PARTNERING TO CATALYZE COMPREHENSIVE COMMUNITY WELLNESS

An Actionable Framework for Health Care and Public Health Collaboration

PUBLIC HEALTH
LEADERSHIP FORUM

Health professionals working to protect and improve health in communities and across the nation realize that none of our distinct systems — not health care, public health, nor social services — is fully equipped to accomplish its mission alone.
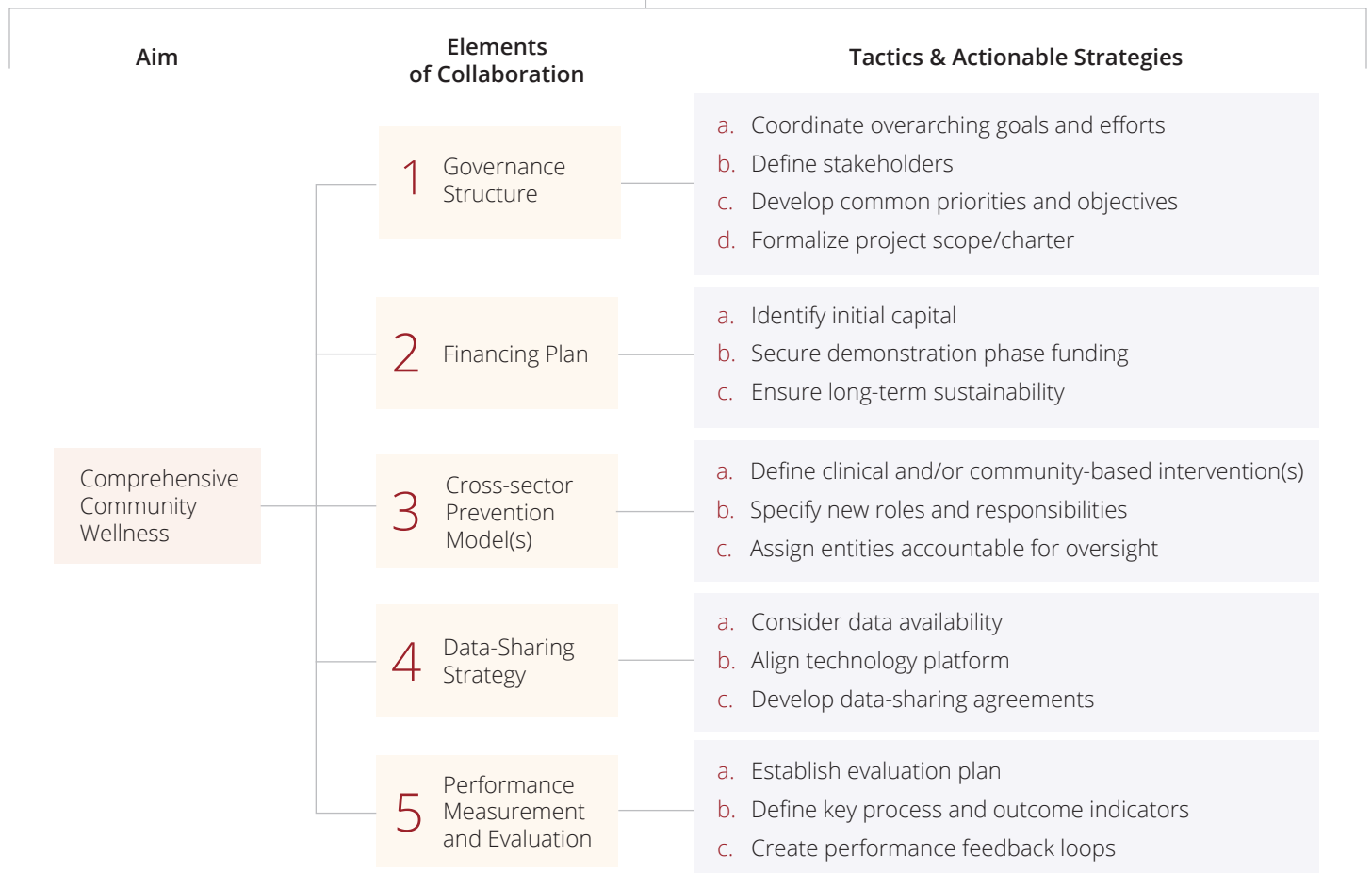
There is mounting recognition that to truly improve health outcomes in the U.S. and curb chronic diseases there must be an interdisciplinary, coordinated, and cross-sector approach to address acute conditions and the upstream social factors that contribute to poor health outcomes. This approach requires transformation of the way the health and human service systems traditionally interact.

In pursuit of this goal, members of the Public Health Leadership Forum (PHLF) and Health Care Transformation Task Force (HCTTF) developed a framework to help catalyze and facilitate collaborative working relationships between the public health and health care sectors. Such partnerships are an essential component of the "comprehensive community wellness approach," one in which effective, collaborative relationships across sectors ensure more seamless care and prevention services for all. Under this approach, public health, health care, and social service and community organizations intentionally build high-functioning partnerships to address health needs in their communities, and invest in the time, staff, information platforms, and oversight structures needed to sustain them. The framework outlines essential elements of collaboration and presents key tactics and strategies for forming or reshaping effective partnerships.

