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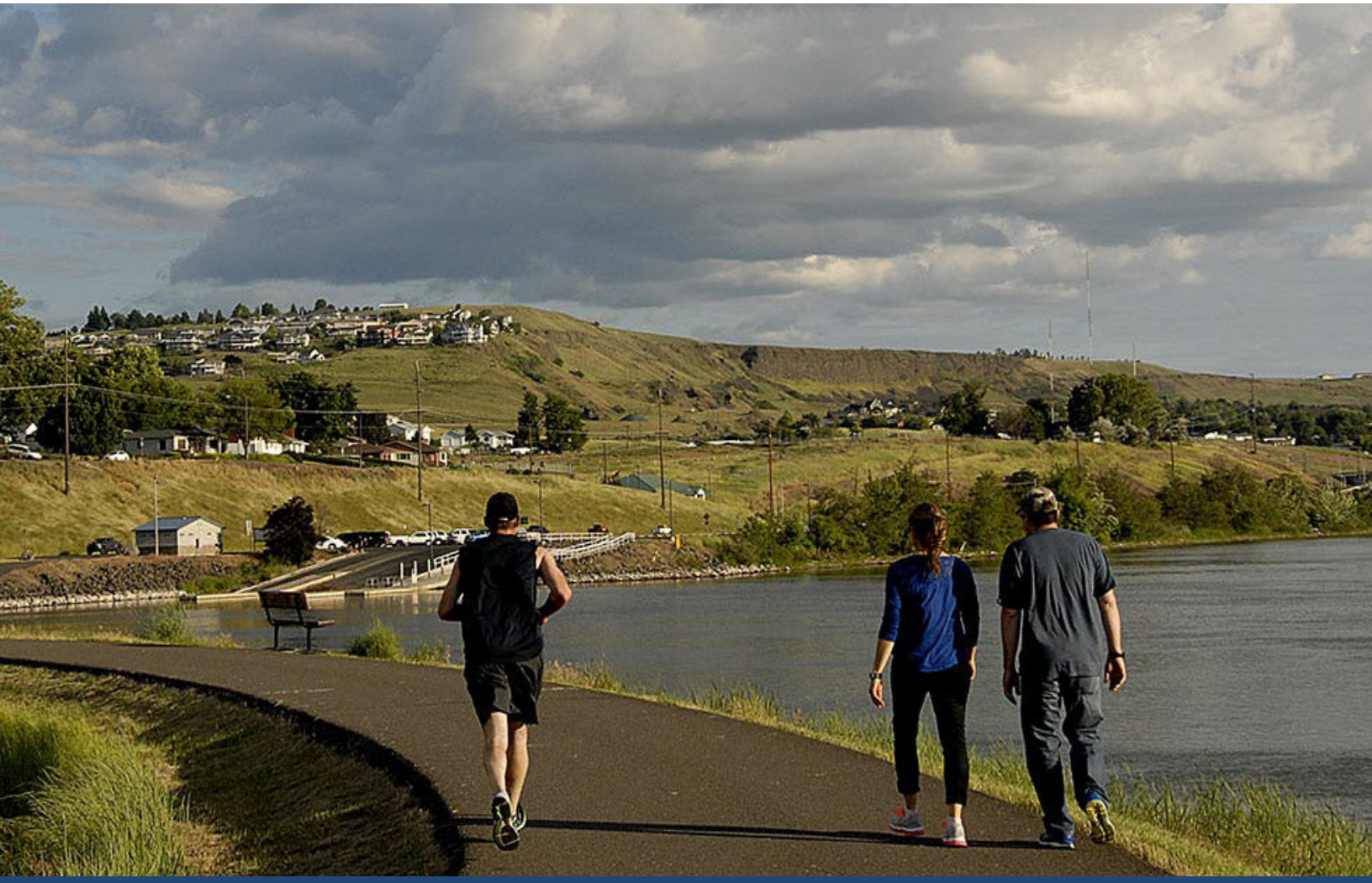

North Central Health Collaborative
Case Study

District 2 Regional Collaborative, ID
2018

THE FUNDERS FORUM ON ACCOUNTABLE HEALTH

The Funders Forum on Accountable Health is a collaborative at George Washington University's Milken Institute School of Public Health that works to advance accountable communities for health (ACH) models by promoting dialogue and catalyzing change among public and private funders of ACH efforts across the country.

