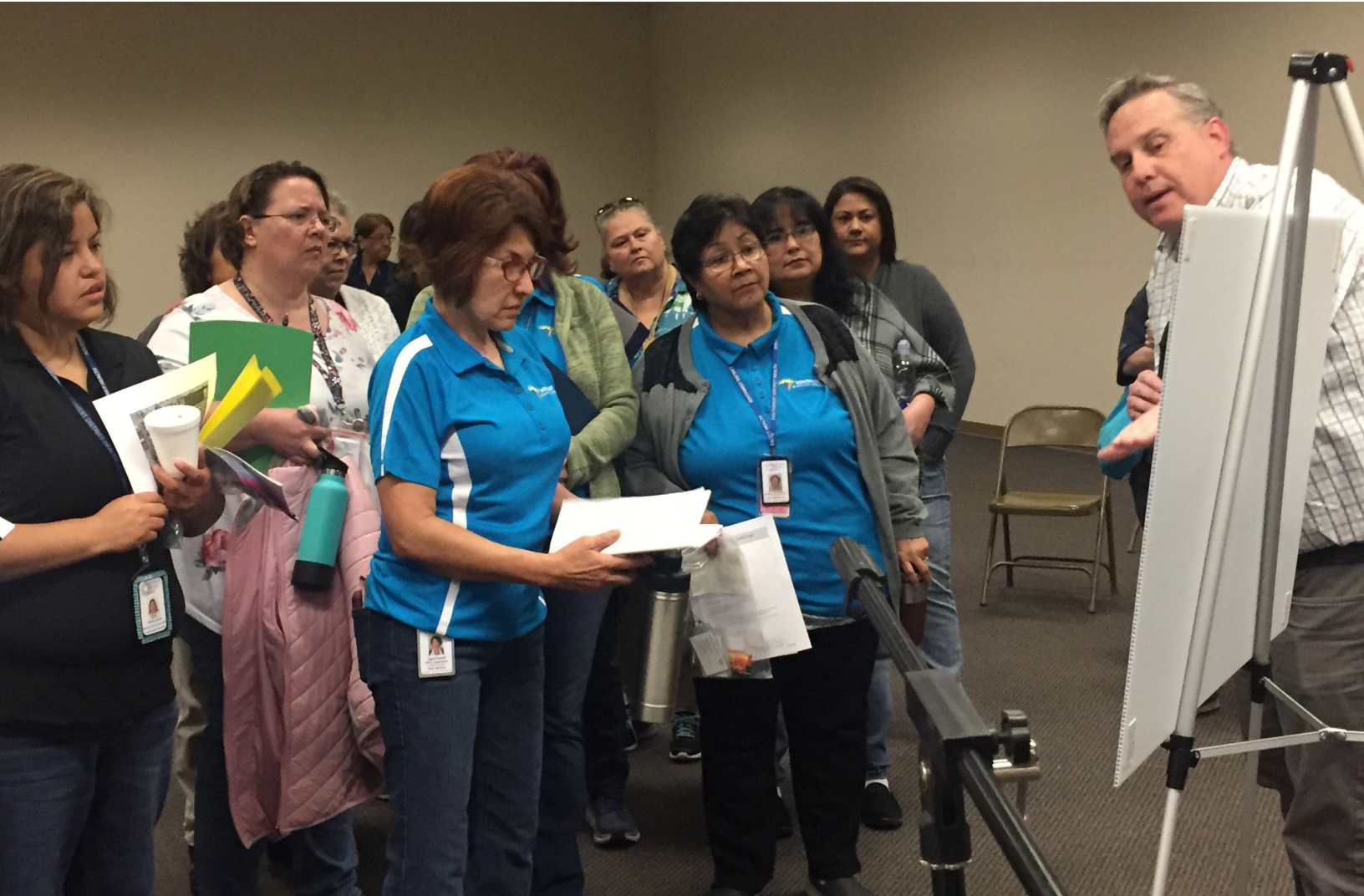




FUNDERS FORUM
on Accountable Health



Southwest Health Collaborative Case Study

District 3 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 Southwest Health Collaborative (District 3 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).

Southwest Health Collaborative

District 3 Regional Collaborative, ID
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What is the Southwest Health Collaborative?

