Prevention Institute

Prevention and equity at the center of community well-being

Opportunities for Advancing Community Prevention in the State Innovation Models Initiative

The Center for Medicare and Medicaid Services Innovation's (CMMI) State Innovation Models (SIM) Initiative presents an enormous opportunity for states to develop a Health Care Innovation Plan that reflects a coherent roadmap for reducing costs and improving health outcomes.

The SIM Model Design and Model Testing FOA and follow up communication with the SIM administrators have indicated the Innovation Center's interest in leveraging prevention to improve population health in the context of health system reform. Through references to the "social, economic, and behavioral determinants of health", description of the Community Centered Health System; and acknowledgement of the need for integration between public health and clinical services, the Innovation Center makes clear its desire that the State Health Care Innovation Plan become an impetus for 'total health system reform.' CMMI staff who were responsible for developing the FOA have consistently emphasized prevention as vital to the initiative in their communications. With that in mind, Prevention Institute has put together this memo to share some initial thinking about how SIM design grantees can integrate and advance primary prevention strategies within a broader state innovation planning process.

Elements of a Community Centered Health System

The SIM FOA called upon states to develop and test innovative approaches to prove that they can deliver significantly improved cost, quality, and population health performance results. Prevention Institute developed a model—the Community-Centered Health Home —that provides a framework for how health care institutions can take an active role in strengthening their surrounding community in addition to improving the health of individual patients and better aligning services. A community-centered health home is only one aspect of a Community-Centered Health System (CCHS) wherein incentives, partnerships, data systems, payment approaches, and staffing support an integrated approach to improving health and safety of both individuals and populations.

A CCHS not only *acknowledges* that factors outside the health care system affect patient health outcomes, but *promotes active engagement* in improving them. The model builds on the typical doctor to patient interaction (patient intake, diagnosis, and treatment) and translates these into a parallel set of activities (inquiry, analysis, action), then uses these interactions to identify patterns of health problems and solve them at their root, rather than simply adjusting services to meet them. Increasingly, states and communities around the country are implementing elements of this model and the approach is receiving growing interest, precisely because health care and clinic partners can see how community conditions such as housing, transportation and pollution are increasing demands for care and driving treatment costs. More importantly, there are opportunities to be effective partners in preventing unnecessary and costly illness and injuries through policy advocacy and systems-level changes.

The CCHS model holds great promise and the SIM planning process provides an important opportunity to move from concept to implementation. Specifically, the following elements can be explored in greater depth:

I. *Data collection and analysis regarding community conditions*:

With expanding sources of health information and capacity to analyze and use that information, steps can be taken to, for instance, export clinical and socioeconomic data from the electronic health records of health providers into uniform regional data systems. This data can then be aggregated to describe health and safety trends and map "hot spots" where clusters of similar illnesses or injuries are occurring. These health problem "hot spots" can be mapped along with community conditions associated with these health problems (e.g. asthma cases and community locations of high volume traffic areas, factory emissions, indoor air quality in schools and housing; or diabetes cases mapped with grocery stores, fast food, corner stores, parks and playgrounds, and street crime). Many tools and approaches are now available for data collection and analysis (see the attached Magnolia Place case study) and these can be utilized to expand the quality of required community needs assessments for federally qualified health centers and non-profit hospitals.

II. *Expanding and building capacity of the workforce:*

- *Navigators:* Also known as community health workers, promotoras, or patient navigators, these individuals interface directly with community members to connect people to necessary care and services and provide health education. Their role can be vital in saving money and lives. For Example, Asian Health Services (AHS), a community health center in Oakland, CA established Patient Leadership Council (PLC) groups to serve as a two-way strategy for engaging and educating community members. The goal of the PLCs is to provide direct input to AHS' leadership regarding the barriers faced by community members and how to improve services, as well as train volunteers to provide peer health education and conduct advocacy activities on behalf of their community's health needs. Similarly, the University of Chicago (a recipient of the Innovation Center's Health Care Innovation Challenge grants) established Community Health Information Specialists, whose role is not only connect community members to key support services, but also gather data on where there are service and resource gaps at the community level, which then become the core of a Community Prevention prescription for the patient. As stated in *Foundations for Community Health Workers* (Berthold, Miller and Avila-Esparza), "Including Community Health Worker's (CHW) within a team model for clinical care will improve the quality of care for patients, improve the health of the community, decrease health inequalities and ensure that health care services are used appropriately, *which in turn will aid in reducing health care costs*. As our society grows and diversifies, and as poorly treated chronic conditions become an increasing strain on the health care system, employing CHW's is a cost effective and culturally appropriate solution."

