care with non-clinical services as illustrated in the examples above, the co-director of Stanford Coordinated Care, Alan Glaseroff, presented a case study on the value of using care coordination to integrate social services with primary care to ensure the in-

dividual needs of the patient are met. Through this process, Glaseroff explains that the health of the patient population, especially those chronically ill or high-cost, high needs, will have a greater likelihood for improvement, thereby improving the well-being of the community. (See Example A.)

Through the use of care coordination and shared data platforms, partnerships can begin to build sustainable care delivery models that allow for integration of clinical and social services that can have broad impact on the health of the community.

### Example A: Improving Population Health through Care Coordination and Integration of Social Services with Primary Care – Case Study

Alan Glaseroff, adjunct professor of medicine at Stanford and co-director of Stanford Coordinated Care, provided an informative case study of how his healthcare organization has successfully integrated social and behavioral services into their medical care processes. He highlighted the need to embed behavioral health in clinical practices, and emphasized that poor health is in many instances rooted in early trauma and other adverse events during childhood. Glaseroff said that when addressing high cost/high needs patients, it is important to tailor their care, and avoid assuming they each have similar problems.

Glaseroff asserts that clinical interventions often cost more than the actual problems they are aiming to solve, which is simply not sustainable in the long run. He suggests that community partners should anticipate future staffing needs, and then recruit the least expensive professionals with the least amount of training who can function optimally without need for back up. The goal should be that individual staff members work up to the limits of their credentials and licensure, and then strive for patient activation, so that individuals under their care acquire the skills and confidence they need to become actively engaged in their own treatment.

Glaseroff introduced an approach for achieving the Institute of Healthcare Improvement's triple aim of improving patient care experiences, improving population health and reducing costs. Called 5/25/125, it entails: 1) talking first with five people to understand a problem that needs solving; 2) designing a perfect response for 25 people who have the problem; and 3) delivering it to 125 people with the same problem. The approach can save significantly on health care costs, particularly for patients with chronic diseases, and health problems that are both medically and socially complex.

The staffing structure at Stanford Coordinated Care incorporates a strong team-based approach: physicians reside at the top of the hierarchy; a care coordinator with minimal training acts as point person for each incoming patient; a nurse serves as clinical backup; a licensed clinical social worker provides counseling and social work services; and a physical therapist and a clinical pharmacist each perform their respective duties. The clinic's basic strategy emphasizes patient ownership, partnering with appropriate resources, small steps, frequent follow-up, and finally care and concern, Glaseroff said.

Patient assessments at the clinic begin by asking, "What are the patient's needs and who is best equipped to handle them? What are his or her goals and where does he or she want to be a year from now?" This patient-centered strategy emphasizes hands-on action, and personal relationships that foster a sense of empowerment, so that patients feel activated and in charge of their care rather than victimized by it. Critical to success is that social service providers are informed of each patient's unique needs and treatment goals, and can stand ready to "catch" patients once they return to the community.

Glaseroff shared an example of a patient who had struggled for years to control her diabetes. In the past, the medical practice had provided all the appropriate clinical services, but the patient still had poor outcomes. Using their new approach, the healthcare providers uncovered serious early life trauma that was impacting the patient's ability to effectively address her diabetes. After referral to behavioral and social services, the patient's diabetes markedly improved. Dr. Glaseroff also shared that this example is one of many that are driving overall improvement in the practice's healthcare quality scores for chronic conditions.

Glaseroff also discussed how his practice has measured outcomes using a metric called the Patient Activation Measure (PAM), which assesses the degree to which individuals acquire the knowledge, skills beliefs and behaviors needed to manage their own conditions. Higher PAM scores often correlate with better outcomes. Glaseroff pointed out that higher PAM scores in one large study were associated with a 59 percent decline in emergency room visits.

The work at Stanford Coordinated Care shared by Dr. Glaseroff provides many examples of how medical clinics can redesign their care to include more integration with behavioral and social services that will improve patients' lives and the medical clinic's results. Regional collaboratives working to improve population health can help spread these lessons to other providers in their communities and help the providers implement changes in collaboration with other organizations in their service area.

# Payment and Financing

## Value-Based Payment and Population Health

Value-based payment models that focus on whole-person care—serving not just medical needs but also food security, housing, behavioral health, and other social factors that collectively account for most of what impacts population health—require innovative financing mechanisms that support non-clinical as well as clinical interventions.