Action from key stakeholders is needed to realize the comprehensive community wellness vision:

1. Public health and health care leaders can use the framework to convene collaborative groups, commit the time and resources needed to effectively collaborate on a shared vision, and grow a generation of health professionals who view multi-sector collaboration as the norm.

2. Local, state, and federal policy makers can learn from the examples of effective cross-sector collaboration that informed development of the framework to advance policies and programs that create the catalysts and conditions in which collaborative wellness approaches thrive.

3. Health practitioners can identify opportunities to engage and support community-based organizations in structured partnerships to ensure health interventions can truly take hold.

Overarching considerations: Equity, Person-Centeredness, Sustainability

Aim	Elements of Collaboration	Tactics & Actionable Strategies
	1 Governance Structure	a. Coordinate overarching goals and efforts b. Define stakeholders c. Develop common priorities and objectives d. Formalize project scope/charter
	2 Financing Plan	a. Identify initial capital b. Secure demonstration phase funding c. Ensure long-term sustainability
Comprehensive Community Wellness	**3** Cross-sector Prevention Model(s)	a. Define clinical and/or community-based intervention(s) b. Specify new roles and responsibilities c. Assign entities accountable for oversight
	4 Data-Sharing Strategy	a. Consider data availability b. Align technology platform c. Develop data-sharing agreements
	5 Performance Measurement and Evaluation	a. Establish evaluation plan b. Define key process and outcome indicators c. Create performance feedback loops

This practical tool was developed with the shared conviction that collaboration between public health and health care entities is a crucial, though not sufficient, step toward achieving comprehensive community wellness. We believe strong health care and public health partnerships can be the foundation around which a larger network of multi-sector allies working to improve community health can form.

PUBLIC HEALTH
LEADERSHIP FORUM

The Health Care Transformation Task Force is an industry consortium that brings together patients, payers, providers, and purchasers to align private and public sector efforts to clear the way for a sweeping transformation of the U.S. health care system. The Task Force is committed to rapid, measurable change, both for itself and the country. It aspires to have 75% of its member businesses operating under value-based payment arrangements by 2020.

The Public Health Leadership Forum is an ongoing platform, managed and facilitated by RESOLVE, to engage a diverse set of public health leaders, practitioners, and other stakeholders in dialogue on current challenges to public health and opportunities for leadership, partnership and transformation within the context of the evolving health system.

A SHARED VISION

Promoting the health and well-being of Americans has always been a multi-sector effort, and the division of labor has traditionally fallen along well-known lines. Public health[1] assumes responsibility for population health issues, providing disease tracking and control, environmental health and family health services, and safety net assurance. The health care[2] sector provides acute, chronic, and preventive patient care at the individual level. Human and social services address access to the housing, employment, education, transportation, and other faculties and services necessary for healthy living.

Increasingly, however, the rigid distinctions among these sectors, their roles, and operating systems expose cracks in our health system, especially as efforts to improve health move "upstream." This is evident in emergency departments crowded with people seeking treatments for conditions that are exacerbated by living environments or lifestyles. We see this in dropped handoffs between health care clinicians, case managers, and social workers. We see this in inflated health care spending that prohibits access to care and crowds out other national investments, affecting our workforce productivity, gross domestic product, and global competitiveness. We see this in troubling trends in U.S. life expectancy, obesity rates, infant mortality, and other health indicators.[i,ii] As our health care, public health, and social service organizations each strive to fulfill their individual missions, there is a growing recognition that those individual missions can only be achieved by working together, that if we remain divided many individuals, and indeed entire populations, fall through the cracks.

Reversing these trends and effectively achieving improved community health outcomes requires transformation; it requires closing gaps and providing more seamless care and prevention services. We can no longer say that health care is fundamentally separate from public health which is separate from social and human services. Rather we must commit to and develop collaborative, cross-sector approaches to "comprehensive community wellness."

A comprehensive community wellness approach is one that values and supports all people achieving their highest possible levels of health by simultaneously addressing all determinants of health.[3] It is a system in which health care professionals, public health, social services, and community-based organizations (CBOs)[4] partner to address acute and chronic illness and injury and the upstream environmental factors, community conditions, and barriers to preventive care that contribute to poor health outcomes in the first place. When assuming such an approach, the health department, hospital, and housing authority share at least one common goal: to improve the health and well-being of the people they serve. They work in concert, each leveraging their own skillsets and that of their partners, to accelerate and achieve the

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1 In this paper, "public health" refers to governmental public health offices/departments. In other contexts, public health is often defined more broadly to include a wide array of entities and actors, both public and private, which promote public health and wellness. However, for clarity of scope, in this framework public health refers only to governmental entities.

2 In this paper, "health care" refers to the sector broadly, and includes the delivery of health care services by clinicians and allied health professionals, as well as stakeholders including patients/consumers, purchasers/employers, and health insurance plans, both public and private, that pay for and receive health care services.

