

BRIDGING FOR HEALTH



IMPROVING Community Health
Through INNOVATIONS
in FINANCING

BRIDGING FOR HEALTH:

Improving Community Health Through
Innovations in Financing

Collaboration &
Collective Impact



Innovations in
Financing



Health &
Health Equity



Praise for *Bridging for Health*

"The Georgia Health Policy Center's latest publication, *Bridging For Health: Improving Community Health Through Innovations in Financing*, is a must read for those interested in improving the health and well-being of the nation's residents. It offers useful tools as well as fascinating case studies and insightful lessons that illustrate both the challenges and potential rewards when multisector partners join together to creatively establish healthier, community-wide conditions."

—John Auerbach, President and CEO,
Trust for America's Health

"*Bridging for Health* provides important insights into how communities can come together across multiple sectors to advance the health and well-being of their residents. This series of case studies shows diverse approaches to building collaboratives and leveraging resources in a community, and will help guide innovators across the country as they address the determinants of health."

—Jeffrey Levi, Ph.D., Professor,
Milken Institute School of Public Health, George Washington University

"If you think financing is just for economists and experts, then think again. *Bridging for Health* shows that anyone willing to step up and act like a serious steward of health and well-being can begin to steer much-needed resources in new directions. The fact that seven out of seven sites pursued some kind of pooled community fund could herald a new era where organizations begin doing business differently together to enhance our common lives."

—Bobby Milstein, Director of System Strategy,
ReThink Health
Visiting Scientist, MIT Sloan School of Management

"This is a long overdue and important new resource in the field of community health improvement. Every innovator needs to read this book and consider how their own community — large or small — can follow this architectural approach to redesigning the use of existing financial resources to sustain local innovation."

—Vondie M. Woodbury, President,
The Woodbury Group

BRIDGING FOR HEALTH:

Improving Community Health
Through Innovations in Financing

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PART I. THE PROJECT, THE PROCESS, AND KEY LEARNINGS

INTRODUCTION

Karen Minyard

The great architect Christopher Alexander has inspired innovations across disciplines, from architecture to software development and beyond.¹ Alexander emphasizes three factors that are crucial to successful innovation in design:

- **Patterns.** Formalized best practices that can be used to solve common problems when designing an application or system.
- **User-driven design process.** Design should come from the people engaging with it; examples include letting people who will be working in an architectural space or using a software program participate in its design.
- **The accumulation of incremental changes.** Begin with small, immediately feasible improvements and then build on them.

As Alexander saw it, people have a right to shape their own environments and, indeed, only the people using an environment know the details of what they need within it. He therefore sought to give people the tools they needed to create their own designs. These ideas inspired our own work as the national coordinating center for Bridging for Health.

Launched in 2014 by the Robert Wood Johnson Foundation (RWJF), Bridging for Health aims to improve population health and reduce disparities through innovations in financing. To do this, the program identifies and supports existing community and collaborative efforts that demonstrate great potential to better bridge health and health care through innovations in financing population health.

In 2014, RWJF selected the Georgia Health Policy Center (GHPC) at Georgia State University as the national coordinating center for Bridging for Health to assist communities with these changes and then to collect, synthesize, and clearly communicate our findings. RWJF leadership launched the project with the idea that financial innovations to support population health and health equity already existed in communities, regions, and states, and these innovations simply needed to be uncovered. However, following a comprehensive scan, we, at GHPC, were unable to identify existing mature financial innovations — though we did find local sites that were interested in implementing them.

In all, seven sites agreed to participate in the Bridging for Health program. To help the local site leaders, we developed a Blueprint for Action and supportive modules to give those leaders the required knowledge and a useful mindset. As it turned out, however, knowledge and mindset were not enough; site leaders and advisors urged us to help their sites take concrete action. We therefore found a private-sector partner to codesign the Innovation-to-Action Cycle. We also established milestones to support the site leaders through this process. Many of the financing innovation

prototypes that resulted are now in the process of being implemented. Each site gravitated toward its own version of a pooled community fund to support a population health strategy. Their variations on this model produced baseline learnings about the sources, uses, and structure that underpin these financing innovations — and the contextual factors and technical assistance (TA) that influenced their innovation process.

Applying Alexander's Ideas to Financing Population Health

Rather than focusing on specific answers or rigid steps, Alexander proposes *patterned approaches* that both provide tools for users and include users at every step of an organic design process. Indeed, one of his chief concerns was that 20th century American society was locked into processes that created a detrimental built environment, yet people were unaware of these processes and thus did not question them.

The same pattern is observable in decisions that have been made regarding financing population health. For many years, we have made financial decisions that fail to create the health we seek. In contrast to these traditional patterns, Bridging for Health suggests a sequenced pattern that includes seven key steps:

- **Move thinking “upstream.”** When focusing on population health, what can we do that will have the highest leverage to improve health and well-being? (See the sidebar for more on upstream thinking.)
- **Look at the money.** Examine the existing dollars in the system. Look in unlikely places.
- **Build stewardship.** Build a culture of collaboration and shared stewardship among thoughtful people from different sectors, both inside and outside of health.
- **Explore the financing vehicles.** Focus on a broad range of previously known and undiscovered funding vehicles and combine them as needed to suit the local context.
- **Look for intersections.** Find the places where health, money, and partners intersect.
- **Invest together.** Work collectively to make investments in health and well-being.
- **Repeat. Repeat. Repeat.**

Upstream Thinking

To go *upstream* means to identify and actively engage other systems and players. Identifying these systems requires taking a bird's-eye view, both to see how population health and health care systems fit together and to find leverage in innovations that improve health and well-being.

Upstream thinking also seeks to understand how various system components — including health, environmental, social, and political elements — relate to one another and how they can be bridged. Engaging those systems and players requires boundary-spanning leadership, as well as the capacity to help others adopt a bird's-eye view, collectively identify leverage, facilitate difficult conversations, and nimbly adapt as efforts unfold.

In addition to emphasizing pattern thinking and involving users in design, Alexander advocates for allowing incremental changes to accumulate. Doing so both helps us realize how a space or process should be ordered and creates a foundation for future improvement. To begin this process focus, on what is working in existing spaces or processes:

By beginning with spaces that are already beautiful, Alexander shows how we can adopt an organic process of city-building and discover the “right” order of places. Designing places in the right order has a major impact on the quality of community life. The right order for a place is often unexpected. To discover the right order of a particular place, we should begin by implementing any tiny improvements that are feasible now. Specific spots or segments in a city that work well do so for a reason, and because they are naturally used by the community, these spaces form the “spine” of the area and make good starting points for wider improvements. According to Alexander, small incremental changes will enhance the spirit of the place and encourage the accumulation of further changes. Using this approach, we can connect new spaces to already beautiful ones while allowing for change and adaptation through lived experience.¹

If we replace “city building” with “financial concepts” here, we achieve the following:

By beginning with financial arrangements that are already in place, we can discover the right order of financing. Designing financing in the right order has a major impact on the financing structure’s quality. The right order for financing is often unexpected. To discover the right order of financing innovations, begin by implementing any tiny improvements that are feasible now. Financing innovations that work well do so for a reason and, because they are naturally used by the community, these financial structures form the spine of the financial innovation and make good starting points for wider improvements. Small incremental changes will enhance the spirit of the collaborative and encourage the accumulation of further changes. Using this approach, we can connect new financing arrangements to already successful ones while allowing for change and adaptation through lived experience.

Bridging for Health’s Innovation-to-Action Cycle mirrors Alexander’s accumulation of incremental changes by supporting agreements, ideation, prototyping, stress testing, and implementation. Each site that participated in the program identified sources of money, strategies to improve population health, and locally determined structures to support incremental financing innovations. Ideally, the future will hold opportunities to build on these initial incremental changes that can be adapted by the communities over time.

Bridging for Health: Key Strategies

As the Bridging for Health national coordinating center, GHPC supported community and regional initiatives developed to advance and sustain a culture of health. RWJF and GHPC realized that moving toward this culture required closer partnerships and cross-sector collaboration among health care, public health, community development, and social services. Indeed, our work offered communities the assistance they needed to catalyze and strengthen partnerships, as well as to look across systems to find high leverage and adaptive solutions to the complex social and other challenges that impact population health.

Our work employed four primary strategies:

- **Technical assistance.** Key activities included developing site readiness assessments; selecting sites; creating learning modules; developing TA frameworks, materials, and plans; organizing and facilitating peer-learning opportunities; and delivering tailored TA. Our GHPC team also linked to other organizations working with communities on similar

initiatives to share learnings and plans, as well as to consultants to develop the Blueprint for Action and Innovation-to-Action Cycle.

- **Research and evaluation.** Key activities included recruiting an advisory panel; drafting the evaluation plan; developing tools and instruments; establishing communication processes, data-collection practices, timelines, and feedback loops; and providing evaluation TA to sites.
- **Communications.** Key activities included naming and branding the initiative, developing the communications plan, designing and supporting a web portal for sites, maintaining a web presence, producing marketing collateral, developing project materials for the sites and the initiative stakeholders, and sharing project information and learnings through meetings and conference presentations.
- **Administrative support.** Key activities included establishing team structure and meeting schedules, conducting internal cross-training to strengthen the skills and capacity of TA liaisons, and managing and reporting contracts and financials.