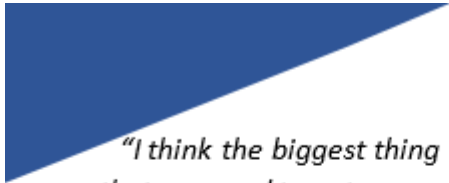
The Southwest Health Collaborative is a product of Idaho's State Health Improvement Plan designed to catalyze regional efforts in health care delivery system reform. With the Public Health District 3 serving as the main convener, partners in primary care, hospitals, dentistry, optometry, housing, public health, local counties, and education have come together seeking to improve community health outcomes, reduce unnecessary health care utilization, and stem costs. Through community outreach in the six rural and frontier counties in the health district, the partners identified four main areas of focus: 1) reducing emergency department utilization, 2) enhancing coordination of social services for seniors, 3) integrating behavioral health with primary care, and 4) supporting collaboration between primary care and dental care. Through ongoing dialogue, partners have identified multiple opportunities to blend and braid existing community resources to address population health and look forward to continuing the work as they transition into value based payment.

Origins of the Southwest Health Collaborative

The state of Idaho is in the midst of transitioning to a value based health care system, building on work started through State Innovation Model (SIM) funding in 2014 and continuing through participation in the Center for Medicare and Medicaid Innovation (CMMI) State Health Improvement Plan (SHIP) program. Under the SHIP, the seven public health districts are each responsible for convening a regional collaborative to guide health care delivery system transformation and support primary care practices in these efforts. Each region receives approximately \$250,000 per year in grant funds from the state to support the work.¹ The Southwest Health Collaborative is the regional collaborative operating in Idaho's Public Health District 3 that includes a mix of six rural and frontier counties: Adams, Canyon, Gem, Owyhee, Payette, and Washington counties.

Under the first year of the SHIP, the Public Health District 3 began recruiting local leaders to partake in what would ultimately become the Southwest Health Collaborative. The SHIP requires all regional collaboratives to be chaired by two primary care physicians. The two chairs of the Collaborative were selected through recommendations by other local leaders and the Idaho Healthcare Coalition. The Public Health District Program Manager, co-chairs, and Public Health District Director met to plan the future of the collaborative, and the Director provided the Program

Manager with the autonomy to spend eight weeks networking and learning from all of the key players in the region. Partners were brought around the table, including: clinical care (primary care, federally qualified health centers (FQHCs), hospitals, health systems, dentistry) and social services (housing, transportation), education, a dietician with WIC, a population health nurse, emergency medical services (EMS), county representatives, health care consultants, public health, and more. Those partners came to consensus around a shared vision: to focus not only on primary care, but also the support structures around primary care, including clinical supports like optometry, dentistry, specialists, EMS, hospice, and hospitals, along with public health and the social services sector – education, housing, child and family services agencies, and organizations that assist people with food insecurity, domestic violence, aging and end-of-life care, and other related needs.



"I think the biggest thing we've learned is that we need to put our own agenda aside, because everyone has one. Everyone has a strategy, and deliverables that they're trying to give to a board or an organization, but we really, honestly, try to put all of that aside and listen to the needs in the community first."

Kendra Witt-Doyle, Blue Cross of Idaho
Foundation for Health

1. http://ship.idaho.gov/Portals/93/Documents/Grant%20Documents/AY3%20Ops%20Plan%20V1.1F_01032017.pdf?ver=2017-01-06-102357-023

Governance Structure

In the Southwest Health Collaborative, the primary care physician co-chair positions are filled by the Chief Medical Officer of a local FQHC and a recently retired physician. Southwest Health Collaborative has embraced an informal governance structure, allowing for any partner organizations who show up to meetings to participate in the regional collaborative.

In addition to the two co-chairs, there is representation from each of the seven counties that collectively comprise a diverse mix of health professionals with unique insights into specific populations or community needs, such as: a care manager from the company that has the contract for dual eligible care coordination who understands the needs of high need and high utilizing populations; a pharmacist who is the regional director for a health plan and is an expert on value based purchasing; a bilingual dietician who provides services for the WIC program who is a strong voice for the Hispanic community; a private dentist and business owner who is new to population health and supports the work but also provides balance by questioning assumptions; a population health nurse who can provide big picture insights on quality improvement; an EMS provider that is working to implement the new Community Health Emergency Medical Services (CHEMS) model being developed in the state²; an optometrist who is familiar with senior needs and home care delivery; the COO of a hospice group to represent end-of-life care needs; academic research institution representative from Boise State University; Area Association on Aging representatives; and representatives from the Idaho Primary Care Association that are dedicated to regional quality improvement and working with the federally qualified health centers (FQHCs.)

The initial partnership group conducted a community health needs assessment, which identified four key priority areas and tasked workgroups with developing clinical and community based interventions to: 1) reduce emergency department utilization, 2) enhance coordination of social services for seniors, 3) integrate behavioral health with primary care, and 4) support collaboration between primary care and dental care.