The Forum is a common table for funders of ACH efforts to share ideas and experiences, explore potential collaborations, support common assessment approaches, and build a community of practice.

Visit our website at accountablehealth.gwu.edu to learn more!

Acknowledgements

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FUNDERS FORUM CASE STUDIES

The Funders Forum on Accountable Health conducted ten case studies of different accountable health models to better understand the key implementation challenges and opportunities they face.

Accountable Communities for Health (ACH) are community-based partnerships formed across sectors to focus on a shared vision and responsibility for the health of the community. They pursue an integrated approach to health that focuses not only on the clinical setting, but also on how the broader community can support health care's "Triple Aim"[1] of better care for individuals, better health for populations, and lower health care costs.

The Funders Forum interviewed leadership from ten ACH sites in order to better understand the various approaches to governance structure, portfolio of interventions, investments in technology, funding sustainability strategies, and anticipated short- and long-term outcomes of their ACH efforts.

The purpose of this report is to provide an in-depth overview of the North Central Health Collaborative (District 2 RC) in Idaho. We wish to thank all the participants in this case study.

Reports on all ten case studies are available on our website at accountablehealth@gwu.edu.

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1. Berwick, D. M., T. W. Nolan, and J. Whittington. 2008. "The Triple Aim: Care, Health, and Cost." Health Affairs 27(3).

North Central Health Collaborative

District 2 Regional Collaborative, Idaho
2018

What is the North Central Health Collaborative?

Started in 2015, the North Central Health Collaborative (District 2 RC) in Idaho brings together public health agencies, medical providers and community organizations across five rural counties in north central Idaho to support primary care transformation and strengthen relationships between health care and community service providers. One of seven regional collaboratives created by the state, District 2 RC's main responsibility is aiding local primary care providers in becoming accredited primary care medical homes (PCMHs). It also facilitates primary care providers' collaboration with broader health care and community service providers in the region's so-called "medical health neighborhood." This has included work with behavioral health providers, dental providers, the area agency on aging, skilled nursing facilities, the fire department, food banks, and the regional public health district. Through the District 2 RC, stakeholders have joined together to improve care coordination and have advanced community-based strategies to address a wide range of issues, including unmet behavioral health and dental care needs, diabetes prevention, and tobacco cessation.

Origins of the North Central Health Collaborative

In 2014, the state was awarded a 4-year State Innovation Model grant from the Centers for Medicare and Medicaid Innovation (CMMI) to transform its health care delivery system. Centered around advancing value-based care, the state health innovation plan (SHIP) set an ambitious goal to transform every primary care clinic in the state to an accredited primary care medical home (PCMH). To support clinics in this process, the SHIP proposed establishing regional collaboratives, one run by each of the seven regional public health districts within the state. These regional collaboratives would convene and support primary care clinics within their community as they pursued PCMH accreditation. These regional collaboratives would also help integrate primary care providers and other local providers and partners in the regions' "medical health neighborhoods," such as hospitals, nursing facilities, behavioral health providers, area agencies on aging, and other community providers.

From this, the District 2 Public Health Department, the regional public health department serving five counties in north central Idaho, received initial funding to establish the District 2 RC. While the state SHIP set some broad requirements related to governance of regional collaboratives, it otherwise allowed each health department to design its regional collaborative in a manner best suited to the needs of its local community. The District 2 Public Health Department felt it was important for this project to be centered on serving primary care clinics as they became accredited PCMHs and providing a safe space for these providers to share best practices and learn from one another. It also decided to use this forum to facilitate collaboration among providers, the public health department, and other partners in the medical health neighborhood. The hope was that these exchanges would build and strengthen relationships across sectors and bring primary care providers to the table for broader discussions about addressing population health challenges facing the region.

Governance Structure

The leadership and governance structure of the District 2 RC reflects a mixture of state requirements and local decisions. Under requirements set in Idaho's SHIP, the District 2 RC must be overseen by the Director of the District 2 Public Health Department along with two local physicians. These "physician champions," were selected from existing physician leaders within the local provider community, including one physician who already served on the board of health and is an established leader in both the medical and public health space. These physician champions also serve diverse geographic areas, with one based in the most populous community in the district and another based in a more rural community. These physician champions are well connected in the community and have helped facilitate provider participation.