In the following chapters, we offer an in-depth review of the Bridging for Health timeline and activities, followed by a discussion of the process, outcomes, and key learnings in four areas:

- The Bridging for Health site-selection process,
- The GHPC approach to TA and peer-learning opportunities,
- The Innovation-to-Action Cycle, and
- The evaluation framework.

Part II includes case studies from each of the seven sites. In Part III, we examine what's next: the emergence of pooled community funds as a common financial innovation and the need for additional understanding about fund stewardship, structure, expansion, sustainability, and TA.

CHAPTER

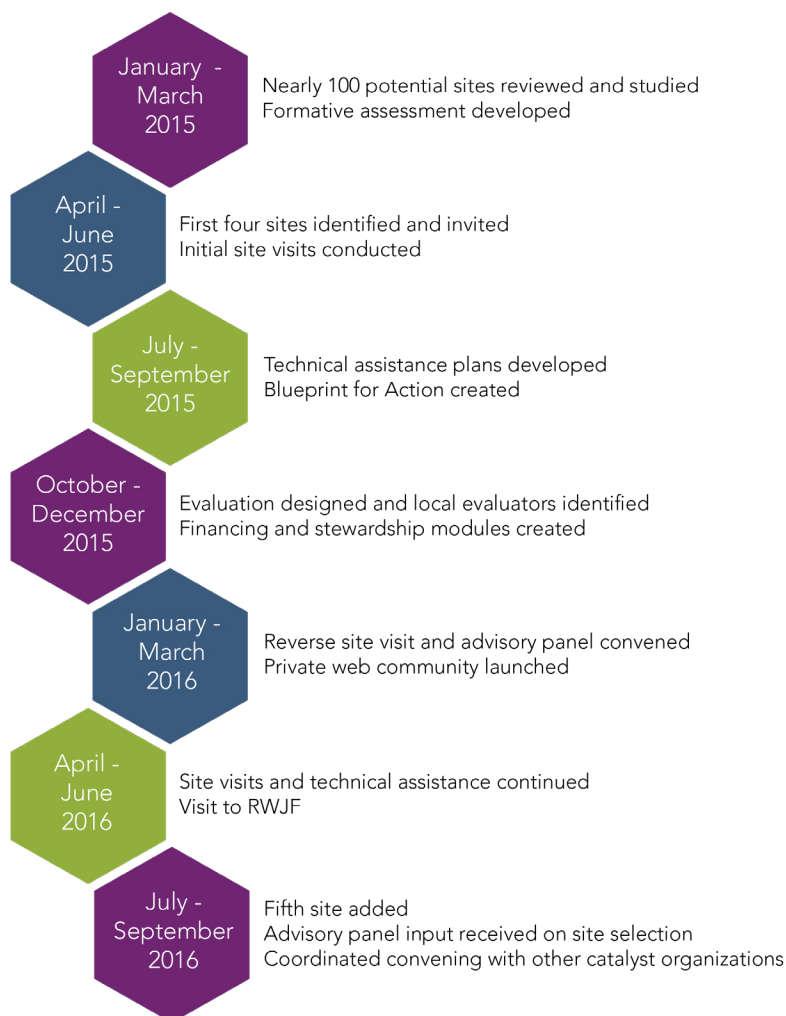
2

BRIDGING FOR HEALTH TIMELINE AND PROCESS

Emily Heberlein and Chris Parker

Although Bridging for Health was initially a three-year initiative, GHPC realized that a fourth year was necessary to develop the Innovation-to-Action Cycle approach and accelerate the site work. Figure 2.1 and Table 2.1 summarize the overall timeline of the initiative and key activities by year.