3 Factors that strongly influence health outcomes include a person's, including: access to medical care, access to nutritious foods, access to clean water and functioning utilities (e.g., electricity, sanitation, heating, and cooling), early childhood social and physical environment, including childcare, education and health literacy, ethnicity and cultural orientation, familial and other social support, gender, housing and transportation resources, linguistic and other communication capabilities, neighborhood safety and recreational facilities, occupation and job security, other social stressors, such as exposure to violence and other adverse factors in the home environment, sexual identification, social status (degree of integration vs isolation), socioeconomic status, spiritual/religious values.

4 In this paper, "community-based organizations" refer to an array of public and private human services (e.g., transportation, housing authorities, social workers, foodbanks, shelters, legal services, etc.) that address social determinants of health.

shared goal. And because an effective community wellness approach is contingent on the strength of its partnerships, each sector invests in the systems and leadership (or "backbone") structures that support collaboration.

Achieving comprehensive community wellness will require departure from the current silos, competing funding streams, and distinct objectives, and instead require commitment to enhanced cross-sector cooperation and communication structures. When successful in this approach, we will be providing better health protection to all persons, improving the experience of care, reducing per capita costs, and improving the work life of those who deliver services. And in so doing, we will alter the U.S.'s trajectory of extremely high spending for relatively poor health outcomes. This is our vision for health in America.

BUILDING MOMENTUM TOWARD COMPREHENSIVE COMMUNITY WELLNESS

Fortunately, there is already institutional momentum moving us toward transformation and toward achieving the comprehensive community wellness vision. Forces within the health system and intensifying social impetus are beginning to align our independent health care and public health systems and shifting the focus of interventions further upstream into communities and lived environments.

Health care professionals are committed to keeping their patients as healthy as possible. They know that doing so requires addressing the conditions their patients face beyond the walls of their practice, including the social and physical environments in which their patients live and work. There is growing recognition that collaboration across health care, public health, and community sectors supports clinical practice by addressing patients' multi-factorial social needs that cannot be provided by primary care alone, but which affect health significantly. This recognition shows in policy, too, reflected by community-focused requirements for health care providers under the Affordable Care Act (ACA), Health Information Technology for Economic and Clinical Health Act (HITECH), and Medicare Access and CHIP Reauthorization Act (MACRA).

The philosophy touted within new provider models such as the patient-centered medical home (PCMH) and accountable care organization (ACO) asserts that individual health is inseparable from the health of the larger community. These models encourage collaboration among the clinical, public health, and community organizations to identify and reach targeted health goals with emphasis on evidence-based preventive health services and identifying gaps in services, particularly for vulnerable populations.

The growing adoption of global payment systems, alternative payment models, and value-based contracts and performance measurement has expanded opportunities for the U.S. health care system to better address disparities through community partnerships.[iii] As health care systems gradually move from "volume" (fee-based reimbursement) to "value" (the outcomes and quality of care provided), they are increasingly incentivized to move interventions upstream and into lower-cost settings. Indeed, there is even expanding interest in taking the volume-to-value model a step further by providing reimbursement for services outside of the clinical setting that address health related social needs like housing, nutrition, or economic support. Proposed "Pay for Performance" models of reimbursement, for example, would directly incentivize keeping patient populations healthy before care or costly intervention is needed.[iv] This model aims to incent physicians to provide needed clinical services and also pay for referral to community-based services to improve health. Such models build on innovative programs within the Medicare and Medicaid programs such as Accountable Communities for Health.

Our public health system is evolving as well, alongside and in response to shifts in health care. Since 1989, with the Institute of Medicine's Future of Public Health publication, the direction of public health investment and energy has been a constant topic of discussion and innovation in the field.[v] Expansion of health insurance access in recent years created an opportunity for public health to rethink its safety net, and consider ways to better invest limited public resources to address the demands of its broad population-based mandate, including infectious disease control, disease and injury prevention, and family and environmental health. At the same time, it grows ever more apparent that these services, and effectively protecting the health of all Americans,

are inextricable from more basic social needs such as food security, education and housing, substance use disorder treatment, and primary clinical services. These are issues public health knows it cannot address on its own.

National public health leaders have rallied around a redefinition of public health termed "Public Health 3.0," steering the field toward a role of a data-oriented community strategist, convener, facilitator, and community leader rather than direct service provider, particularly when and where services can be better provided by other enterprises within the community.[vi] Public health professionals know this role requires new and strengthened collaborations with the health care system and community partners. This is evident from the proliferation of collaborative initiatives such as in Hennepin County, Minnesota. There the county partners with local companies, schools, and CBOs to provide healthy lifestyle programs, resources, and educational materials to its residents and instill a culture of wellness in its homes, classrooms, and workplaces.[vii]

Bringing health care and public health together in a community-wide effort is not just an abstract exercise in efficiency. It has become clear that most of the serious health challenges Americans face cannot

be solved within a clinic alone or by public health agencies operating in isolation. Chronic diseases are the biggest driver of poor health outcomes and high health care costs.[viii] Outcomes for chronic diseases such as asthma, heart disease, obesity, and diabetes all relate to environmental, social, and economic factors or conditions where Americans live, learn, work, and play.[ix,x] It is only through collaboration between public health and health care — along with other community-level activities and services — that a comprehensive approach to these costly conditions can be implemented. Similarly, two emerging crises in US health care, maternal survival and infant mortality and the expanding opioid crisis, are prime examples where health care and public health must partner in order to have in place the services, policies, and other supports that are needed to reverse these trends.