Decision making processes are informal, and work groups are given deference to select projects and implement them. Within the workgroups, there is diversity in representation; for example, the work group on senior health is comprised of more than just home care, hospice, and geriatricians, but also includes members from other sectors. Work groups report back to the rest of the regional collaborative with progress on milestones.

The public health district serves as the backbone organization for the collaborative. They hired a manager for the coalition who does outreach to all partners to understand their goals and challenges and plays a major role in connecting organizations with shared interests and needs. This networking and convening has led to a significant number of new opportunities to strategically align existing resources around the partners' shared priorities.


Blending and Braiding Resources to Improve Population Health

The regional collaborative receives approximately \$250,000 a year in funds from the state SIM grant in support of the State Health Improvement Plan (SHIP). The funds primarily go to support the backbone and convening functions. Many of the interventions the group has identified are supported by in-kind contributions or a realignment of existing resources, with supplemental grants from hospitals and local foundations. By convening regular workgroup meetings with community partners, the Southwest Health Collaborative has identified multiple opportunities to creatively integrate existing resources, identify areas of need, and improve coordination of care across settings. For example, the collaborative implemented a pilot questionnaire in four dental offices asking about an individual's blood pressure levels and whether or not they have a primary care

2. <https://healthandwelfare.idaho.gov/Medical/EmergencyMedicalServicesHome/CommunityHealthEMS/tabid/2179/Default.aspx>

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home. The pilot found that 40% of individuals seeking dental care did not have a primary care provider, and 15% of individuals seeking dental care had unmanaged high blood pressure and were without a primary care provider. After reviewing that data, the oral health workgroup decided an appropriate solution would be to place a care coordinator in dental offices to help connect patients to primary care, regardless of their insurance status. The collaborative considered seeking funding for that project, but then a partner from Delta Dental recognized an opportunity – they connected dental hygienists, who usually worked in schools but needed something to do during the summer, to the dental offices to serve as care coordinators for the duration of the summer months. This was an in-kind contribution from Delta Dental.



“I think that there’s a lot of problems that we could work on as a community if we just knew where to connect better, and so, those regional collaborative members...just them being able to connect with people they know or programs they’re aware of, I would say is our number one asset.”

Rachel Blanton, MHA
SHIP Manager
Public Health District 3

Co-locating behavioral health at schools provided another opportunity to use existing resources more effectively. Given the high number of teen suicides in the region, the collaborative wanted to focus on youth behavioral health. Earlier models of having behavioral health providers do some pro bono work in the schools was viewed as successful but funders encouraged them to pursue a more sustainable approach. They settled on a pilot of co-locating behavioral health at the schools, recognizing that most of the referrals would be covered by Medicaid, thereby providing a sustainable funding stream. The school vetted potential service agencies and identified a partner. The cost involved finding space for the counselors and developing a memorandum of understanding that outlined roles and responsibilities for how the partnership would work, including protecting student privacy. Students referred for behavioral health are also screened for social determinants of health and connected with local resources. Funding from the Blue Cross of Idaho Foundation for Health is used for evaluation and creation of a roadmap to replicate the model across the state. The regional collaborative is exploring ways to scale up this intervention in other schools within the Nampa School District, and potentially other counties, too. The services and the payment mechanism existed in the community already but having the services co-located at the school removed barriers, such as transportation. Being able to simply walk students over and start the process right there in the building allowed for timely connections while students were still motivated and engaged. The model is viewed as a “win-win” for the schools, students, parents and the behavioral health agency. Students can more readily access services and the behavioral health services are covered by Medicaid, with fewer missed appointments.



“[Co-locating behavioral health in the school] is working so well for so many families, not only in our school, but even families that, by word of mouth, know that this is available right here at Nampa High School...The only cost is really about managing the space and allowing for the space to be accessed by the [behavioral health] partners.”

Scott Parker, Executive Director of Secondary
Education for the Nampa School District

The collaborative also works with the State Medicaid office to identify policy opportunities for behavioral health and clinical integration. The partnership with the State Medicaid office fosters state-regional relationships, allowing the regional collaborative to advocate effectively for their partners and community residents. Recently in Idaho, Medicaid opened up health and behavior codes, allowing for practices to get paid appropriately for integrated services. This new development was seen as a huge win among the Southwest Health Collaborative members.