Figure 2.1. Timelines by Phase for Bridging for Health



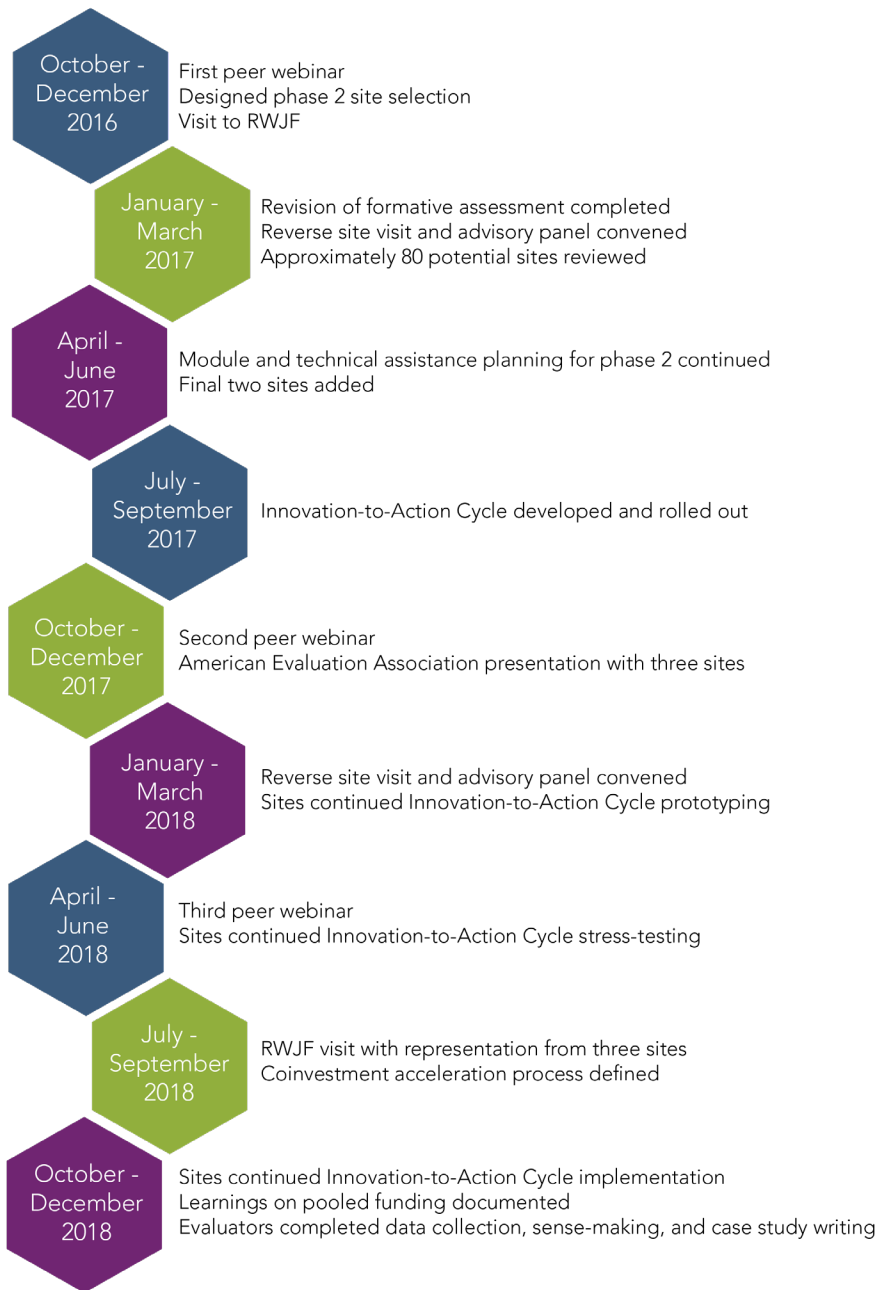


Table 2.1. Key Activities by Bridging for Health Program Year

2015 (YEAR 1)	2016 (YEAR 2)	2017 (YEAR 3)	2018 (YEAR 4)
<p>Technical Assistance</p> <ul style="list-style-type: none"> • Worked with RWJF's project team to monitor progress and adjust approaches. • Conducted a rigorous reconnaissance and assessment process that led to the identification and participation of four sites: The Bexar County Health Collaborative (San Antonio, Texas), Allegheny County Health Department (Pittsburgh, Penn.), Spartanburg's Way to Wellville (Spartanburg, S.C.), and Yamhill Community Care Organization (McMinnville, Ore.). • Conducted at least two in-person visits per site and developed TA and support plans for each based on additional organizational assessments. • Participated in an exploratory understanding of a San Bernardino-Riverside County (Inland Empire, Calif.) collaborative and their potential to be engaged as part of this effort. 	<p>Technical Assistance</p> <ul style="list-style-type: none"> • Facilitated peer learning and exchange across Bridging for Health sites through two major events: an in-person reverse site visit in Atlanta (February) and a three-hour webinar on hospital community investing (November). • Completed development of four modules to support the delivery of TA in the field and revised the Blueprint for Action. <p>Provided regular TA and thought partnership to sites, including multiple in-person visits and regular monthly calls; during this year, one site reached agreement to establish a small public health improvement/wellness fund.</p> <ul style="list-style-type: none"> • Identified and engaged the participation of an additional site in California's Inland Empire and formally began exploring efforts in other communities to identify additional sites. 	<p>Technical Assistance</p> <ul style="list-style-type: none"> • In February 2017, we designed and conducted a two-day meeting of the sites, the advisory panel, and TA providers to facilitate a deeper dive into population health financing and encourage adaptive leadership. • Continued to refine and deliver modules at all sites, with the goal of changing stakeholder mindsets about equity, financing, stewardship, and strategies. <p>Engaged a business innovation expert and founder of Springboard Strategies to provide thought partnership in developing the appropriate process to accelerate work at the sites as they developed population health interventions and discussed ways to fund them. Important elements of that process include getting to agreement, prototyping, stress testing, and pilot implementation.</p>	<p>Technical Assistance</p> <ul style="list-style-type: none"> • Continued TA support and designed and implemented the Innovation-to-Action Cycle. • In February 2018, we conducted the final peer learning and advisory panel convening, incorporating Innovation-to-Action Cycle prototyping and preparation for stress testing. • In June 2018, we convened the sites to present their stress-testing results and plans for implementation. • During the last six months of the year, TA teams continued their support of implementation planning and connections to other technical experts. <p>Evaluation</p> <ul style="list-style-type: none"> • Evaluation work continued with increased emphasis on sense-making, documenting lessons learned, and case study writing.

2015 (YEAR 1)	2016 (YEAR 2)	2017 (YEAR 3)	2018 (YEAR 4)
<ul style="list-style-type: none"> Convened an advisory panel to provide counsel and oversight for the work. Developed a health financing module for use as part of each site's TA curriculum. <p>Evaluation</p> <ul style="list-style-type: none"> Conceptualized and drafted the evaluation framework. <p>Communications</p> <ul style="list-style-type: none"> Launched and branded the initiative as Bridging for Health, while supporting sites in developing and disseminating press kits. Created initial site snapshots. Produced initial Bridging for Health collateral (brochure, advisory panel, TA approach). <p>Administration</p> <ul style="list-style-type: none"> Engaged staff to support the project. 	<ul style="list-style-type: none"> Re-evaluated and revised customized TA plans to reflect learnings and local context. <p>Evaluation</p> <ul style="list-style-type: none"> Built out the cross-site evaluation plan using the realist framework and began data- and information-collection activities. Contracted with local evaluators to participate in information gathering and sense-making at each site. Conducted a series of stakeholder interviews at each site to begin gathering baseline information about mindsets and expectations. <p>Communications</p> <ul style="list-style-type: none"> Released the Blueprint for Action postcard, which has been widely used (even outside of Bridging for Health) to foster a mindset change to enable innovations in financing. 	<ul style="list-style-type: none"> In June 2017, we identified and selected two additional sites to participate in the Bridging for Health Initiative: Michigan Health Improvement Alliance and the Caledonia and S. Essex Accountable Health Community in St. Johnsbury, Vt. In November 2017, we facilitated a cross-site peer-learning webinar aimed at underscoring and clarifying the process for accelerating the creation of innovative funding mechanisms. <p>Evaluation</p> <ul style="list-style-type: none"> The team continued its data collection, sense-making, and interim summaries. The GHPC evaluator and three site evaluators presented at the American Evaluation Association annual meeting. <p>Communications</p> <ul style="list-style-type: none"> Released the Bridging for Health overview video. 	<p>Communications</p> <ul style="list-style-type: none"> Released the Local Financing Innovations series for all seven sites, which examines innovations aimed at financing improvements in population health at the sites, often independent of their core Bridging for Health work. Produced second Bridging for Health video highlighting the pooled wellness community fund financing innovation.

BRIDGING FOR HEALTH SITE SELECTION

Alyssa Lowe and Criss Sutton

In our proposal to RWJF, we recommended identifying up to 10 sites that were pursuing innovations in policy, health care delivery, and financing with the goal of improving outcomes and rebalancing and aligning investments in community health. Working with GHPC, RWJF identified approximately 60 potential sites; additional communities were also added based on our secondary research and conversations in our own network of stakeholders and organizations. We categorized sites as state, regional, or county and described their collaboration, leadership, and financing innovation levels. After further research and extensive discussions with RWJF, 10 sites were selected for the program's next phase.

Assessment Process

To launch that phase, we developed a readiness assessment tool and used it to assess each site. The tool was based on GHPC research and experiences working with federal agencies, communities, and states around the country. To obtain the information required to complete the assessment, we studied each site, conducting research about the area, receiving input from RWJF, and interviewing key stakeholders. The assessment criteria included eight key factors:

- Demographics,
- Collaboratives and partnerships,
- Health care infrastructure,
- Disparities,
- Leadership,
- Philanthropic involvement,
- Current financing strategies, and
- Outcomes.

We scored each site based on its strengths in collaboration, leadership, innovative strategies, disparity-reduction efforts, relevance, outcomes, and sustainability. We also held discussions with other TA providers working in similar spaces to gain insights into the communities being considered for the Bridging for Health program.

Our assessment revealed that the communities were not as advanced in innovative financing strategies as we had originally envisioned. However, the varied geographic locations, missions,

collaborative structures, strategies, and progress-to-date of these communities suggested that much could be learned from them. The assessment also revealed many ways in which the program could support the sites and help them develop, evaluate, and share their efforts, with the goal of generating further innovations in financing to improve population health.

Initial Site Selection

After extensive research, interviews, and, in some cases, site visits, five initial sites were selected for the Bridging for Health program:

Allegheny County Health Department. In the Pittsburgh area, several large foundations² had created a \$500,000 fund dedicated to public health department infrastructure. The fund was used to assess community health and information technology; additional partners funded a behavioral risk survey. Further, in 2014, the Pittsburgh Regional Health Initiative and the Jewish Healthcare Foundation — through a grant from RWJF — sponsored a Payment Reform Summit that brought together the region's leaders from community hospitals, insurers, physicians, foundations, federal and state agencies, and other important stakeholders. The summit's goal was to discuss and consider new payment models and innovative opportunities aimed at reducing costs and improving health outcomes.

The Health Collaborative in Bexar County. Under a Texas 1115 Medicaid waiver, health care, behavioral health, and public health organizations proposed independent strategies in their applications for funding as Delivery System Reform Incentive Payments (DSRIP) projects. The DSRIP program operated through 22 different multicounty regions throughout the state, and more than 100 projects were already being implemented in the San Antonio region. RWJF engaged the Public Health Foundation and the Center for Health Innovation at the New York Academy of Medicine to assist the San Antonio Metropolitan Health District in thinking through implementation strategies and evaluating their work. Since 1997, Bexar County's Health Collaborative had been working to improve the community's health status through collaborations. It had a powerful network of citizens, community organizations, and businesses, and was ideally suited to be a supportive backbone organization for the San Antonio effort.

Way to Wellville Spartanburg. In South Carolina, Spartanburg was exploring a Pay for Success model to support an early education initiative. The Institute for Child Success in Greenville was mentoring the site in using the model to improve outcomes for young children. Spartanburg had also partnered with Purpose Built Communities, which was transforming the city's Northside community into a high-quality, mixed-income, mixed-use area, with the vision of making it a home for exceptional education, health care, social service, and employment opportunities.

Yamhill Community Care Organization (CCO). Oregon's Yamhill CCO was a full-risk, community-based Medicaid plan; in the first two months of its operation, 100 percent of participants were assigned to physicians. The state defined the budget and the cap on what could be spent and, if managed well, stakeholders could receive incentive payments for performance that exceeded established targets. With CareOregon as an infrastructure partner, Yamhill planned to reinvest a portion of the incentive payments back into population health improvement. All of the site's efforts were focused on driving innovation and transformation to improve health outcomes.

San Bernardino, Riverside Counties. San Bernardino and Riverside are two of the largest counties in the United States, with 2.1 million and 2.3 million people, respectively. Both counties were

exploring options to redesign how they fund health and social services, including restructuring and other financing streams such as social impact investing and the Accountable Communities of Health model.

Second-Round Selections

In November 2016, we launched the second round of site selection by widely disseminating a request for information (RFI). GHPC generated a list of more than 80 potential sites, which we assessed according to the process established in phase 1. By March 2017, we had narrowed the list of potential sites to 14 and began further engaging these sites through interviews with key stakeholders.

We began by sending emails to potential key informants, requesting their participation in a brief (30 minute) phone interview. These introductory emails and interview questions varied slightly to suit each of the three target groups:

- Organizations that work with collaboratives,
- Collaboratives that responded to the RFI, and
- Collaboratives that we identified.

Key informant interviews were facilitated and documented by various GHPC TA liaisons, depending on their availability. Immediately following the interviews, TA liaisons reviewed their notes to ensure accuracy, and all interviewers discussed next steps — such as whether additional data or perspectives were needed — with the GHPC leadership team.