Clearly, momentum toward the comprehensive community wellness vision is building. Collaborative cross-sector approaches to improve community health have emerged in pockets across the country, catalyzed by grant dollars, in response to an acute community health problem, or by an enterprising organization seeking to promote its health equity mission. It is time to intentionally bring them into common practice.

COLLABORATIVE FRAMEWORK

Effective partnerships between health care and governmental public health can catalyze the provision of more broadly accessible, coordinated health and social services, and lead to improved community health and individual care experience. Public health is often uniquely situated to track local health trends, associated needs, and provide the skills and direct services to address them. Health care offers knowledge of its community's clinical profile, a robust system for reimbursing and paying for services, and clout as a policy advocate. Together these systems wield complementary capacities that can and should be leveraged to better target interventions, reduce redundancy, and maximize the

impact of available resources and skill-sets. To do so, cross-sector relationships among public health, health care, and other community organizations must be built so that sustainable systems for information exchange and service referral can be put in place.

The following framework serves a practical reference meant to facilitate the building of partnerships between governmental public health and health care systems. It outlines essential elements of collaboration and key questions to address when beginning or reshaping such relationships. It is informed by leading experts and practitioners in

both public health and health care, and draws on lessons from those already working to achieve such partnerships, including communities in Washington, Idaho, Iowa, Maryland, and Michigan.

The framework provides a base approach for successful partnership building and is meant to be adapted to community circumstances and contexts. It assumes that partnerships will be actualized differently depending on unique aspects of the locality (rural, urban, existing coalitions, partnerships or demonstrations, community resources, etc.) and the intended goal of collaboration. For example, the "Elements of Collaboration" are not listed in order of importance nor necessarily chronologically (e.g., an intervention model may be developed before a financing plan).

This framework concentrates specifically on collaboration between public health and health care, but other types of catalyzing partnerships are possible and desirable. For instance, strong community-based organizations or foundations may be better positioned as partners (with public health, health care, or both) to catalyze a comprehensive community wellness approach. Collaboration between public health and health care is just one piece to the puzzle. Comprehensive community wellness will engage the myriad of organizations and programs that contribute to community health, including CBOs, NGOs, faith-based organizations, and paid and unpaid social services.

Overarching considerations: Equity, Person-Centeredness, Sustainability

Aim	Elements of Collaboration	Tactics & Actionable Strategies
Comprehensive Community Wellness	1 Governance Structure	a. Coordinate with "bigger picture" goals/efforts b. Define stakeholders c. Develop common priorities and objectives d. Formalize project scope/charter
	2 Financing Plan	a. Identify initial capital b. Secure demonstration phase funding c. Ensure long-term sustainability
	3 Cross-sector Prevention Model(s)	a. Define clinical and/or community-based intervention(s), service(s), and/or program(s) b. Specify new roles and responsibilities c. Assign entities accountable for oversight
	4 Data-Sharing Strategy	a. Consider data availability b. Align technology platform c. Develop data-sharing agreements
	5 Performance Measurement and Evaluation	a. Establish evaluation plan b. Define key process and outcome indicators c. Create performance feedback loops

AIM
Comprehensive Community Wellness

The collaborative needs to **set an aim** to focus on what will drive the system closer towards the community wellness vision. The aim should meet the SMART criteria: be specific, measurable, achievable, relevant, and time bound. The aim could address a single issue (e.g., improve maternal mortality by 20% by 2020) or a more inclusive goal (e.g., become the healthiest community in America by 2025), and have associated benchmarks that enable forward progress. While public health and the health care system are just two of the many players necessary to a comprehensive community wellness approach, these two sectors play an important role in addressing acute illness and injury, the upstream environmental conditions, and the social determinants of health within a given community that contribute to poor health outcomes and rising health care costs.

Community Health Needs Assessments (CHNAs) or Community Health Assessments (CHA) can serve as a strong catalyst and resource for aim setting. Both public health and health care now have legal or accreditation requirements to do CHNAs, which provide them with "situational awareness" of their communities' pressing health challenges and the policies, systems, and environmental factors enhancing or inhibiting their ability to address those challenges. Indeed, a number of jurisdictions now do joint CHNAs, bringing public health departments and non-profit hospitals together to take stock of their community's health, already modeling effective collaboration.