How to pay for these community-wide services is one of the thorniest issues that stakeholders in population health face today. Health systems and social service organizations both want to provide for their communities and prevent individuals from falling into high-need categories, but they also need to reconcile the up-front costs with longer-term returns on investment. The essential questions are *who* should pay and *how much* should be paid for *what* actions and outcomes? How can interventions be funded sustainably? Should providers be held accountable for social service activities beyond their four walls? And how will reimbursements for non-clinical interventions flow between health and non-health care sector partners?

*Learning Collaborative*: *Establishing Sustainable Financing for Population Health*. On a NRHI/AcademyHealth-sponsored learning collaborative call held on July 24, 2017, Ellie Zuehlke, Director of Community Benefit and Engagement from Allina Health presented on their experience, as a large health care system in Minnesota, in addressing population health. She highlighted Allina's Center for Medicare and Medicaid Services Accountable Health Community Cooperative Agreement. She provided an overview of the implementation of their Health-Related Needs Assessment by clinics and the related issues to the referral process, data sharing with community partners and the evaluation method.

Supported by a $2.5 million, 5-year Accountable Health Communities (AHC) CMS grant, Allina is in the midst of a small-scale pilot project aiming to assess the feasibility and effectiveness of a screening and referral intervention with two primary goals: 1) respond to the priority health needs of Allina's population, of whom 36 percent are on Medicare or Medicaid; and 2) apply population health interventions to improve care and quality while lowering costs. Ideally the intervention will capture lessons learned and provide insights into how it can be sustainably financed.

To cultivate ownership over (and engagement with) the project, the screening tool and the process for its use was developed during a planning event held over four days and attended by all potentially impacted staff. What emerged from those deliberations was an intervention that connects vulnerable individuals with local services for health-related social needs.

Presently, individuals arriving at any one of Allina's numerous clinics fill out a 10-item screening questionnaire focused on issues such as housing instability, food insecurity, transportation needs, utility needs, interpersonal safety, family and social supports, and obesity-related health behaviors. A work in progress, and customized for Allina's local populations, the questionnaire draws from the National Academy of Medicine's standardized screening tool for accountable health communities. Incoming patients who report social service needs or have had a minimum of two recent trips to the emergency room receive a personalized after-visit referral summary, as well as assistance from social and community health workers—called navigators—who establish connections with needed services close to where the patient lives. Navigators will also follow-up and track the patient's utilization of those services for up to one year to confirm that reported needs were in fact addressed. These efforts require that navigators cultivate trusted personal relationships with social service providers.

To reduce inefficiencies, Allina is implementing a software platform called NowPow. Developed through cooperative agreements with researchers at the University of Chicago, **NowPow** provides data linkages between healthcare and social service organizations. Allina uses an extract process to upload patient data into the software (there is no feedback into the electronic medical record), which allows providers and social service groups to share information and track their referrals.

The pilot began in January 2017 with providers in pediatric and family practices who reported that the added burdens on workflow were minimal. Initial results so far look promising: 100 percent of screened individuals completed the questionnaire, 40 percent of them reported social service needs (pertaining mostly to utilities and housing), and a third of those referred to social services used the resources to which they were referred.

Most CMS funding for the project goes towards covering its administrative cost, such as salaries, IT infrastructure, and contracts with the local Medicaid agency. And assuming the intervention achieves its over-arching objectives, particularly a reduction in emergency room visits and unnecessary care, the essential question will be how it can be financed sustainably after the grant-funding period has ended. Allina is working towards an approach to financing that will be sustainable and not create resource shortages over time.

The initiative has not yet begun to exchange money and, in fact, CMS prohibits collaborators from using its funding to pay for housing and other social service needs. Rather, the project is setting the stage for new integrated partnerships informed by technology, data, a better understanding of community needs, and an improved grasp of how health care and social service groups can work together effectively. Overall, Allina Health's population health efforts reveal common financial concerns that value-based payment methods will have to contend with in the future.