For each site, we applied a site-selection rubric to the generated information. To be included, a site had to have:

- A mature, well-organized, and appropriately staffed collaborative in place,
- An innovative financing concept already underway, ready to implement, or in the planning stages, and
- A vision and strategy to improve the community's overall health, with an eye toward health equity.

With input from RWJF, we identified two additional sites and contacted them. The correspondence invited them to participate in the program and indicated that GHPC would provide them with TA through December 2018. The two sites — along with the financing innovations that were underway when they were selected for Bridging for Health — are as follows:

Michigan Health Improvement Alliance (MiHIA). Serving 14 counties in central Michigan, MiHIA partners were pursuing the ambitious goal of improving population health by focusing on the local economy. MiHIA's Health and Economic Initiative sought to deliver improved health and sustained economic growth in the Great Lakes Bay Region communities. The first phase of the multiyear initiative was to build a shared purpose among stakeholders for planning, identifying, and prioritizing a portfolio of regional ideas to improve health and deliver economic benefit. The effort served as a basis for MiHIA's Bridging for Health work.

Caledonia and S. Essex Accountable Health Community (CAHC). Serving the Northeast Kingdom (NEK) region in Vermont, CAHC had previously tested capture and reinvest strategies as part of the State Innovations Model funding. CAHC was considering various options, including a focus on streamlining health care and social services costs, opportunities to partner with community

development financial institutions, and further strengthening its collaborations through increased community engagement strategies, particularly by including people with lived experience. The name of both the team and its Bridging for Health initiative was NEK Prosper!

Accomplishments and Outcomes

- As Table 3.1 shows, during the site-selection phase, we created and revised a formative assessment tool that provided useful information and criteria for both selecting sites and identifying areas of focus for TA.
- We developed a database of multisectoral collaborative initiatives across the United States, which should prove highly valuable for future work.
- For the second-phase sites, we established a standardized yet flexible approach to site assessment and onboarding based on what we learned in the first phase.

Key Learnings

- Local collaborations do not commonly possess knowledge and expertise in implementing financing innovations. Our experiences showed that communities rarely fully grasped how innovative financing strategies worked, yet they did not realize this gap in their knowledge.
- Contextual factors at individual sites create both opportunities and challenges. It is thus essential to build relationships during the TA process in order to promote the trust and understanding needed for success. At some sites, for example, formative assessment review uncovered nuanced interorganization relationship dynamics; these required careful navigation and a focus on principles of stewardship and collective impact.
- Taking a staged approach to recruiting sites affords time to learn, build, and refine TA processes. During the first round of site selections, the Bridging for Health national coordinating center team gained crucial understanding of the readiness required for financial innovation, as well as the importance of site context. This information proved invaluable in selecting sites for the second round.
- Identifying and recruiting sites for participation yielded a pool of sites that would not have responded to a request for proposals, yet were eager to participate. As they readily acknowledged, several selected sites were limited in their capacity to identify and apply for grants. In part because of this lack of capacity, they did not view their collaboratives as strong contenders for the Bridging for Health project. Thus, without the nationwide scan and outreach, we would not have had the opportunity to partner with these sites.
- Providing grant resources to support staff positions for Bridging for Health affords needed project-management capacity. To enable their capacity to facilitate and evaluate change in their communities, sites required seed resources. Additionally, this allowed individuals beyond the leadership of the organization/collaborative to be dedicated to locally facilitating the financing innovation agenda.

Table 3.1. Key Criteria Used to Select Bridging for Health Sites

BRIDGING FOR HEALTH NEW SITE-SELECTION RUBRIC								
Site	Location and Innovation Cycle	Collaborative Maturity	Health Equity Focus	Capacity for Engagement	Leadership Structure	Contextual Factors	Contact	Totals (rank)
Description	<ul style="list-style-type: none"> Aware of need and opportunity Generating and developing ideas Selecting interventions and financial innovation Implementing and evaluating 	A mature collaborative that has the trust of the community; strong, established relationships with multisectoral partners; and demonstrated success.	How much is health equity incorporated into the collaboratives' strategy, structure, programs, and interventions?	Does the collaborative have the resources required to engage with Health? To what extent do we expect it to interact with GHPC and the larger Bridging for Health community?	Is the leadership structured? Are the roles defined, and are they filled by the right people? Do the leaders have the experience and authority needed to guide decision-making?	All external environmental factors, including political will, community support, available funding, and local tolerance for innovation.	Who contacted whom?	Total score Ranking among all potential sites
Scale	<ol style="list-style-type: none"> Not at all Early stages (discussion, conceptual, interest) Commitment to innovation with an intent to develop a plan Plan exists but is not being implemented Doing/ implementing 	<ol style="list-style-type: none"> No clear stewards, limited structure, no staff Structured, no staff, no formal agreements Structured, some staff, some formal agreements in place Structured, have staff, have long-standing relationships with partners Stewards, organized, appropriately staffed, long-standing relationships with multisectoral partners 	<ol style="list-style-type: none"> Not at all Early stages (discussion, conceptual, interest) A stated commitment to health equity Health equity is a cross-cutting theme in the collaboratives' work Health equity is a value and its implications are considered in all activities 	<ol style="list-style-type: none"> None at all Minimal capacity, may not meet minimum project deliverables Capable of accomplishing minimum project deliverables Able to participate in thought partnerships and strategic thinking with GHPC Engaging with other sites 	<ol style="list-style-type: none"> No structure, limited skills in coalition building, role confusion, inexperience in collective impact/ population health, etc. Discussing the development of leadership structure and role definition Structured, with clearly defined roles Clearly defined roles, limited experience with coalition building Long-term experience with population health/ collective impact, clearly defined and appropriate roles, demonstrated success in coalition-building 	<ol style="list-style-type: none"> High barriers, no identified funding opportunities Moderate barriers, minimal funding opportunities Equal barriers/ facilitators Low barriers, multiple funding opportunities Multiple facilitators, diverse funding opportunities 	N/A	1-5 (1-5)

BRIDGING FOR HEALTH TECHNICAL ASSISTANCE APPROACH

Tanisa Adimu and Glenn Landers

The Bridging for Health national coordinating center's TA approach was grounded in GHPC's extensive experience working with both rural and urban communities across the country. GHPC's nationally tested model balances coaching and training support across technical and adaptive opportunities, provides tailored support to individual communities, encourages peer learning, and focuses on long-term sustainability.

Our TA support for community sites was guided by a set of core principles:

- **Focus on relationships.** The most effective TA is provided by individuals who are in an ongoing relationship with the communities they serve. Our TA liaisons built relationships and trust with those they served, acted as thought partners and coaches, translated data to support decision-making, and collaborated with and brokered other resources and subject matter expertise. In-person contacts are critical for understanding the community context and the stakeholders, and for building strong relationships.
- **Offer technical and adaptive support.** Technical challenges have clear solutions and experts who can share them. For adaptive challenges, however, problems are not easily identified and the answers are unknown; communities must therefore collaborate, learn, and adjust their strategies over time. Recognizing that a community's efforts to address upstream drivers of health requires both technical and adaptive skillsets, we focused on building adaptive leadership capacity to help communities develop technical and adaptive solutions to accelerate population health improvements.
- **Utilize a team-based TA approach.** We assigned a team of two TA liaisons to support each community site throughout the grant period. Team members' experience and expertise were blended to ensure robust support that was relevant to the community's context. This relationship-based team support was highly customized and flexible to suit the emerging needs, challenges, and opportunities that community sites and their partners faced throughout the support period.
- **Engage the smartest people to cultivate a strategic mindset.** The Bridging for Health advisory panel supported Bridging for Health efforts by acting as thought partners with the TA team and communities; assisting in site selection; providing coaching support; and offering guidance on evaluation, research, translation, and the dissemination of innovations. The advisors brought expertise in health care financing, health equity, community coalition building, leadership development, collective impact, economic development, social determinants of health, and population health.

- **Be systematic but flexible.** The TA process was progressive, focusing first on developing a strategic mindset, then on building the requisite skills and capacities associated with the Blueprint for Action (described below), and finally on documenting and sharing breakthroughs and lessons learned related to financing innovation development and implementation. All elements, whether offered individually or to groups, built on and reinforced each other.
- **Focus on sustainability.** Bridging for Health defined the sustainability of community interventions as the creation of sustainable resources and the ways in which multisector consortia could position themselves to have a sustained impact. Based on a synthesis of what we have learned in the field and from the literature, GHPC's Sustainability Framework© provided the logic for this work.
- **Learn together on the journey.** Our approach evolved through a continuous learning process that promoted innovation and the integration of new ideas, lessons learned in the field, insights from local evaluators, and funder expectations.