The District 2 RC regularly convenes local primary care clinics that are transitioning to become accredited PCMHs. It also invites primary care clinics that have successfully become PCMHs to participate in these meetings, to serve as mentors to providers beginning the process of becoming a PCMH. Participants from these clinics can range from CEOs and medical directors of clinics to quality improvement staff within the clinics. These convenings of providers are focused on facilitating peer learning across clinics and spurring collaboration to address population health challenges.

In addition, the District 2 RC hosts meetings that include partners in the broader "medical health neighborhood." These convenings are often focused on specific population health concerns. Their aim is to generate broader community input on the work of the District 2 RC, and foster relationships and collaboration across sectors.

> *"When the community, our primary care providers, and our hospitals all see that the Director for Public Health is at the table with the primary care physicians that are leading this charge, it brought a level of credibility that says "it's this important."*
>
> Carol Moehrle, RN, BSN
> District Director for Public Health
> Idaho North Central District Health Department

Within this structure, the Public Health District staff provide core backbone support for the District 2 RC, regularly convening physician and community partners, providing technical assistance to clinics seeking PCMH accreditation, and arranging shared trainings for clinics participating in the District 2 RC.

Finding Stakeholder Alignment on a Health-Centric Agenda

From the beginning, the District 2 Health Department wanted to use the District 2 RC to engage providers in discussions related to improving population health, looking beyond the operational challenges of payment reform implementation. Over time providers have come to value this focus on health outcomes, given its alignment with their long-term success in a changing health care system.

Within this framework, the District 2 RC look to participating providers to lead the discussion in determining what priority health issues the group tackles. This discussion is informed by community level data from the health department, with providers focused on issues that are both pressing public health challenges and aligned with clinical quality areas that they are held accountable for under a PCMH model. This agenda setting process has led them to work on a range of issues, including tobacco cessation, diabetes prevention and management, and behavioral health needs.

Facilitating Data Sharing to Support Collaboration

In order to best engage primary care clinics in improving population health, the District 2 RC has had to find feasible ways to collect and share real-time health data for its region. This has been challenging as most real-time health data is still held by individual providers. While the state has a health information exchange, its data is limited due to technological challenges and limited provider participation. In addition, data held by the State health department is often at least a year delayed.

To overcome these challenges, the health department has worked closely with primary care clinics to identify specific aggregate data metrics that they are willing to voluntarily share with one another, drawing from clinical quality measures that they are required to capture as PCMHs. Stakeholders credit having the District 2 RC in place as being critical to building the trust necessary to facilitate this data sharing. Through the District 2 RC, providers are now regularly sharing specific metrics, such as the proportion of their diabetes patients with

controlled A1C levels, and tracking changes in these outcomes overtime. This data sharing has provided a more holistic and current picture of population health outcomes in the area. In addition, the hope is that, over time, it will enable more real-time assessment of whether the work of District 2 RC partners is successful at improving health outcomes in the region.

The trust built within the District 2 RC has also helped primary care providers become more comfortable sharing data with other partners in the broader medical health neighborhood. For example, one large multi-clinic health system is now sharing summary reports of its emergency department high utilizers with the local fire department, which manages emergency medical services (EMS). Similarly, the fire department is sharing summary reports of their own data on high utilizers of EMS. Through this collaboration, both the health system and the fire department have been able to improve their work processes. The fire department staff now have a direct phone line for a nurse manager in this health system who they reach out to when responding to emergency calls from this system's high utilizer patient population. Through this process, the two organizations work together to decide optimal care directions for these patients, cutting down on unnecessary emergency room visits and freeing up EMS workers to focus on true emergencies.

Building Mutually Beneficial Partnerships Across Sectors

Since initial implementation of the District 2 RC, discussions between local primary care providers, the health district, and other service providers have spurred multiple collaborative initiatives, tackling diverse local health concerns. In building these projects, partners have strived to work together in ways that are mutually beneficial and that consider the unique needs of individual partners.