In addition to this presentation, the learning collaborative call provided opportunities for the participating regional collaboratives to provide updates on their initiatives with respect to building payment and financing. Under the leadership of Community First, the Hilo-based regional health improvement collaborative, the Complex-Patient Centered Medical Home (C-PCMH) for high-cost, high-need patients is scheduled to open soon with the completion of the facilities of the Family Medicine Clinic at the Hilo Medical Center (HMC). This clinic will be located next to the emergency department to enable seamless triage of patients who do not require emergency services.

The Hawaii Medical Service Association and HMC are in the final negotiations of a new payment model that will be targeted toward a cohort of patients predicted to remain or become high cost, covering a comprehensive intake assessment including social determinants, and providing a higher fee-for-service schedule for visits, as well as a per-member-per-month payment for care management for several months or until the patient is stabilized. This new payment model will pay for a new interdisciplinary team based care model, which will include behavioral health workers, social workers, and community health workers.

As Community First developed the C-PCMH they recognized the need to coordinate social services with medical services and created the Community Action Network (CAN), which brings medical and social services providers together. There is a functional directory under development on "Facebook at Work" as well as a community care improvement team which will review cases that may be better served by both the medical system and various social service providers. There will be a legal structure in place to protect the privacy of the discussions of this team similar to that afforded to quality assurance committees.

Through the highlighted presentation from Allina and discussions with NRHI and the participating regional collaboratives, it was recognized that regional collaborators should employ the following tactics to design sustainable payment models that support community-wide population health initiatives:

- Leverage and align existing payment models at the intervention's earliest stages;
- Identify payment models that serve collective needs;
- Align funding and financing from multiple sources, including community benefit dollars;
- Explore innovative Medicaid financing opportunities;
- Prioritize interventions that promise positive returns on investment; and
- Start small with interventions that can be scaled up to accommodate larger goals.

## Conclusion

In the year since AcademyHealth and NRHI held their January meeting in Austin, Texas, participating regional collaboratives have made significant strides in the four topic areas that collectively drive improvements in population health. Taken together, their efforts are helping providers and social service organizations work together to address the priority health needs of their communities, and establish the infrastructure needed to move towards value-based payment models.

In the area of cross-sector collaboration and governance, regional collaboratives have taken on crucial roles as trusted conveners who help forge strong partnerships and build trust among disparate groups without a shared history of working together. Regional collaboratives are helping health providers and social service groups develop common metrics and mechanisms for sharing data and evidence, so they can use it to solve community-wide problems. They are facilitating the development of integrated IT platforms, and better care delivery systems targeted towards vulnerable populations. And they are tackling one of the thorniest issues facing population health: the need for innovative financing and funding mechanisms to pay for needed interventions.

As hard as these challenges are, regional collaboratives are rising up to meet them, and to address the over-arching goals of improving population health while also lowering health care costs.

# Appendix: Virtual Meetings and Webinar

**I. June - Data and Population Metrics:** Data and Information Sharing that can Impact Population Health

1. Topic Profile: Data and Population Metrics -http://www.nrhi.org/uploads/academy-health-documents/ah_topic-profile-data-final-1.pdf
2. Learning Collaborative Agenda - http://www.nrhi.org/uploads/academy-health-documents/nrhi_academyhealth-62617-learning-collaborative-agenda.docx
3. Learning Collaborative Key Take Aways - http://www.nrhi.org/uploads/academy-health-documents/nrhi_academyhealth-key-takeaways-062617.pdf
4. Learning Collaborative Video Recording I -A Three-Pronged Approach to Data Use, Kristin Paulson - https://vimeo.com/226141570
5. Learning Collaborative Video Recording II: Moving Beyond Geography and Race, Kristin Paulson – https://vimeo.com/239106605

**II. July - Sustainable Financing:** Establishing Sustainable Financing for Population Health

1. Topic Profile: Payment and Financing - http://www.nrhi.org/uploads/academy-health-documents/ah_topic-profiles-payment-and-financing.pdf
2. Learning Collaborative Agenda - http://www.nrhi.org/uploads/academy-health-documents/nrhi_academyhealth-72417-learning-collaborative-agenda.docx
3. Learning Collaborative Key Take Aways - http://www.nrhi.org/uploads/academy-health-documents/nrhi_academy-health-key-takeaways-072417.pdf
4. Learning Collaborative Slide Presentation: Population Health and the CMS Accountable Health Communities Model, Ellie Zuehlke - http://www.nrhi.org/uploads/academy-health-documents/cms-ahc-overview-for-nrhi-1-1.pptx
5. Learning Collaborative Video Recording - https://vimeo.com/228400074