Technical Assistance: The Key Elements

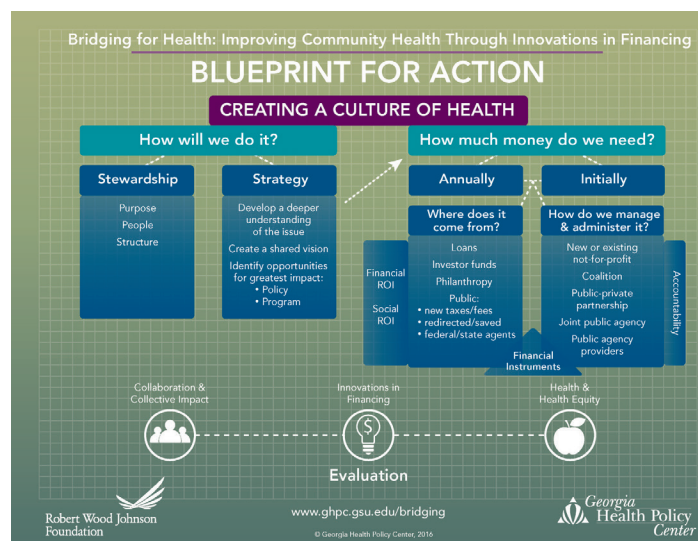
The TA program's content revolved around the GHPC Blueprint for Action and a TA process that ensured a logical progression of activities to support communities in accomplishing their goals.

As Figure 4.1 shows, the Blueprint for Action illustrates how community health can be achieved through innovations in financing. It focuses on mapping the theory of change between what a program or change initiative can do and the desired goal of achieving a culture of health. It achieves this mapping in three steps:

- Identify the best approach for determining the collaboration's purpose and structure and strategic goals,
- Determine the required initial and annual resources, and
- Select the most feasible and effective financing mechanism.

Blueprint for Action includes a portfolio of tools and training resources that are delivered “just in time” — that is, when community sites and their partners are ready to engage with a particular subject matter, or when an issue or opportunity emerges.

Figure 4.1. The Bridging for Health Blueprint for Action



The individual modules help focus stakeholders on four specific topic areas and the mindset each area requires for success:

1. Health Equity

A *resilient community* is one with secure housing, safe streets, parks, good jobs and education, and other factors that contribute to well-being. When these factors are not distributed evenly across the community, some community members have less opportunity than others to be healthy and prosperous. Disparities show up between different groups in the community in outcomes such as asthma, diabetes, and heart disease and keep the whole community from thriving as it should. Health equity focuses on these differences in outcomes, searches for underlying conditions that contribute to them, and applies the best of the community's diverse knowledge, perspectives, and ingenuity to finding solutions.

This module engaged participants in understanding:

- The equity mindset in relation to population health initiatives,
- The types of conditions that lead to local disparities, and
- How to find leverage for reducing disparities and lifting overall community well-being.

2. Stewardship

Bridging for Health defines *stewardship* as accepting or assigning responsibility for shepherding and safeguarding the valuables of others. Following the principles and ideas of Elinor Ostrom, 2009 Nobel memorial laureate in economic sciences, we sought to understand and foster effective, stewardship-minded collaboratives. Developing a mindset for collective stewardship focuses on three topics:

- **Purpose.** Having a clear, shared, encompassing mission.
- **People.** Having the right leaders in the room.
- **Structure.** Holding planned and productive meetings, creating forums and tools to call out important issues and have healthy conflict resolution.

By promoting stewardship, communities enhanced the planning and management of health-related resources. The stewardship model aligned coalition members by:

- Developing a shared understanding of the stewardship principle,
- Assessing the current state of the coalition, and
- Understanding the tactics needed for continually building a stewardship mindset.

3. Strategy

Building a strategy to answer the fundamental question — How will we do it? —requires not only a commitment to good stewardship but also partners to develop an understanding of interventions with both a proven success record and an ability to overlay the local landscape, including community health needs, challenges in addressing those needs, available assets, and opportunities for greatest impact. Considering the evidence and local context creates a shared vision, which facilitates the creation of the best set of strategies to achieve goals.

This module brought together elements of stewardship, equity, and financing to align them with the local context and move toward action. The module achieved this by:

- Framing the issue to be addressed,
- Creating a shared vision,

- Identifying similar approaches and adapting them to the local context, and
- Assessing the impact or consequences of actions.

4. *Financing Innovation*

Bridging for Health helped communities develop and implement financing mechanisms that rebalanced and aligned investments toward upstream drivers of health. This module recognizes that both technical solutions and adaptive skills are required to effectively address complex challenges. Further, no one financing mechanism can meet the needs of all communities. Innovation requires adapting known financing mechanisms to particular settings, combining financing tools in new ways, or creating new financing vehicles that align with the local context.

Given the work involved in selecting, tailoring, and implementing financing options, this module guided participants to:

- Clarify community needs,
- Explore novel financing examples,
- Understand the innovation cycle, and
- Analyze which tools are appropriate given the community's assets and context.

Technical Assistance Activities

GHPC's TA approach was designed to be practical, relevant, and tailored to the needs of community members. The delivery of these learning modules and other TA activities — which offered intensive, ongoing support to a core implementation team — was balanced with convenings and trainings for full consortium membership and other stakeholders. The other TA activities combined on-site visits with remote support. The on-site visits proved to be the most effective mode for bringing partners together to assess community assets and gaps, develop shared goals and objectives, and create action plans. The TA liaisons used phone calls and email to coach implementation teams, track progress, and broker appropriate information and resources, including connections to advisory panel members and other subject matter experts. The TA framework provided three fundamental services to all community sites: peer-learning opportunities (discussed in Chapter 5), individualized TA, and generalized TA.

Individualized TA. The TA liaisons offered highly individualized and tailored support. We assigned a TA liaison team to each community, and that team supported the site for the duration of the award period. We also blended each team's experience and expertise to ensure robust, relevant site support. This support included:

- Facilitating strategic planning sessions with board members,
- Designing meetings and participating in stakeholder convenings,
- Providing connections to the advisory panel and other technical experts, and
- Identifying resources about implementing the Collective Impact model.

The ability of TA liaisons to understand and assess a site's requirements and identify the specialized resources to meet them was critical to the flexibility required to meet each community's specific needs. Maintaining regular contact with community sites through monthly calls let the teams effectively track their site's progress and respond to needs as they emerged. The TA liaisons also conducted site visits in which they typically convened multiple partners or stakeholders to jointly plan,

reach agreements, and set future directions. These site visits also let the teams provide intensive, site-specific training and support for Bridging for Health learning tools, including the learning modules and the Innovation-to-Action Cycle.

Generalized TA. This element of the TA encompassed capacity-building areas that were relevant to most or all of the sites. Designed to achieve efficiencies for similar site support and training needs, generalized TA support and content could be effectively delivered to large groups. Modes of delivery for this cross-cutting TA support included webinars, connections to trainings and resources provided through the peer web portal, and other self-directed Innovation-to-Action Cycle resources shared directly with the participating sites. As Chapter 5 describes, reverse site visits — in which all site leaders met together at the GHPC — are another critical aspect of generalized TA.

Accomplishments and Outcomes

- GHPC's thought partnership approach to TA contributed to each site's development in four crucial areas:
 - Developing or refining ideas or plans,
 - Encouraging strategic thinking, including for planning broader or longer-term goals,
 - Setting concrete next steps and timelines to move toward goals, and
 - Building adaptive capacity to manage changing community circumstances and priorities.
- Connecting sites to other experts or communities doing similar work allowed the sites to:
 - Learn from each other,
 - Gain confidence in their own work as pioneers, and
 - Recognize that they were joint pioneers for local innovation.
- Learning modules and site visits changed how people thought about the work, although the impact was dependent on the group's readiness, preparation, and composition, as well as the presentation conditions.
- GHPC built internal TA capacity and developed tools and resource connections for future work.

Key Learnings

- **Set and reinforce the vision, goals, and pace.** Achieving consensus on a vision and goals, as well as maintaining a sense of urgency for the Bridging for Health work, influenced progress.

Our experiences resulted in five key learnings related to timing, pace, and structure:

- Sites benefit from having a deadline or other urgent need to achieve progress. As much as competing priorities and resources permit, ensure that ongoing action and a sense of urgency are central to the project.
- Itemize site deliverables to increase accountability. Use funder expectation and deliverables, including rapid cycle testing, small wins, and leadership development, to catalyze action.
- Engage in prework to understand local innovations and experience and tie them into the Bridging for Health effort.

- Readiness for change can be dynamic, and it is affected by the collective sense of urgency and motivation. Often, change readiness is rooted in a core group or leader, then activated across the “right” group of people. Because urgency is felt in different ways across stakeholders, leadership is essential.
- Incremental approaches are often more attractive, especially in sites that lack clarity on where to find additional dollars inside or outside of the system.

In relation to vision and goals, we realized six important lessons:

- It is important to engage in early discussions with the group to establish the vision for stewardship.
 - Stewardship commitment takes energy, especially when the conversation and action involve the use of fiscal resources. It is often challenging for board members or collaborative stakeholders to put aside their own organizational priorities, even under the influence of the broader group’s declared attention to an agreed-upon scope and purpose.
 - Sites benefit from clear definitions of deliverables, roles, and success — that is, what is the ideal state at the end of the project?
 - Momentum and skills can grow from continual, incremental change. Look for a small group of people who are passionate, have a clear vision, and are authorized to take action.
 - Get clear on the goals and strategy before you move to the financing innovation, and focus on matching the financing innovation with the population health strategies.
 - Emphasize the fact that there is no cookbook or playbook.
- Deliberate identification and clarification of roles — the core workgroup and the broader stakeholder group — supported by effective communication strategies across those groups aids progress.