One example of this is a recent pilot project in which the health district provides the Medicare Diabetes Prevention Program (DPP) onsite at a local primary care clinic. The DPP is a relatively new service offered by the health district, which received national recognition from the Centers for Disease Control as a DPP provider in 2017. Through the District 2 RC, the health district has been able to educate local providers about this new service and ultimately build this pilot project with a clinic. This has expanded access to the program and created new provider referral pathways to the program. It has also been an opportunity for the health district to build greater experience delivering this lifestyle program. Now, the health district is pursuing a partnership with a local Medicare Advantage plan to receive Medicare reimbursement for delivering this program. Health department staff credit its initial pilot project as helping prepare them for pursuing this new venture with a health plan.

The health district and primary care clinics have also found creative, mutually beneficial ways to expand access to tobacco cessation services. While the health district has long offered tobacco cessation counseling services, many providers were unaware of this local community resource. Through the District 2 RC, the health district has expanded provider awareness of this service. Some providers have taken steps to build systems in their electronic medical records that automatically refer eligible patients to the health department for tobacco cessation counseling. The health district has also been able to help fund the community health workers (CHWs) at one primary care clinic, by training these CHWs as tobacco cessation counselors and reimbursing them for delivering this service through tobacco settlement grant funding, thereby providing seed funding as the clinic works to identify other funding streams to support their CHWs' work.

Working as a Coalition to Advance Systemic Community Change

Interviewees noted that the District 2 RC is only one of many local convening tables focused on improving population health outcomes. The region also convenes multi-stakeholder groups focused on issues such as behavioral health, cancer prevention, and diabetes. By facilitating collaboration between the medical health neighborhood and primary care providers, the District 2 RC has helped primary care providers engage with and

strengthen these other community-wide initiatives.

The most significant example of this exchange has been the District 2 RC's involvement in a broad coalition effort to improve the behavioral health infrastructure in the region. Within the first year of the District 2 RC, participating clinics identified unmet behavioral health needs as a significant issue that they wanted to address. Interested in figuring out how to better integrate behavioral health into primary care, these primary care providers began holding meetings on behavioral health needs with other partners in the medical health neighborhood, including behavioral health providers.

A parallel community group had been developing a proposal to expand access to crisis response centers in the community. These are safe spaces with counselor services that law enforcement can divert individuals in mental health crisis to, rather than housing them in jails. Stakeholders, including hospitals and the local sheriff's office jointly decided that the community needed at least one dedicated crisis response center in each of the region's five counties. This was a departure from the approach in other areas of Idaho, where multiple counties share a single crisis center. Given the rural communities within District 2's region, stakeholders were concerned that sharing a single site would severely constrain access for people in more remote areas.

Ultimately, implementing this proposal required additional state funds. Once the District 2 RC was educated about this work, they began working alongside other stakeholders to lobby state policymakers to appropriate funding for this project. This broad coalition effort was successful. The region secured $2.8 million in state funding over two years to establish crisis response rooms in conjunction with a hospital in each of its five counties. Interviewees emphasized that bringing providers from the District 2 RC to the table and combining the energies of multiple population-health focused initiatives helped bring greater attention to this work. Ultimately, having such a diverse range of stakeholders all advocating for the same policy was critical in securing funding from lawmakers.

> *"As behavioral health became a major emphasis in our clinics, bringing providers from the District 2 RC to the behavioral health table and combining the energies of multiple population-health focused initiatives helped bring greater attention to our joint work. Ultimately, having such a diverse range of stakeholders all advocating for the same policy was critical in securing funding from law makers."*
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> District Director for Public Health
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Building a Forum for Peer Learning

In addition to formal collaborative projects, participants in the District 2 RC emphasized that simply having a dedicated, confidential space for providers to learn from one another has helped organically propel innovation. It has enabled the sharing of best practices and has fostered mentorship relationships across providers at different stages of transforming their practices' to PCMHs. For example, because providers are now coming together to share data on specific metrics, practices underperforming on certain quality metrics are now able to identify high performing peers who could be valuable resources. Through convenings, practices have assisted one another on areas as diverse as chronic care management, care transition processes, and implementation of the new Medicare incentive payment programs. In sum, these convenings have helped providers build a network of peers to turn to for help when troubleshooting challenges or adopting innovative practices.