- *Integrators:* Essentially, an integrator is an entity that serves a convening role and works intentionally and systemically across various sectors to achieve improvements in health and well-being for an entire population in a specific geographic area. Nemours, which has taken on the role of an integrator to improve child health and well-being in Delaware, has advanced thinking on this concept. It helps solve the problem of how underlying contributors to illnesses revealed within medical environments can be pinpointed and modified in the community. Examples of integrators range from integrated health systems and quasi-governmental agencies to community-based non-profits and coalitions to those organizations' individuals and staff. The integrator role is not "one-size-fits-all", but rather must be flexible to adapt in response to the needs of the community or population it serves.

- *Provider engagement and training and when necessary, certification*: In order to fully advance primary prevention practice, clinical providers must be engaged and informed of the strategies necessary to address prevention issues within the clinical context. Clinicians often do not see how, within the constraints of their jobs, they can have an impact on the factors that lead

to many illnesses and injuries *in the first place*. Part of the plan should include trainings on community prevention for clinical providers and other health care organizations to build a cadre of individuals that are deeply versed on community prevention principles and strategies. Our experience reveals that while many providers and staff recognize the influence environmental, social, and cultural factors have on health, given resource and time constraints, they often do not have the background, tools, and training to address them. It is vital, however, that clinical professionals and staff feel prepared, and have the necessary background and supports, to engage in clinical care-community prevention integration efforts. This is in part a workforce issue but is also a skills-development, training, and health-system concern that will be critical to understand and explore through the planning process as well. Through such training, a more seamlessly integrated clinical and community strategy can emerge.

III. *Payment Reform Innovations*

A key opportunity for advancing and incorporating prevention is the development of reimbursement mechanisms and financing policies within health care systems that reward and incentivize prevention practice. Shaping such strategies will be a key element of the planning process. Insurers, businesses and families have accrued savings from successful public health initiatives to, for instance, reduce tobacco consumption and exposure to toxins, such as lead. Prevention Institute, Trust for America's Health, the Urban Institute, and The California Endowment released a report demonstrating that investing $10 per person per year in community initiatives pays for itself in less than 2 years and shows a 5-to-1 return in 5 years. Health care providers and organizations struggle with how to 'capture' and sustain funding to maintain proven prevention strategies. During the six-month planning phase, the SIM initiative could host targeted conversations and bring together prevention and public health experts, health care providers, health care economists, and others to discuss how prevention strategies reduce clinical costs and demand, and explore the development of sustainable mechanisms for paying for these strategies, as well as engaging with other states exploring innovative solutions.

The following strategies could be explored during the planning process for feasibility, alignment with current efforts, potential impact, and inclusion in State Health Care Innovation Plans:

- *Wellness Trusts*: The idea of a "wellness trust" has been discussed in a variety of different contexts (local, state, and national) and with a range of details and structures, but the basic concept is consistent: create a pool of resources to fund broad, population-focused prevention and wellness activities. The potential resources for a Trust can come from the public and private sectors and specifically those who stand to benefit from improved health in the population (employers, insurers, government, etc.). There is a common refrain that insurers don't have a vested interest in prevention because the return on their investments would accrue to other payers. Wellness Trusts address this issue by compelling shared investment and distributing rewards across the population. A number of states have developed programs that resemble Wellness Trusts (for example, the Prevention and Wellness Trust Fund in Massachusetts and the State Health Improvement Program in Minnesota, see attached case studies).