We consistently found three subgroups at each of our sites:

- The champions. This is often the original contact person (or people) for the site.
- A core workgroup. A relatively small group of people who typically lead the work.
- The stakeholders. A broader group of people who have been assimilated into the work.

We realized several lessons in relation to these subgroups and the various roles that people play within them:

- Sites benefit from clear definitions of deliverables, roles, and success — that is, what is the ideal state at the end of the project? It is important to define the roles of all stakeholder groups including the GHPC at each site. The champion and the core workgroup membership design and implement the financing innovation. To ensure the strategy is aligned with the community’s financing needs, intensive work with that smaller group is needed.
- Convening large or broader stakeholder groups for mindset change and smaller groups for planning and action yielded good results. It was also important to anticipate succession and plan for onboarding new people without slowing down or repeating training and information within the existing group.

- o Progress was impacted by the capacity of individuals to be fully engaged in their roles for the full project period — the champion/leader, the program manager (convener, keeper of the process, data, etc.), and workgroup members.
 - o Given the challenge of “building the plane while flying it” — continuously refining the process — it was hard for sites to keep up; occasionally they needed to go back to definitions and purpose, especially during the innovation acceleration phase.
- Mindset change through learning modules is only the starting point.
 - o The work to affect mindset around stewardship, equity, strategy, and financing laid the groundwork to move to the later stages of the Innovation-to-Action Cycle, where different work was/is needed. It is critical to be intentional about delivering the modules as part of the TA package. Doing so helps stakeholders think differently and prepare for action ahead of the sessions; groundwork should be laid and sites should do prework to get the message out, invite stakeholders, and keep the work going.
 - o The current set of modules gets people started on thinking differently and/or buying in to the concepts; the next level is to get people to act. To make this happen, additional tools and skills are needed. The modules should be described as part of the TA package that facilitates sites doing work and making progress in between and not only at site visits. An ideal pairing of modules is equity/stewardship and strategy/financing.
 - o The delivery context is critical — Who is attending? What is their stage of readiness/progress? Is the TA site visit merged into existing meeting structure or separate? Is sufficient time allocated to deliver the material?
- Technical assistance must adapt to the stage of the work.
 - o Setting and managing the expectation that this is a learning journey for everyone — we are pioneers together — was important to the success of the project.
 - o TA has an evolving role in this process. It is therefore important to balance the role of the TA provider between being the expert, pushing for progress, and “walking alongside” site stakeholders as a thought partner. Being clear and prescriptive about the expectations of the process and products that sites will be responsible for, as well as TA details to support their work, helped them achieve.
 - o Differences between the sites necessitated different approaches. For some communities, “walking alongside” them (that is, playing the standard TA role as facilitator) is readily accepted, while others might require more up-front TA leadership and expertise.
 - o Tools and processes are needed to guide how people act, to support knowledge application, and to evaluate the merits and applicability of different innovations (e.g., form Foundation Strategy Group (FSG)).
 - o Flexibility in adjusting the level, content, and timing of TA is important to these kinds of efforts. Some sites needed more heavy or frequent TA (high touch) to assist them in making progress.
 - o A critical component of the approach was teaching and modeling how to manage the innovation work and effort in the context of uncertainty.
 - o Quickly connect sites to experts (including advisory panel members) or to other communities working on similar issues to build capacity, being clear on the need for support in thinking through and solving adaptive versus technical challenges.

CHAPTER

5

BRIDGING FOR HEALTH — REVERSE SITE VISITS

Chris Parker

Peer-to-peer learning was a central component of the TA approach. We therefore incorporated multiple methods for encouraging exchange among Bridging for Health sites, including reverse site visits and peer-to-peer webinars. As Table 5.1 shows, GHPC organized two primary peer-learning opportunities each year.

Table 5.1 Biannual Peer-Learning Opportunities

February 2016	The advisory panel and sites were brought together to learn from each other and to encourage the sites to begin thinking about and framing their work in the context of the Bridging for Health Initiative. The event served as a kickoff for the initiative.
November 2016	The sites engaged in a formal learning collaborative webinar in which Pablo Bravo of Dignity Health provided details on one hospital's investments in improving the health of its community.
February 2017	We designed and conducted a two-day meeting of the sites, the advisory panel, and the TA providers to facilitate a deeper dive into population health financing. The meeting also sought to encourage adaptive leadership through changing times and environments. Stakeholders left that meeting with a resolve and commitment to actively initiate financing solutions to support population and public health interventions.
November 2017	We facilitated a cross-site peer-learning webinar aimed at underscoring and clarifying the process for accelerating the creation of innovative funding mechanisms. As described in the "Innovation-to-Action" section, this process borrows from a process used in business innovation. Most sites had already begun the process of coming to agreement on the likely intervention or set of health improvement interventions in their communities. The webinar specifically focused on developing an appropriate prototype and test for the mechanism that each site was considering.

February 2018	<p>The final peer visit had four key goals:</p> <ul style="list-style-type: none"> • Understand and cross-walk the collective learnings to date, • Strengthen and develop financing innovation prototypes to support population health improvement in awarded communities, • Prepare lead organizations and partner institutions for stress-testing the innovations, and • Support the exchange of ideas, learning, and networking across sites. <p>Four panelists — Anne De Biasi (Trust for America's Health), Barbara Masters (California Accountable Communities of Health Initiative), Jim Kisch (Passumpsic Savings Bank), and Bill Barnett (Northside Development Group) — reflected on national and local examples of ongoing efforts to develop pooled community-based and -administered funds focused on health and wellness.</p> <p>Each site came to the site visit prepared to present its prototype or financing innovation idea and to receive collegial feedback from peers, advisors, and GHPC staff. After assimilating the feedback, site teams enhanced their prototypes and set about designing the stress-test elements that would govern their activities for the next three months.</p>
June 2018	<p>We held a webinar for sites to share progress, highlights, insights, and updates on their proposed financing innovations to rebalance and align resources and community efforts to achieve meaningful and sustainable health improvement within their respective communities. Specifically, the sites were tasked with sharing the results of their stress tests. Stress-testing is a specific phase of the innovation process that is facilitated by the TA teams and follows the ideation and prototyping phases of the work.</p>

Accomplishments and Outcomes

Attendees described multiple meaningful outcomes of participating in the reverse site visits, including that the visits:

- Helped attendees refocus on the financing innovation, rather than solely on program implementation,
- Confirmed where they were in relation to their goals and helped them feel confident about their next steps,
- Provided feedback from peers and the advisory panel,
- Gave workgroups time to plan next steps, and
- Let participants learn about and from other sites' work.

Key Learnings

In-person meetings of the communities, including peer learning opportunities, advanced their individual efforts:

- The reverse site visits were highly valued and impactful for sites; they functioned as deadlines to move the work forward and also helped the sites learn new ideas and increase their motivation.
- During this innovation-acceleration stage of the project, peer visits afford focused team time and valuable connections to other sites, and build energy and momentum toward crystallizing a succinct, shared understanding of what they are trying to accomplish. Examples and connections to other places and experts provided by TA give sites opportunities to identify and address questions and challenges.
- Sites benefited from advisory panel participation and feedback during the peer visits, building connections for additional advice.
- A peer-learning, online platform designed to support communication and information sharing among sites did not have the intended engagement and impact. Connections were best facilitated by individual contacts through TA or independently.

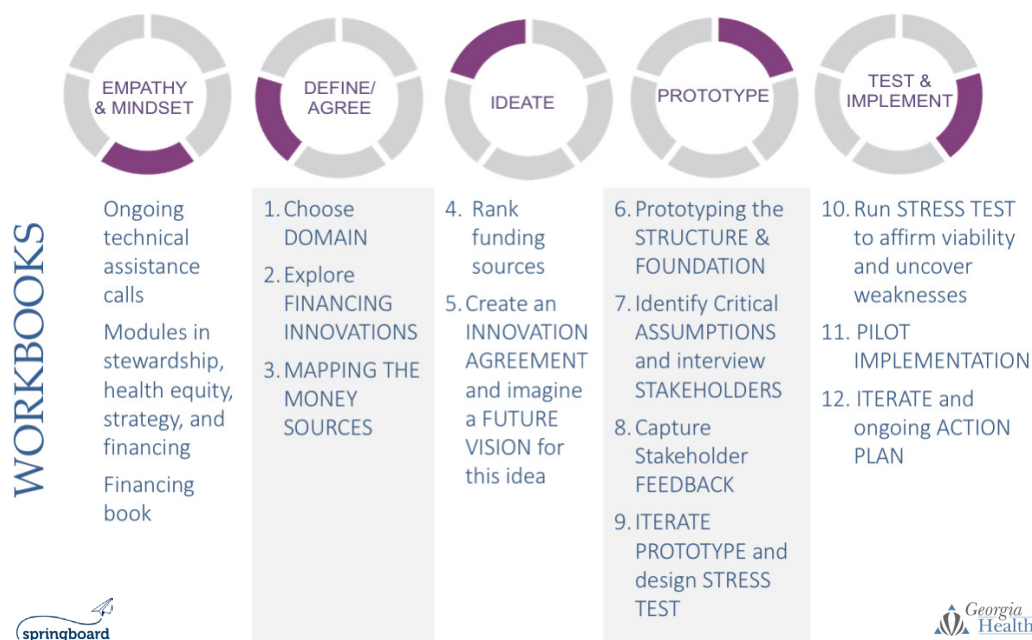
INNOVATION-TO-ACTION CYCLE AND FINANCING INNOVATION OUTCOMES

Emily Heberlein and Chris Parker

We focused much of our efforts in the project's final 18 months on accelerating action to develop the financing innovations in the first- and second-phase site communities.