Interviewees shared multiple instances when such peer to peer learning organically helped providers pursue feasible strategies for addressing population health challenges in the region. In one instance, a discussion related to limited dental care access led one clinic to share its experience providing fluoride varnish within

its practice. This simple conversation spurred multiple providers to consider incorporating this dental service into their own primary care practices. Clinics are now seeking help from this leader clinic on practical issues, like billing for this new service. Similarly, while telehealth could help expand timely access to care in this rural region, many primary care clinics have faced operational challenges incorporating telehealth into their practices. Via the District 2 RC, these providers have been able to learn from one site that has successfully started using telehealth, to aid them in incorporating telehealth capabilities into their own practices. "I think the value of the regional collaborative meetings is they're mentoring and sharing with each other. They have never had a safe space to do that before," noted Carol Moehrle, District Health Director.

> *"All the people that were in the room, we just completely agreed that we're all aiming for the exact same thing. We all have the same patients, and we all have different capabilities. We have a completely different perspective as the physician than the public health department, and were really able to help each other with that, close those care gaps, and reach patients differently."*
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> Delana Bunting, PCMH CCE
> Director of Incentive Payment Programs
> Catalyst Medical Group

Funding and Long-term Sustainability

As part of Idaho's SHIP, funding for the District 2 RC has primarily come from the state's SIM grant. These funds have supported District 2 public health in providing backbone support functions for the coalition, such as convening partners, providing technical assistance, hosting shared trainings to clinics and providing community health data. While primary care providers are not funded to participate in this collaborative, the state's Medicaid program provided upfront, lump sum payments to providers that opted to pursue PCMH accreditation. These payments were designed to help practices invest in infrastructure like community health workers and telehealth technology. In many instances, this infrastructure has been leveraged in work tied to the District 2 RC. Most of the collaborative projects and interventions that partners within the District 2 RC have pursued have been funded through a variety of outside sources. Partners have leveraged existing public health district funding sources, as well as sought out ways to bill for new services through Medicare, Medicaid and private plans.

Long-term funding for the District 2 RC is a challenge that remains unanswered. It is unclear whether, as the state moves forward with payment reform, health systems will be willing to financially contribute to maintaining this collaborative. Stakeholders emphasized that they are most committed to maintaining a forum to foster relationship building across sectors, regardless of whether it is housed within the District 2 RC or another existing coalition in the region.

Challenges

Stakeholders emphasized that data limitations remain a challenge. Ideally, it would have been preferable to have the District 2 RC's work be guided by shared, current baseline clinical data and real time community health data. However, because the health district typically works with national data sets that are delayed by multiple years this was not possible. This reliance on time-delayed data has also created information gaps between the health district and providers, who are relying on more real-time claims data to inform their priorities. While finding limited ways for providers to share data has helped overcome some of these challenges, limited community-wide data sources remain a problem.

Stakeholders report the opportunities to meet and share best practices are highly valued, but may require creative solutions to continue beyond SHIP. They want to maintain the connections and mentoring that has occurred between clinics and have made it a priority to build opportunities for continued conversations into