The collaborative has also helped behavioral health agencies and primary care clinics to establish co-management agreements. These agreements usually define how and what partners will communicate during and after a patient is referred to new services. A large part of the collaborative's work centers around behavioral health and clinical integration. Behavioral health consultants have been linked to behavioral health administrators across the state, creating a robust network of technical assistance for integrated practices. Networking sessions build trust among partners, and strengthen referral relationships.

The regional collaborative structure has enabled the Southwest Health Collaborative to apply for additional monies through Idaho's SIM funds. At the time of our interviews, members of the collaborative mentioned that they experienced a great influx of investment since forming the collaborative. Some of the funders most commonly engaged with the Southwest Health Collaborative include the Blue Cross of Idaho Foundation for Health, Saint Luke's Foundation, and Optum.

Finally, the Public Health District 3 Director received a grant from the Kresge Foundation to join the second cohort of Emerging Leaders in Public Health. Reflecting on that experience, the Public Health District 3 representative credited the Emerging Leaders in Public Health experience as a major catalyst for some of the ideas the regional collaborative has implemented and will continue to implement going forward. The Kresge Foundation grant also provides technical assistance to grantees, and the Public Health District 3 representative hopes that technical assistance will aid in the development of a long term sustainability plan for the work groups, partnerships, and coordinating infrastructure.

Health Information Technology and Data

The collaborative is working to track data on use of behavioral health services at the schools so they can better understand how this has impacted attendance and other outcomes. In the future, the collaborative hopes to use telehealth technology to improve access for individuals living in hard to reach rural areas. Otherwise, the collaborative has not significantly invested in information technology.

Data received by the regional collaborative is mostly public health data and other, qualitative data collected through community engagement. Pfizer's Top Health group and Blue Cross of Idaho has also provided the collaborative with some data sets – the collaborative hopes to use the data to paint a better picture of the community's needs, resources, and gaps, but has not yet engaged in major data analysis.

Social Determinants of Health

Addressing social determinants of health is a major focus of many of the activities the collaborative is undertaking, ranging from co-locating behavioral health services at schools to address transportation challenges, to developing a directory of social service agencies to make it easier to connect seniors with available community services.

The collaborative is currently working on a project to connect at risk seniors with community health workers as part of their effort to reduce emergency room utilization. They have developed a screening tool to assess individuals' needs such as access to transportation and safety in the home. They have also developed resource pathways for referrals as needs are identified. While this project is in the beginning stages and the pilot site has not yet been formally identified, the collaborative hopes to eventually track success rate of referrals, and develop a feedback loop among participating providers.

The collaborative also created a directory of care coordinators which has made it easier for care coordinators to contact each other and improve transitions of care across settings. This has been viewed as very successful and the collaborative has committed to supporting networking events and continuing education among care

coordinators in the region.

Challenges, Lesson Learned, and Next Steps


Within the school-based behavioral health care integration project, a significant wait list for students to receive services has emerged, demonstrating a larger need than originally anticipated. The general shortage of behavioral health providers in the state may make expanding the program challenging, particularly in rural areas.

Data has been an ongoing challenge. Through the SIM grant, Idaho is building out the State Health Information Exchange (HIE) functionality, including a dashboard to present information. However, that project is behind schedule, and it is unclear if it will be usable at all under the current grant cycle.

Having dedicated time for community outreach is viewed by the public health district as an important factor in their ability to help identify resources and facilitate important connections between partners. They wish they had invested more time earlier on with partners outside the health sector, such as housing commissioners and schools, as it would have given them more time to build the relationships and integrate them into the work.

Early in the collaborative, leaders noticed that participants would focus on how challenging it would be to pay for interventions, particularly given Medicaid policies in the state. To keep momentum moving, the partners would counter by saying, “What can we do at the local level?”

Bringing the collaborative partners together and allowing them to take turns presenting about their work has been key to identifying opportunities to align existing local resources. For example, an optometrist was listening to a presentation by a Community Health Emergency Medical Services (CHEMS)³ partner who was lamenting how impossible it is to get a patient with a payer source to a vision appointment. The optometrist mentioned that he and his whole network do home visits and they are now riding along with CHEMS to deliver vision services to the older rural population in the north region.