In May 2017, Bridging for Health engaged Amy Zehfuss, the founder of Springboard Strategy, to consult with the GHPC team and the selected sites. The goal was to move the portfolio of Bridging for Health work forward from innovation to action. GHPC staff cross-walked the initial Blueprint for Action with a business innovation model to create an approach that would intentionally accelerate the collaboratives to action. We joined with Zehfuss in a thought partnership to codesign a process that would accelerate the work of the sites as they developed population health interventions and discussed ways to finance them. The centerpiece of this innovation work was the five-step Innovation-to-Action Cycle (see Figure 6.1).

Figure 6.1. The Five-Step Innovation-to-Action Cycle



The Innovation-to-Action Cycle Approach

The codesigned Innovation-to-Action Cycle approach includes workbooks to guide collective action and accountability. It also provided basic training for GHPC staff on prototyping and cofacilitated discussions with the sites to introduce concepts and expectations. At this point, we also redesigned subawards to the selected sites to be deliverable through an extended project period of December 2018.

Prior to engaging Springboard Strategy, our work focused on the first two steps of the Innovation-to-Action Cycle — Empathy and Mindset and Define and Agree — with limited work in ideation and prototyping.

Empathy and Mindset. This step was the focus of the four Bridging for Health modules — stewardship, health equity, financing, and strategy — delivered to each site. It also launched the process of identifying community health needs (which all sites did prior to participating in Bridging for Health), as well as cultivating relationships with necessary partners. Broadening the partner base was a common outcome of participation in the modules. Zehfuss built upon this existing mindset work by introducing the innovation mindset, which included learning fast, championing the cause, trusting the process, and having comfort with ambiguity.

Define and Agree. Bridging for Health work highlighted the need to find high-leverage strategies at the intersection of community health needs and priorities, available financing, and evidence-based strategies that improve population health. The Define and Agree stage aligned this existing Bridging for Health work and the Innovation-to-Action Cycle. At the end of 2017, six of the seven sites were able to reach an “innovation agreement,” which was the culmination of the Define and Agree stage. This agreement ensured that leadership teams at each Bridging for Health site and their key community partners were aligned and in agreement with the Innovation-to-Action Cycle. Achieving this entailed confirming a list of viable ideas to pursue, prioritizing those ideas, agreeing to a success scorecard, and committing to terms of engagement.

Ideate. Prior to introduction of the Innovation-to-Action Cycle, most sites had homed in on the community health need and strategy they were interested in and on identifying necessary partners; progress around financing innovation, however, was slow.

The Innovation-to-Action Cycle, coupled with increased project structure, created renewed momentum by examining financing combinations and finding support for learning fast, iterating, and improving the innovation. Key activities in the ideate step include seeking experts and success stories, exploring new partnerships, aligning with other initiatives, and balancing the iterative decisions on selecting financing and strategy.

Prototype. The 2018 peer site meeting focused on engaging sites in the prototype-development phase. The main purpose of prototyping was to establish enough details behind a funding/financing concept to get feedback and input from key partners and potential investors. Sites came to the meeting ready to share their innovations with peers and advisors, collected feedback that strengthened the prototypes, and left with a plan for how to stress-test their innovations.

Test and Implement. Using the philosophy of “investing a little to learn a lot,” sites stress-tested a small-scale version of their innovations. A stress test challenges assumptions to prove or disprove them, affirms viability, and uncovers weaknesses in a prototype. This testing helps reduce risk and increase knowledge on a small scale to help participants re-evaluate and pivot while the

stakes are low. It's an inexpensive way to learn quickly. This testing also helps teams address "deal killer" assumptions and demonstrate a small-scale proof-of-concept to prepare them for pilot implementation.

When the stress test's scope — that is, its design and audience — is carefully crafted, it can help teams quickly determine flaws with the idea and pivot, changing the chosen approach, modifying the strategy, iterating the new concept or idea, and testing again. Feedback and analysis are key components of the stress test, as it serves as a barometer to ratify or disprove key assumptions and uncover needed additional work and discussion.

Pilot implementation scales up the testing; the goal is to prove the concept following rigorous stress-testing, ample feedback from stakeholders, and several rounds of iteration or modification. At this point, key assumptions have been proven or disproven. A good pilot test should be mapped out and include a set of benchmarking data to measure effectiveness, a budget, and seed funding. For Bridging for Health, running the pilot test required sites to first accumulate and set aside enough money in a fund, establish early governance and accountability structure, and use some of their funding to define a strategy and the need for the innovation.

Iterate. Reflecting on a pilot implementation's results and learning is critical. This reflection summarizes what was learned in the implementation, including any surprises that emerged, any changes required, and whether the innovation should proceed. The team is then prepared to decide on the broader implementation based on "go/no go" criteria.

Summary. Rolling out the Innovation-to-Action Cycle followed similar patterns of other new learnings that had previously emerged from Bridging for Health. A core group worked with Zehfuss to adapt the Innovation-to-Action Cycle to Bridging for Health work. Zehfuss and the GHPC Bridging for Health team engaged in person with a few sites directly and with all of the sites through webinars. A "train the trainer" approach enabled the TA providers to work directly with their sites to complete the Innovation-to-Action Cycle and have their prototypes ready for the 2018 peer meeting.

Accomplishments and Outcomes

Financing innovations. All sites planned, established, or expanded a pooled community wellness fund as their Bridging for Health financing innovation.

- Experts recognize that leveraging and coordinating multiple funding streams is an important strategy for sustainably financing community health improvement efforts.³ Up-front capital investment is necessary and may be blended and braided from diverse sources, such as government resources (e.g., a tax or designated program), philanthropic grants, hospital community benefit dollars, community bank loans, or, ultimately, the reinvestment of the shared savings generated as a result of program success.
- The seven Bridging for Health sites are all serving as integrators — including bringing partners together to develop a strategic plan; building, managing, and integrating pooled community wellness funds; overseeing program implementation; evaluating the process; and ensuring sustainability and accountability.
- If communities are to make real progress in developing their pooled community wellness funds, they must answer three critical questions:
 - Sources. Where does the money come from?
 - Purpose. What will funds be used for?

- o Structure. How do we manage, allocate, and provide stewardship for these funds?
- While varying in composition, purpose, and scope, all the Bridging sites are building pooled community wellness funds to address either the primary prevention of chronic conditions or an upstream driver of health.

Supportive mindsets and strategies practiced by sites. GHPC identified common mindsets and strategies among sites that successfully completed the Bridging for Health Innovation-to-Action Cycle. Not all sites demonstrated all of the following successful “ingredients,” but these trends expanded our knowledge, which we can in turn spread to the broader field:

- Maintain financing innovation as the initiative’s focus and align it with a strategy that meets community needs.
- Communicate effectively to different audiences when pitching the financial innovation, including overcoming language differences and describing the whole concept, not just the strategy.
- Reach sufficient consensus on an initial strategy. (Some sites, for example, are developing a phased plan for uses of pooled funds.)
- Take advantage of available resources and expertise.
- Persist in building partnerships.
- Shift from looking for answers (finding the cookbook or playbook) to taking responsibility for doing the homework, learning from others, making the case locally, and recognizing that the TA team cannot direct the implementation.
- Learn where money in the system is going and leverage the opportunities.
- Think of the initiative in phases, as a learning process, and embrace its iterative nature. For example, build enough structure to test and learn, rather than waiting on final decisions.
- Aspire to outcomes beyond health measures, including economic development.

Additional site outcomes. Sites demonstrated additional, complimentary outcomes leading to and going beyond the stress-testing and pilot implementation of pooled community funds. Those outcomes included the following:

- Establishing governance structures for funds (charters, memorandums of understanding, administrative backbone) and workgroups,
- Increasing support for the pooled fund concept,
- Progressing in the strategy design and financing plan,
- Building skills in business plan development,



- Achieving buy-in from agencies, health plans, and other investors,
- Increasing the understanding of the time, resources, and skills needed to operate the strategy and manage the pooled funds,
- Changing the way the collaborative seeks funding or applies for grants,
- Influencing larger proposals, projects, and expertise by linking community priorities to funding proposals,
- Strengthening cross-sector relationships, and
- Identifying multiple contributors to the pooled funds.