- *Social Impact Bonds/Health Impact Bonds*: Also called Pay for Success, these initiatives use an impact investing model to increase the level of prevention investment in niche areas. Most programs that exist today are focused on social issues such as cutting crime and homelessness, and there is limited precedent in impact investing's application to health care and the role of community prevention. However, a health impact bond pilot program has been initiated in Fresno, CA to reduce the rates of asthma related hospitalizations through

prevention-based home remediation interventions for at risk patients. This pilot, designed by Collective Health, a health impact investment firm, and researchers at UC Berkeley, is expected to generate positive return on investment while improving asthma patient health outcomes and can serve as a blueprint for similar schemes elsewhere.

- *Leverage the establishment of Accountable Care Organizations*: Incentives in the ACA are driving the formation of Accountable Care Organizations (ACOs) between groups of providers across the country. Much of the emphasis of ACOs is on streamlining and coordinating clinical care, but there is significant potential to focus on innovative, collaborative ways for improving health and reducing costs. This is particularly true in situations where an ACO covers a defined geographic region and provides service to a majority of the local population. In such cases, the rationale for focusing resources and attention on community conditions would be obvious. A real world example of this is the Accountable Care Community (ACC) being developed in Akron Ohio, facilitated by Austen Bioinnovation, which builds collaboration between health systems and a large set of community partners to take shared responsibility for the health of the entire population of Summit County, OH. The collaborative is funded through a unique negotiation between the local health systems, payers, the public health agency, and Austen Bioinnovation, which allows for the capturing of savings in reduced health care costs and the sharing of these savings among the health systems while covering the operating costs for Austen Bioinnovation to facilitate the collaboration. The ACC has already engaged in community prevention work, such as establishing a new bus route from an underserved community to a local national park, which residents of the community can now easily access for physical activity opportunities

- *Explore methods that take advantage of treatment funding to advance community-wide strategies*: There is widespread recognition that the best practices for improving outcomes for people with chronic illnesses include a combination of clinical interventions (e.g., inhalers, pharmaceuticals, surgery) and community approaches (such as increased access to healthy food and safe places to be physically active). There is a significant opportunity to identify strategies that would have positive impact on those with chronic illness, and paying for such strategies with healthcare funding (in the chronic care model such funding is part of current practice). One pool of resources that could potentially be tapped to fund community approaches in tandem with clinical interventions would be hospital community benefit dollars.

- *Explore MediCal Waivers*: Medical/prevention coordination requires new models and new ways of doing business. California and a number of other states have already initiated use of CMS funds creatively through 1115 Waivers. That waiver encourages "implementing models for more comprehensive and coordinated care for some of California's most vulnerable residents". As part of the Model Design process, the provisions of the 1115 waiver, as well as other mechanisms for creating flexibility in the use of Medicaid dollars, should be explored for potential relevance for the Innovation Plan.

Examples of CCHS in Practice

Below are examples drawn from across the country that represent CCHS activity and that could be instructive for SIM grant recipients.

Health in All Policies Task Force

California

Overview

California's Health in all Policies Task Force was established in 2010, and is comprised of 19 state agencies and departments including Health and
Human Services, Transportation, Housing and Community Development, Parks and Recreation, Planning and Research, and Education. The Task Force was charged with identifying priority actions and strategies for state agencies to improve community health while also advancing sustainable development goals.

Fundamentally, the Task Force represents a recognition that health is affected by decisions that are made throughout government but that health is often not considered in decision-making processes. Between April and November of 2010, representatives from member agencies, departments, and offices came together in multiple individual and Task Force meetings, hosted public workshops, and received written comments from a diverse array of stakeholders. These State leaders developed a broad-ranging set of recommendations on feasible strategies and actions to promote health while also meeting environmental and economic objectives.

The Task Force's recommendations support a future in which every California resident has the option to safely walk, bicycle, or take public transit to school, work, and essential destinations; live in safe, healthy, affordable housing; has access to places to be active, including parks, green space, and healthy tree canopy; is able to live and be active in their communities without fear of violence or crime; has access to healthy, affordable foods at school, at work, and in their neighborhoods; and that California's decision makers are informed about the health consequences of various policy options during the policy development process.