CASE EXAMPLE: OREGON AND WASHINGTON | COLUMBIA GORGE REGIONAL COMMUNITY HEALTH ASSESSMENT[xi]

The Columbia Gorge Regional Community Assessment 2016 is jointly produced by 14 hospital, public health, and community organizations in seven counties in Oregon and Washington. This cross-sector, cross-county assessment allowed the cohort to identify a set of priority health needs for the region and a collaborative Community Health Improvement Plan for addressing them. This assessment satisfies each individual organization's state and federal CHA requirements, and replaces multiple independent and smaller efforts. It reflects a shared belief that collaboration supports optimum health in the region.

Principles of Collaboration

- "A collaborative approach to the Community Health Survey (CHA) and the Community Health Improvement Plan (CHIP) is better for our region, yielding more accurate and more actionable products, as community providers agree on the needs within our region and communities and as we align our abilities to address those needs together.

- A collaborative approach to the CHA and CHIP will maximize collective resources available for improving health in the region.

- A collaborative approach to the CHA and CHIP must be truly collaborative, requiring commitments of cash or in-kind resources from all participants who would use it to satisfy a regulatory requirement."

Partners

- Columbia Gorge Health Council
- Four Rivers Early Learning Hub
- Hood River County Health Department
- Klickitat Valley Health
- Klickitat Public Health
- Mid-Columbia Medical Center
- Mid-Columbia Center for Living
- North Central Public Health
- District One Community Health
- PacificSource Community Solutions
- Providence Hood River Memorial Hospital
- Skamania County Health
- Department Skyline Hospital
- United Way of the Columbia Gorge

CORE ELEMENT	TACTICS AND STRATEGIES
1 **Governance Structure**	a. Coordinate with "bigger picture" goals/efforts b. Define stakeholders c. Develop common priorities and objectives d. Formalize project scope/charter

Successful public health and health care delivery system partnerships hinge on a clear governance structure that sets the scope of work and priorities. A comprehensive community wellness approach is a large undertaking that can feel akin to trying to boil the ocean; therefore, it is essential that partnerships **coordinate** their aim **with "bigger picture" goals/ efforts** that may be underway at a state or federal level and have related objectives. Coordinating with other initiatives is essential to maximize resources, reduce redundancy, and define the appropriate scope. Collaboratives should therefore clearly **define stakeholders** that can impact the aim both within the public health and health system, and in the greater community to include other organizations such as: community-based organizations, schools, food banks, faith-based organizations, transportation authorities, housing services, etc.

Once the stakeholders have been defined, the collaboration should **develop common priorities and objectives** to guide the work they plan to do. It can be useful to define common terminology as some terms carry different meaning depending on whether they are used in the clinical or public health setting (e.g. population health, prevention). Furthermore, to ensure a shared understanding of the work, collaborations should **formalize the scope** and establish the oversight and decision-making structure **in a project charter**.

CASE EXAMPLE: IDAHO | STATE HEALTHCARE INNOVATION PLAN (SHIP)[XII]

The collaboration in Idaho was jumpstarted by the state's participation in a State Innovation Model (SIM) grant. Idaho has seven Public Health Districts that receive SIM funding to support regional collaboratives (RCs).

a. **Coordinate with "bigger picture" goals/efforts:** Each individual regional collaborative in the seven health districts meets independently to address the specific health needs within their community in coordination with the state's broader SIM-funded effort to transform all primary care practices in the state into Patient Centered Medical Home (PCMH).

b. **Define stakeholders:** Each regional collaborative established a "medical neighborhood" to include community services and supports, behavioral health, dental/eye doctors, food banks, transportation, schools, etc. The local Public Health District leads the RC with two primary care providers from the local health system. Each RC has a regional stakeholder advisory board that provide input to the state.

c. **Develop common priorities and objectives:** The regional collaboratives use the Community Needs Assessment to align performance metrics in the PCMH with the identified areas of need (the aim).

d. **Formalize project scope/charter:** Each regional collaborative establishes a strategic plan and charter.

CORE ELEMENT	TACTICS AND STRATEGIES
2 **Financing Plan**	a. Initial capital b. Demonstration phase funding c. Long-term sustainability

While an ultimate goal of public health and health care system collaboration is sustainable financing, many effective partnerships are catalyzed by short-term funding. Identification of **initial capital** is an essential first step to start the collaboration. Successful collaborations have defined an initial business case to receive support from grant funding, appropriations, and hospitals' community benefit investments. Many of the case studies used to validate this framework utilized the Center for Medicare & Medicaid Innovation's (CMMI) State Innovation Models initiative funding. The initial business case should incorporate plans for long-term sustainability by identifying feasible financing sources.

A glidepath to long-term sustainability will require **demonstration phase funding** that supports evaluation and refinement of new services and interventions. Distinct from start-up costs, the demonstration phase must find financial support either within the existing reimbursement structure or through supplemental reimbursement structures in order to sufficiently assess the impact of the new approach. One approach to financing interventions is by aligning resources from multiple sources that are dedicated to aligned efforts to gain efficiencies; for example, by pooling health system resources to conduct Community Health Needs Assessments through one coordinated avenue. Another approach to support additional services could be through a shared utility service model. For example, the state of Vermont implemented a multi-payer per member per month (PMPM) contribution to support Community Health Teams that supplement the services of patient-centered medical homes for patients regardless of payer. Health care systems should identify other specific public health programs and services that can be supported or expanded through direct contracts.