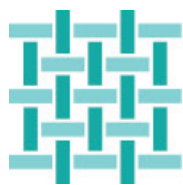
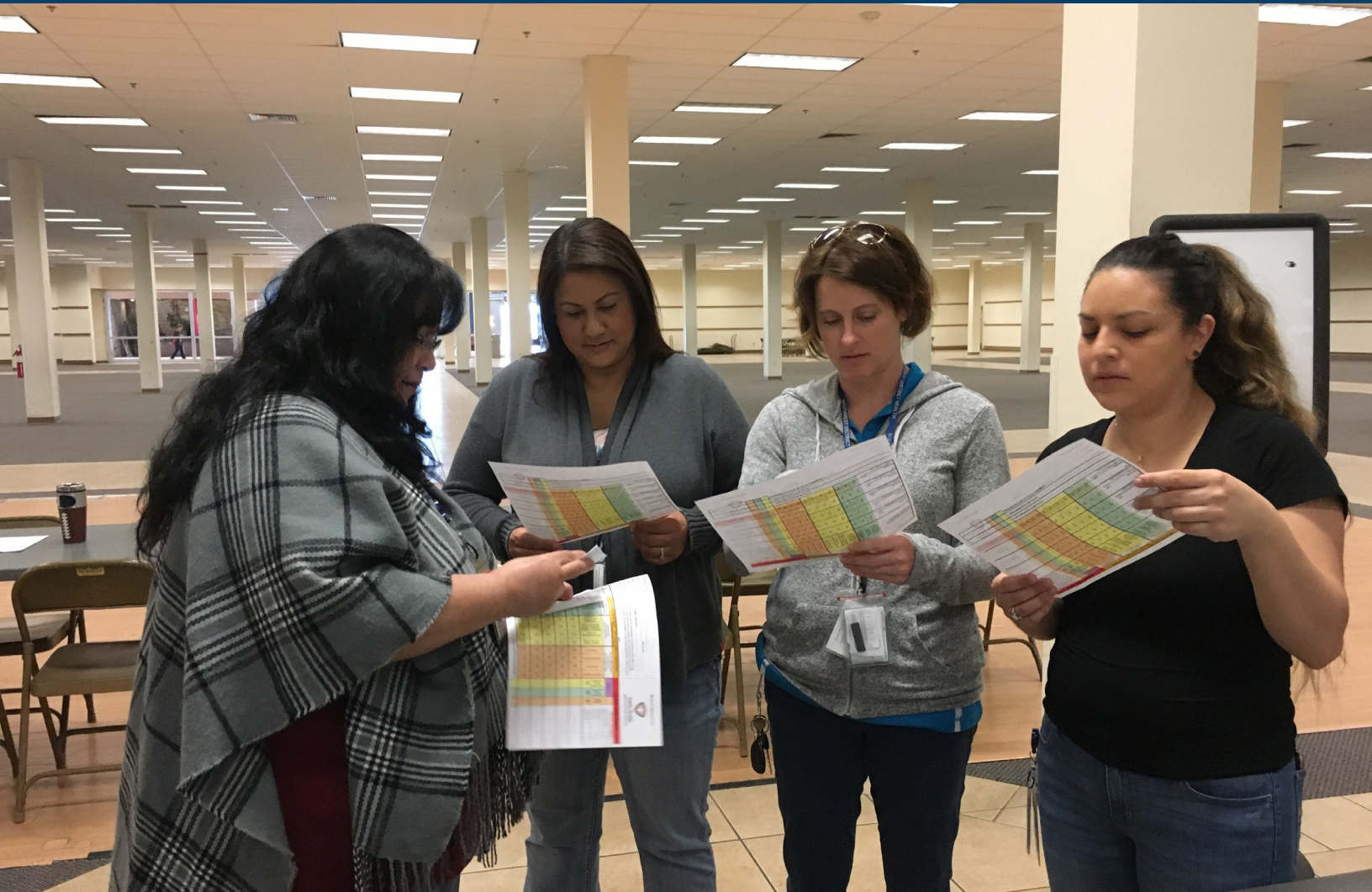
“To have dedicated time for relationship development is huge. I am so thankful that our team can walk into almost any meeting and not necessarily say, “I have the answer for that.”...But, I think we can almost always say, “I have somebody I think you should talk to.” I think that has been huge and gives us trust and connection with our communities and I think it strengthens the participation.”

Rachel Blanton, MHA
SHIP Manager
Public Health District 3

Involving the physician leaders in ongoing meetings has been a challenge given their clinical schedules, though they are highly supportive of the work. As a result, the public health district has had to assume more leadership than was in the original design and makes a point of being strategic about when to involve the physician leaders in decisions.

The regional collaborative is now working to be one of the initial participants in the state’s value based payment model. The collaborative has received feedback from the hospitals and community partners that they want to maintain the collaborative structure. They are optimistic the successes they have had thus far will allow them to continue to have a strong voice as the region moves into value based purchasing.

3. <https://healthandwelfare.idaho.gov/Medical/EmergencyMedicalServicesHome/CommunityHealthEMS/tabid/2179/Default.aspx>



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