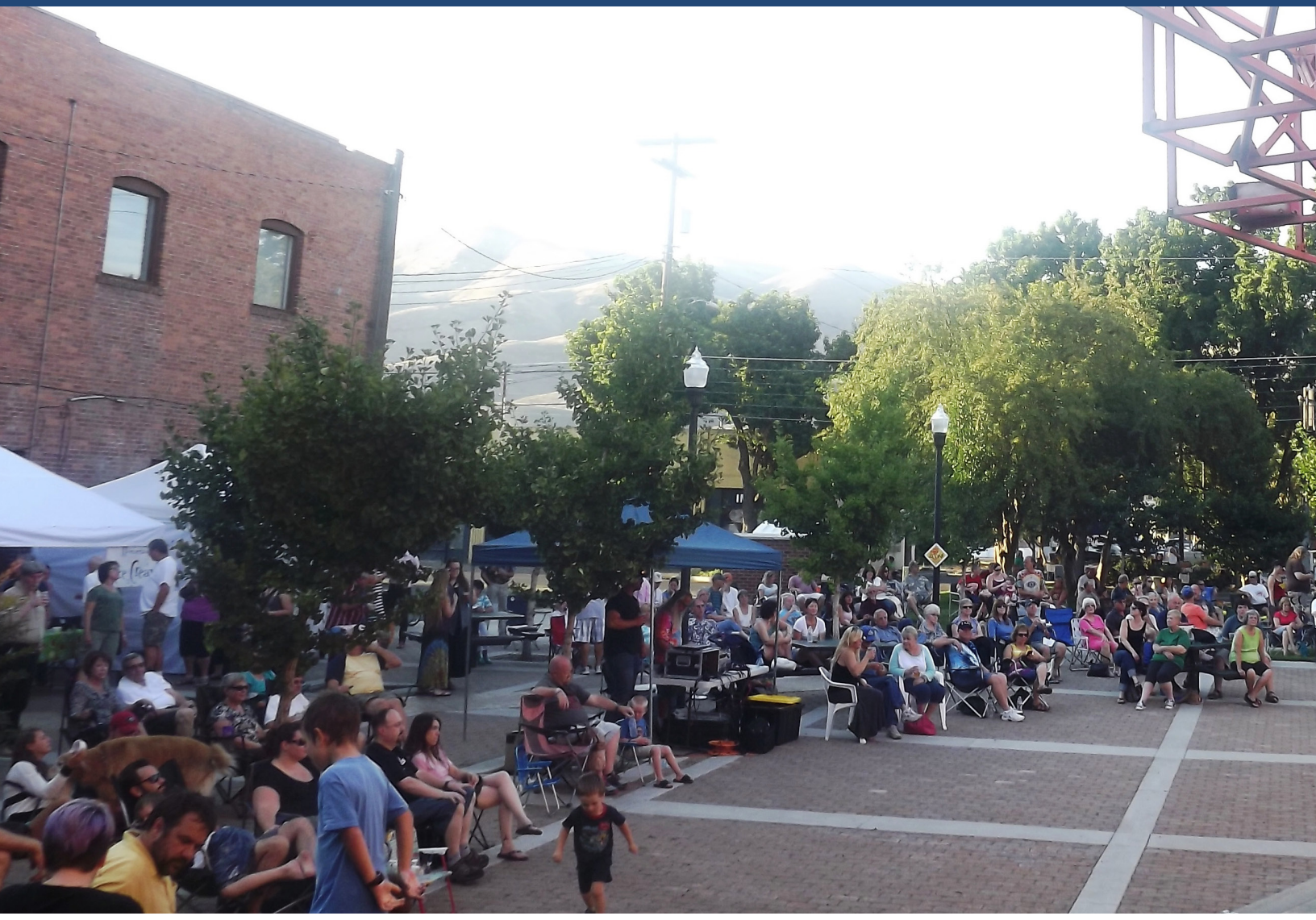
other collaborative work in the region.

Lessons Learned

Stakeholders pointed to a number of lessons learned. They emphasized that having the right leadership involved in the District 2 RC has been critical to its success. While the District 2 public health district was initially concerned that having its Director lead this collaborative was not the best use of staff resources, it now sees the Director's involvement as a major asset of the program. It has helped build credibility with stakeholders and sends a signal to community partners that this project is being taken seriously by the region and state. Having physician champions has also proved critical to bringing providers to the table and ensuring the collaborative remains physician-driven.

Stakeholders also noted that building this type of collaborative effort in a rural community presents unique challenges and opportunities. Because the area has limited health care resources, direct service providers' time is immensely valuable. While the District 2 RC is a significant time commitment, public health partners have strived to not overburden provider partners. Being in a rural area has also offered unique advantages. For example, the clinics are often right next to the hospitals and when a patient presents at the emergency room, the patients' doctor can easily walk over and better assess whether a hospital admission is warranted. Working in a smaller scale community has also helped partners build closer working and personal connections.

Finally, stakeholders emphasized that one of the most important outputs of the District 2 RC has been the creation of a forum for safe conversations and relationship building. The District 2 RC has helped generate greater trust across stakeholders, allowing for more open and honest conversations. Often times, conversations that started within the District 2 RC have planted the seed for partnerships that are built largely outside of this formal collaborative. Interviewees noted that through this process, people have become more open to listening to other stakeholders' needs and perspectives. Only with this greater understanding, have groups been able to consider whether there is a better way to work together.



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