Long-term sustainability will be a challenge for many public health and health care partnerships, even those that are longstanding and have achieved positive health outcomes. Collaboratives should establish a reinvestment plan that reallocates a portion of health system savings back to public health for locally-identified public health objectives. Partnerships should seek to move away from one-time funding streams and embed support for public health and health outcomes into the health care delivery and payment system value-based contracts. It is imperative that any long-term sustainably plans also address social determinants of health and ensure that reinvestment simultaneously furthers community health objectives and health equity.

CASE EXAMPLE: JACKSON COUNTY, MICHIGAN | HEALTH IMPROVEMENT ORGANIZATION (HIO)[XIV]

Unsustainable rising health care costs were the catalyst for collaboration in Jackson County between Public Health, the local health system, and 40-45 other community organizations invested in health improvement.

a. **Initial capital** consisted of the hospital's community benefit dollars to fund prevention and community health staff.

b. **Demonstration phase funding** included the pooling of resources from the hospital, local Federally Qualified Health Center (FQHC), and public health department to complete their Health Needs Assessment, and SIM grant funding to build a social service navigation platform. Funding was also provided for a shared Health Officer (50% of time spent at Public Health department, 50% at hospital) to integrate public health services within clinical system and to align key population health measures.

c. **Long-term sustainability:** The partnership is still in the process of evaluating the impact their intervention has had on cost, quality, and patient experience. There is an acknowledgement that the time frame for evaluation might not be long enough to fully realize the impact of the changes they have made.

CORE ELEMENT	TACTICS AND STRATEGIES
3 Cross-sector Prevention Model	a. Define clinical and community-based intervention(s) b. Specify new roles and responsibilities c. Assign accountable entities for oversight

Collaboratives must collectively identify improvement priority area(s) and **define the clinical and community health interventions** that have the greatest likelihood of successfully advancing the collaborative's aim.

Public health and health care bring different — and potentially synergistic — assets and approaches to improving the health of their communities and the populations they serve. Using a public health approach, evidence-based interventions can be identified through a 4-step process: 1) surveillance and problem definition; 2) identifying risk and protective factors; 3) developing and evaluating interventions; and 4) implementing and scaling up effective policies and programs. The Institute for Healthcare Improvement's Model for Improvement of "Plan-Do-Study-Act" can be integrated with this approach (at step 3) to define the desired changes — which may include internal process improvements — and plan for incrementally testing and refining those changes.

To put it simply, the prevention model should define a set of interventions in terms of **who, what, and why**. *Who* will be accountable for carrying out new tasks or taking on new roles? *What* will they be responsible for doing differently? *Why* is the change being implemented (i.e., how will we know the change is working)? The cross-sector interventions may depend on public health workers, community groups, and health care providers and consumers to work together in new ways to advance the collective model; the interventions may also include changes that are specific to one group. The governance body must **assign responsible entities** for each intervention and establish appropriate accountability structures to oversee the collective "model" that comprises the various interventions and determine how the interventions will be coordinated with the other components of the collaborative framework.

CASE EXAMPLE: NORTH CAROLINA | PREGNANCY MEDICAL HOME INITIATIVE[XVI]

A collaboration between North Carolina Community Care Networks (NC3CN, a physician-led nonprofit that helps manage care for 1.4 million Medicaid recipients) and the North Carolina Department of Health and Human Services (manages Medicaid and Health Choice programs) and Division of Public Health sought to provide comprehensive, high-quality maternity care to Medicaid beneficiaries to improve birth outcomes and improve stewardship of public funds for perinatal health.

a. **Clinical and community health intervention:**
  - Pregnancy Medical Home Initiative (PMHI), modeled on N3CN's successful primary care medical home program.

b. **Roles and Responsibilities:**
  - Local Health Departments employed pregnancy care managers who are responsible for coordinating prenatal care.
  - Physician practices agreed to reduce elective deliveries prior to 39 weeks; reduce primary C-section rates; use standardized initial risk screening; prevent recurrent preterm births.

c. **Accountable entities:**
  - Design, oversight, and monitoring accountability is jointly shared among the North Carolina Division of Medical Assistance, the North Carolina Division of Public Health, and Community Care of North Carolina.

CORE ELEMENT	TACTICS AND STRATEGIES
4 Data-Sharing Strategy	a. Data availability b. Technology platform c. Data-sharing agreements

Cross-sector collaboratives will need to share data to support the operational aspects of the community-based and clinical interventions as well as interim assessment and longer-term evaluation, as discussed below. A data-sharing strategy should be established in tandem with designing the intervention — in order to determine operational feasibility — rather than after the fact when the intervention is too fully planned to make major adjustments. The collaborative should consider **data availability** when designing the intervention and seek to use existing data sources where possible.