Outcomes

The Task Force expects to positively affect rates of injury and chronic illnesses such as asthma, diabetes, and stroke through outcomes and actions including: leveraging government spending to support healthy and sustainable food procurement; inserting health and health equity criteria into state grants; broadly implementing crime prevention through environmental design; and advancing smart housing siting to improve air quality-related health outcomes and physical activity.

Population Focus

The Task Force is focused primarily on the activities of state government agencies with an emphasis on improving environments in communities across the state, particularly low-income, under-resourced communities.

Role of State Health Agency

The California Department of Public Health (CDPH) is specifically designated to facilitate and staff the Task Force and they have done so with support from the Health and Human Services Agency.

Key Partners

The 19 state agencies that have participated in the Task Force have been the key partners. CDPH also has an advisory committee made up of leading health and equity organizations, and solicits input regularly from policy experts and local health departments across the state.

Payment Mechanism

The Task Force has received significant fiscal support from The California Endowment (a private foundation), as well as project-specific funding from the Kaiser Permanente Community Benefits fund and the American Public Health Association.

Related Efforts

Other regions acting on related efforts include the Galveston, TX, Health in All Policies Project. The concept of Health in All Policies is well-developed in European countries and Australia.[32] Similar concepts and approaches are evidenced by the National Prevention Strategy and the federal Partnership for Sustainable Communities.

Statewide Health Improvement Program

Minnesota

Overview

The Minnesota *Statewide Health Improvement Program* (SHIP) launched as part of the bipartisan state health care reform legislation enacted in 2008. SHIP tackles the top the top three preventable causes of illness and death in the U.S.: tobacco use & exposure, physical inactivity, and poor nutrition. These three factors have been estimated to cause 35% of all deaths in the U.S., or 800,000 deaths annually.

Rather than focusing on individual behavior change, SHIP works to create sustainable, systemic changes that make it easier for Minnesotans to choose healthy behaviors. The program takes proven best practices from the Centers for Disease Control and Prevention (CDC) and other leading public health organizations to create a menu of health improvement strategies. Grantees, which include local health departments and tribal governments, choose from this menu in determining which policy, systems, and environmental changes to implement in their communities. Working in four settings (schools, health care systems, worksites, and the community in general) examples of strategies include: improving nutrition by working with schools to increase the availability of fresh fruits and vegetables, decreasing exposure to second-hand smoke by assisting owners of multi-unit housing wishing to make their buildings smoke-free, lowering insurance costs by supporting employers interested in workplace wellness programs, and increasing physical activity by helping communities make biking and walking safer.

In the first two years of SHIP funding, 41 grantees covering all 87 counties and 9 tribal governments began this work, and resulted in the following: improved nutrition at 544 child care sites serving approximately 8,564 children, the creation of 255 city-wide plans to increase walking and bicycling, and increased Farm to School efforts in 350 schools and 22 school districts serving at least 200,000 students.

Outcomes

With sustained funding at the $27 million per year funding level, the program was projected to move as much as 10% of the adult population in Minnesota into a normal weight category and as much as 6% of the adult population into a non-smoking category by 2015. A robust framework for conducting local and statewide evaluation of the program has been developed to track progress towards meeting these goals.

Population Focus

SHIP targets the entire population of the state of Minnesota in order to reduce obesity rates and tobacco use and exposure. Individual grants target specific populations based upon the needs of the community identified by the local coalitions.

Role of State Health Agency

The Minnesota Department of Health (MDH) administers the program, including compiling effective strategies from national experts; awarding program grants; providing technical assistance and training; and tracking progress for monitoring and evaluation.

Key Partners

The Statewide Health Improvement Plan is in partnership with the Minnesota Legislature, the Center for Disease Control and Prevention, local health departments, tribal governments, schools, local businesses, Minnesota-based corporations, health care providers, and community-based organizations.

Payment Mechanism

Under this program, $20 million in grants were awarded for 2010, $27 million was awarded for 2011, and $11.3 million has been awarded for 2012. For the first SHIP funding cycle, grants were awarded to communities on a per capita basis of $3.89 per person, which is the minimum recommended amount by the CDC for comprehensive health interventions that address chronic disease prevention.