**III. August – Multi-sector Care Delivery** – Engaging Care Systems and Communities in Care Improvement Strategies that Impact Population Health

1. Topic Profile: Alignment Across Sectors – Multi-sector Care Delivery - http://www.nrhi.org/uploads/academy-health-documents/ah_topic-profiles-care-delivery.pdf
2. Learning Collaborative Agenda - http://www.nrhi.org/uploads/academy-health-documents/nrhi_academyhealth-82817-learning-collaborative-agenda.docx
3. Learning Collaborative Key Take Aways - http://www.nrhi.org/uploads/academy-health-documents/nrhi_academyhealth-key-takeaways-082917.pdf
4. Learning Collaborative Slide Presentation: Designing for Intent in a Defined High-Risk Population - http://www.nrhi.org/uploads/academy-health-documents/nrhi-health-doers-webinar-8-29-17.pptx
5. Learning Collaborative Video Recording - https://vimeo.com/232660530

**IV. September - Governance** - Governance Issues for Sustaining Provider and Community Organization Participation in Population Health

1. Topic Profile: Alignment Across Sectors: Trusted Convener and Governance - http://www.nrhi.org/uploads/academy-health-documents/ah_topic-profiles-alignment-convener.pdf
2. Learning Collaborative Agenda - http://www.nrhi.org/uploads/academy-health-documents/nrhi_academyhealth-92517-learning-collaborative-agenda.docx
3. Learning Collaborative Key Take Aways - http://www.nrhi.org/uploads/academy-health-documents/nrhi_academy-health-key-takeaways-092517.pdf
4. Learning Collaborative Slide Presentation I: From Crisis to Thriving: Building Strategic Industry-Community Partnerships to Improve Health - https://community.healthdoers.org/wp-content/uploads/bp-attachments/20994/QC-From-Crisis-to-Thriving-FINAL-5.2.16-PDF-1.pdf

5. Learning Collaborative Slide Presentation II: Elizabeth Mitchell - http://www.nrhi.org/uploads/academy-health-documents/ah-governance-1.pptx

6. Learning Collaborative Video Recording - https://vimeo.com/246849904

V. **HealthDoers Network P4PH Webinar** - Improving Community-Wide Population Health with Focused Efforts on Payment Reform

1. HealthDoers Virtual Event Agenda - http://www.nrhi.org/uploads/academy-health-documents/webinar-agenda-101817.docx

2. HealthDoers Virtual Event Slide Deck - http://www.nrhi.org/uploads/academy-health-documents/healthdoers-powerpoint-deck-101817-lk-revisions.pptx

3. Payment Reform for Population Health Iconographic: Improving Community-Wide Population Health - http://www.nrhi.org/uploads/academy-health-documents/p4ph-infographic_final.pdf

4. Improving Community-Wide Population Health with Focused Efforts on Payment Reform Webinar Video Recording - vimeo.com/239106605

# Endnotes


1. Accelerating the Implementation of Value-Based Care and Payment: Recommendations from the 2016 National Payment Reform Summit. (2016, June 17). Retrieved from http://www.nrhi.org/uploads/2016_nationalpaymentreformsummit.pdf.
2. See Appendix video recording links from each of the four learning collaboratives.
3. We spend $750 billion on unnecessary health care. Two charts explain why. Sarah Kliff (2012, September 7). Retrieved from https://www.washingtonpost.com/news/wonk/wp/2012/09/07/we-spend-750-billion-on-unnecessary-health-care-two-charts-explain-why/?utm_term=.ebc84f1358fc.
4. The Structure of Regional Health Improvement Collaboratives. Available from: http://www.nrhi.org/about-collaboratives/structure/.
5. http://www.civhc.org/
6. Billioux, A., K. Verlander, S. Anthony, and D. Alley. 2017. Standardized screening for health-related social needs in clinical settings: The accountable health communities screening tool. Discussion Paper, National Academy of Medicine, Washington, DC. https://nam.edu/wp-content/uploads/2017/05/ Standardized-Screening-for-Health-Related-Social-Needsin-Clinical-Settings.pdf.