The data-sharing strategy must also address the **technology platforms** that will be used to support data-sharing, and the associated costs for implementation and maintenance. Building out business use cases and requirements makes it clear where/why there are gaps with existing technologies and how a new technology solution can solve them. There are several factors to take into consideration when identifying the most appropriate and effective platform. *Adoptability:* Can the new solution be embedded into the current workflow or with minimal changes to the current workflow? *Interoperability:* Does the platform need to be integrated, or if it will be a stand-alone product, what are existing industry standards for future integration?

Introducing new technologies can present challenges with adoption, integration, interoperability and engagement, particularly in a regulated and data-entry intensive space like healthcare. Where possible, the collaborative stakeholders should consider reusing or expanding existing platforms to additional users. Buy-in and early feedback from front-end users is key.

The collaborative should also engage legal counsel in the development of **data-sharing agreements** to ensure compliance with all applicable federal and state laws and regulations. Due to current HIPAA rules and regulations, there are some challenges that health providers face when working with community partners. First, social service agencies are rarely considered covered entities or business associates of covered entities.[xvii] Second, Organized Health Care Arrangements (OHCAs) are currently composed solely of covered entities and therefore, social service agencies are not included.[xvii, xix] And finally, addressing a patient's social needs is generally not considered "treatment" as defined under HIPAA. For these reasons, opportunities for sharing "protected health information" (PHI) with these partners is limited.

However, there are ways for health providers to share data with community partners. For example, in some situations, a community partner may qualify as a "third party" assisting the covered entity with treatment under HIPAA's definition of treatment. Also, in some limited situations, a Business Associate agreement can be executed which allows health providers to share more data with their partners. Alternatively, patients can provide authorization for providers to share data with community partners. Health providers should closely evaluate the type of services provided by community partners, and understand the interrelationship with clinical care to determine appropriate characterization of the agency under HIPAA. Providers should also be mindful that "minimum necessary" and other standard HIPAA requirements still apply to any disclosure of PHI.

CASE EXAMPLE: OKLAHOMA | ROUTE 66 ACCOUNTABLE HEALTH COMMUNITY COLLABORATIVE[xx, xxi]

The Route 66 Accountable Health Community (AHC) Collaborative is led by MyHealth Access Network, and includes the Oklahoma City-County and Tulsa Health Departments and more than 200 other health care and social service organizations in Oklahoma. In 2017 the Collaborative received a $4.5M AHC grant from the Centers for Medicare & Medicaid Services (CMS) to screen patients for social needs in five key areas: housing insecurity, food insecurity, utility assistance, interpersonal violence, and transportation. Using this information, "navigators" at health departments can help connect patients to the appropriate social service organizations. The Route 66 AHC is one of the first to support linkages to social services, rather than to health care, in an effort to more directly address underlying social determinants of health.

Data Sharing Strategy:

Data collection and exchange is facilitated by the MyHealth Access Network, a non-profit coalition of over 400 health-related organizations that provides the technology and policy support to enable the exchange of electronic health information for thousands of Oklahomans, and coordinate care between providers, public agencies, and social services. For the Route 66 AHC, MyHealth serves as the project's bridging organization, hosting the social needs data collected through screenings, and connecting those in need to community social service navigators in health departments. Navigators, a new role funded by the AHC grant, work with patients and their families to evaluate needs and help them select the best organizations to improve their situation. One of the goals of this effort is to "close the loop" on service referral, directing patients to nearby services and tracking how many patients actually access them. This will help assess whether there are sufficient services available in the community and identify gaps.

MyHealth Access Network is one of the longest-active health information exchanges (HIE) in the country. Their strong foundation of cross-sector data sharing is one of the elements positioning the Route 66 Collaborative' s program for success.

CORE ELEMENT	TACTICS AND STRATEGIES
5 Performance Measurement & Evaluation	a. Establish evaluation plan b. Define key process and outcome indicators c. Performance feedback loop

The impact of the overall effort and the component interventions should be evaluated. The **evaluation plan** should define the data collection methods, analysis methods, key indicators, and consider the stakeholder needs and how the evaluation findings will be used. The performance measurement and evaluation strategy should also include mutual understanding of what is needed to build a solid business case for continued investment.

The evaluation design should identify **key process and outcome measures** that serve as meaningful indicators of both public health and health care performance and outcomes. Consider measures that can serve dual purposes — such as measures that can be incorporated into value-based payment measures sets and also track actual public health outcomes — to minimize the burden of data collection. For example, measures should ideally track health behavior changes or outcomes (e.g., smoking cessation) rather than process measures (e.g., referral to tobacco quitline). The evaluation design should also incorporate a health equity lens to determine measurable impact on overall health disparities and assess unintended consequences to vulnerable populations.

The evaluation plan should determine how evaluation findings will be communicated back to the stakeholders through **performance feedback loops**. Collaborative improvement efforts demand as close to real-time feedback as possible to support implementers in refining the interventions and collaborative structure on a rapid-cycle basis.