Related Efforts

SHIP is one component of Minnesota's statewide Health Reform Initiative, passed by the legislature in 2008, which also includes the establishment of a medical home program, and quality, cost, and payment reform within the state's health care system. The development of SHIP was informed by Minnesota's Plan to Reduce Obesity and Obesity- Related Chronic Diseases: 2008–2013, a statewide collaborative effort to develop a roadmap for creating policy and environmental changes that support healthy eating, physical activity, and achieving or maintaining a healthy weight.

St. John's Well Child and Family Center

Los Angeles, CA

When clinicians at St. John's Well Child and Family Center noted a significant number of patients with conditions ranging from cockroaches in their ears to chronic lead poisoning, skin diseases, and insect and rodent bites, they inferred that many of the cases might be related to substandard housing conditions. The clinic incorporated into office visits a set of questions about patients' housing conditions and was able to collect not only standard health condition data (e.g., allergies, bites, severe rashes, gastrointestinal symptoms) but also housing condition information (e.g., presence of cockroaches, rats, or mice). St. John's clinic partnered with a local housing agency, a human rights organizing agency, and a tenant rights organization to form a collaborative to address substandard and slum housing in Los Angeles. The data that St. John's collected made them an asset in the collaborative and helped the collaborative to gain partners. The collaborative developed and pursued a strategic plan to improve housing conditions in the area. The plan included community engagement, research, medical care and case management, home assessments, health education, litigation, and advocacy. The collaborative passed local administrative policies and secured agreements from high level leadership at different government agencies (LA City Attorney's Office and LA Department of Public Health) that led to improved landlord compliance with standard housing requirements. The clinic now serves a surveillance role, reporting landlords that perpetuate substandard housing, and the community now has the infrastructure in place to ensure that landlords not in compliance are dealt the proper financial and legal consequences. Evaluation results show that residents' living conditions and health outcomes both improved as a result of the collaborative's efforts.

Magnolia Place Community Initiative

Los Angeles, CA

(Case study courtesy of UCLA Center for Healthier Children, Families, & Communities)

The Magnolia Place Community Initiative is a voluntary, virtual network of organizations that came together with the vision of children living in a 100 square block community near downtown Los Angeles succeeding at unprecedented levels. The Magnolia Initiative in West Adams, Pico Union and the North Figueroa Corridor is implementing a primary prevention model designed to integrate three strategies: building neighborhood based and/or common link social networks; increasing economic opportunities and development; and

increasing access and use of family-desired services, activities, resources and support. The goal is to support and galvanize community residents to create their own local response to improving their communities and contributing to safe and supportive environments for the neighborhood's children. The Initiative uses a community change approach that recognizes the ecological context of child development, health and learning, drawing from the protective factors (Strengthening Families) framework.

The Initiative uses a peer production process to make positive changes that move the community toward improved outcomes. Community engagement is a central feature. The Initiative is using community dialogues to engage community members in identifying the neighborhood boundaries that define the Early Developmental Instrument (EDI) maps. By using data to engage residents and to document and illustrate the community needs, the Initiative is able to direct the attention and collective investment of residents as well as the network of organizations on systems changes and universal strategies that will change outcomes for the full population of children in the community.

The Magnolia Initiative uses a Community Data Dashboard to focus the cross-sector network of local and county organizations on agreed upon community level outcomes. Specific improvement efforts include increased cross-sector collaboration, linkage and referral processes, identifying sustainable and scalable strategies that target social isolation as well as maternal depression and child development concerns, and strategic allocation of resources to meet needs in areas of high vulnerability. Agencies that are taking lead roles in changing institutional practice include the Children's Bureau of Southern California, the Echo Center, the Los Angeles County Departmental of Mental Health, a County Team led by the Los Angeles County Chief Executive Office, SAJE (Strategic Actions for a Just Economy), the UCLA Center for Healthier Children, Families and Communities and the Los Angeles Perinatal Mental Health Task Force.