WHAT REALLY MAKES COMPREHENSIVE COMMUNITY WELLNESS WORK?

Strong partnerships between public health and health care can enhance the impact of both sectors, better leverage available resources, and catalyze the formation of a larger network of alliances and systems that enhance community wellness. The elements, considerations, and questions embedded in the above framework provide a vehicle and roadmap for collaboration, but true movement toward partnership requires an engine. This driving force could take many forms, but health care and public health leaders already participating in these partnerships across the country consistently point to two ingredients that really make collaboration possible: committed leadership and initial investment.

Realizing the cross-sector partnerships emblematic of a comprehensive community wellness approach will require dedicated leaders at the helm. Having the right leadership with sufficient decision-making capability — and the right *combination* of leaders — is critical to successful collaboration and overall outcomes. To truly bring public health and health care organizations together, champions among both health care executives and local health officials are needed. They hold sway within their communities and their endorsement can engender other providers, health departments, and community partners to the importance of integrated community wellness. Together they brandish considerable resources, a powerful advocacy position, and credibility within their respective sectors.

Such leadership is needed not only to initiate partnerships but also to sustain dedication to the cause. Effective collaboration involves system building and habit forming; it is not an overnight exercise. It takes time and the willingness to remain invested even when progress on health outcomes or return on investment (ROI) is not immediately evident. Leaders in public health and health care must invest the necessary hours and model commitment for others in the community to benefit and achieve improvements in wellness. Indeed, this is what transpired in many communities where these linkages are firmly formed.

Committed leaders can also unlock access within their organizations and within their communities to the initial capital investment necessary to form robust cross-sector partnership. Ultimately, the vision of comprehensive community wellness is one supported by shifting and aligning payment models. Long-term ROI is inherent to the community wellness vision. However, the nature of such systems, which rely on the combinative effect of a network of upstream and downstream interventions, does not lend itself to direct cause-effect evaluation and makes financial returns difficult to measure, particularly in the short term. This can discourage funding entities, both public and private, that either want to or must demonstrate the value of their investments within short time frames.

Upfront investment to sustain partnerships is necessary to realize the long-term health and financial benefits of a comprehensive community wellness approach. Thus far, support for integrated community health models has typically come from federal grant programs, but it could also be provided by foundations, private health systems, or through other innovative sources. With payment reform and financial incentives in place at the federal level (CMMI, CMS), the ground work has been laid for providers to leverage their funding mechanisms in this way, so long as there is the vision and leadership to prioritize it.

INVITATION TO ACTION

As leaders in public health and health care, we are committed to forging the partnership networks necessary to address all determinants of health and support people in realizing their healthiest possible selves and fellow community members. We invite our colleagues in communities across America to join us. Together we can catalyze and jumpstart this type of transformation in our communities and across the nation. We have the tools, resources and expertise to take real steps — even if incremental — to form the relationships and systems that will shift the tide toward comprehensive community wellness.

We know that transformational change requires both visionary leadership *and* sustained commitment. As such, we can start by familiarizing ourselves and our organizations with innovative health paradigms and models, putting time and resources into launching and supporting these efforts, and creating a generation of health professionals who view cross-sector integration as the norm. The framework we have outlined is one of several tools at our disposal. In those localities where strong public health and health care partnerships already exist, we hope to sustain and support them and to pull in additional community partners, and to share lessons from that experience more broadly. In those localities where public health and health care partnerships are budding or have not yet formed, we believe this framework provides a starting point — and that momentum will build from there.

We also recognize that while alignment between public health and health care is a step toward achieving comprehensive community wellness, it is certainly not the only step. Comprehensive community wellness requires a larger orbit of actors and partners committed to improving health outcomes. Businesses, large and small-scale employers, volunteer groups, faith-based organizations, foundations, food banks, fitness centers, and many other community-based organizations are integral to achieving this vision.

We seek to strengthen and formalize our relationships where they exist and establish new ties wherever possible, and we call on public health and health care leaders nationwide to do the same. Building upon the unique relationship between health professionals and the constituents served — combined with a willingness to innovate — can enable health interventions to truly take hold within a community.

Additionally, we recognize our limits. While we can build partnerships and transform our organizational practices and policies to support comprehensive community wellness, we must ultimately be responsive to the economic and political realities in which we work. We know that communities are starting from different places in their transformation journey, and the resources available to them are disparate. We also know that certain funding strategies and public policies create the enabling conditions that allow collaborative approaches to community wellness to thrive. We encourage local, state, and federal policy makers to work with public health and health care leaders to advance policy and system changes that support comprehensive community wellness.

Professional paradigms in public health and health care are shifting. Mounting appreciation for how social determinants affect health and the economic imperatives of escalating health care costs, declining public health budgets, and the pivot toward paying for outcomes, are all accelerating change. There is true recognition that improving health outcomes — both in the clinic and in communities — must be a coordinated, cross-sector endeavor. This sense of shared responsibility and cooperative commitment between all of the entities that promote and protect our health is at the heart of the comprehensive community wellness vision. It is imperative that it be proactively pursued and realized.

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