Key Learnings

- **Community collaboratives may more readily embrace evolutionary rather than revolutionary approaches to innovation in financing population health.**
 - The relatively short time frame of the initiative, the simplicity of the mechanism, and the opportunity to evolve over time made developing pooled community funds the most attractive and feasible option for financing innovation. Incremental approaches are often more attractive, especially in sites that lack of clarity on where to find additional dollars inside or outside of the system.
 - When a collaborative is just getting started with financing innovations, it is not inclined to begin with capital that has to be paid back. It is more feasible to start with more traditional means, then move forward.
 - As solitary approaches, other mechanisms including payment reform, social impact bonds, and/or tax initiatives are perceived to be more complex and less feasible to accomplish at the local level. Sites nonetheless understand how significant those mechanisms might be in expanding and sustaining the pool of available resources for implementation over time.
- **Fascination with the financing mechanisms is not a substitute for understanding the flow of money in the region and around the health system to enable the innovation.**
 - Exploring the potential match of a specific or a variety of financing vehicles (“shiny objects”) for the community was sometimes a valuable tool in onboarding and engaging sites and meeting collaboratives where they were. It was sometimes however a distraction from them looking at the money in the system and finding the places where health, money, and partners intersect.
 - The pace of innovating quickened when stakeholders had a common understanding of and were comfortable with the topic of health financing and potential mechanisms, and it was important to distinguish terminology of financing, investing, and fundraising.
- **Maintaining a focus on the financing innovation — not program implementation — is critical and often challenging.**
 - Conventional thought regards financing as one of the components to be worked out during the testing and implementing of an innovative strategy or design. Accordingly, many site stakeholders were more comfortable thinking and designing the set of strategies than crafting the financing innovation.
 - Progress, breakthrough, and broad stakeholder buy-in seemingly occur more quickly when the people who live in the “structure and sources” world of finance and

economics (the “money whisperers”) are engaged early. Their engagement also supports greater understanding and comfort across the collaborative about health financing, financing mechanisms, and the actual development of the fund.

- **Thinking and acting to finance upstream health can be hard for health collaboratives that have often focused on care and access to it.**
 - Full commitment to the population health approach and thinking “upstream” was not realized. Most sites are still working on strategies between that fall in the space between clinical care and population health to attract the interest and investment of local stakeholders and/or collaborative partners.
- **Leadership and the collaborative dynamics are critical contextual factors that can impact the process and outcomes.**
 - Site leaders played a significant role in helping to maintain focus and direct the effort. Success was often associated with a pioneering spirit in leadership — a willingness to experiment and a readiness to take action beyond the status quo and risk failure. Not surprisingly, in those communities where leadership changed, the focus and pace was often interrupted. There may be risks to attaining the project’s goals in those sites where the largest/most influential stakeholder is leading the work.
 - Size, number of players, and geography are all influential to the success of the effort. The collaborative’s history, reputation, trust, and the diversity of organizations constituting the group also had an impact on pace and progress, strategy alignment with usual work, evidence base, and outcome expectations.
 - Competing demands and complimentary initiatives were common challenges to financing innovation across sites.
- **The Innovation-to-Action Cycle with its framework, project guidelines, and deadlines made the work a priority, keeping teams on track and accountable.**
 - Tools and methods for prototyping and testing helped move the work forward, and the stress-testing process was influential as it requires seeking support, opinions, and participation from the key stakeholders.
 - Use of an iterative and prescriptive process landed laser focus on identifying sources, uses, and structures for the work.

BRIDGING FOR HEALTH EVALUATION

Emily Heberlein

Evaluators are increasingly called upon to evaluate complex initiatives implemented in broadly different contexts, requiring them to combine evaluation approaches, understand context-specific elements, and incorporate design flexibility. The Bridging for Health evaluation offers an example of — and lessons learned from — combining evaluation approaches in a multisite design using a local-national evaluator model.

Evaluation Approach

The Bridging for Health evaluation team used developmental and realist evaluation approaches. Developmental evaluation emerged in response to the need to better evaluate complex, innovative interventions that operate in complex, ever-changing systems.⁴ This approach is particularly suited to social change initiatives and interventions because it supports the collection and analysis of real-time — or close to real-time — data, which in turn facilitates continual feedback and informs iterative decision-making. At its core, developmental evaluation provides insight into how an intervention fits into a broader system in which it was purposed to impact while accounting for and adapting to complex, real-world factors and circumstances that influence the intervention's design, development, and implementation.

Developmental evaluation allows program evaluators and implementers to adapt their interventions or innovations to changing needs and context. The approach motivated the decision to embed evaluators at each site and at GHPC. Doing so maximized the evaluator's capacity to understand context and provide rapid data collection and observation for ongoing feedback loops at the site level and at GHPC, allowing for continual learning and adaption of the TA approach.

Realist evaluation is a theory-driven approach that is also used to evaluate social programs and initiatives. Unlike other evaluation approaches, which focus on outcomes achieved or produced from interventions, realist evaluation focuses on how the outcomes were achieved.⁵ Specifically, realist evaluation addresses what works, for whom it works, to what extent it works, what context it works in, and how it works. This approach helps program developers and policymakers understand the varying conditions in which an intervention takes place and explain the underlying contexts and mechanisms that influence the intervention outcome. Accordingly, three concepts are addressed in a realist evaluation: context, mechanism, and outcome.

GHPC found realist evaluation particularly suited to the Bridging for Health initiative for two key reasons. First, it explicitly focuses on the influences of context and how outcomes are achieved. Second, its goal is to build and test a theory through iterative sense-making activities. The realist framework serves as the underpinnings for three evaluation questions:

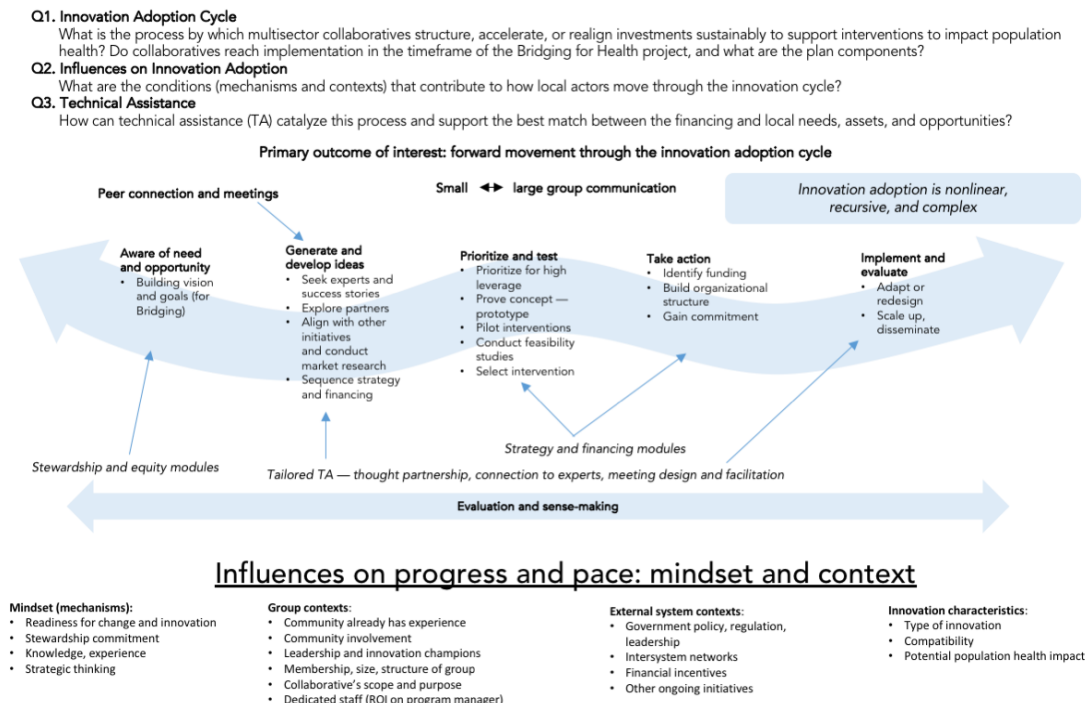
- What is the process by which multisector collaboratives structure, accelerate, or realign investments sustainably to support interventions to impact population health?
- What are the conditions (mechanisms and contexts) that contribute to how local actors move through the innovation cycle?
- How can TA catalyze this process and support the best match between the financing and local needs, assets, and opportunities?

The evaluation team also used the realist framework to organize, analyze, and interpret data describing attributes of four key factors:

- The context of each site, including state policies and programs, regional and community characteristics, and the nature and strength of the collaborative,
- The characteristics of the GHPC TA process and resources provided (that is, the mechanisms theorized to impact collaborative members and the financing innovation implementation),
- The collaborative's reasoning, opinions, behaviors, plans, and actions for implementing the financial innovation (the mechanisms for adopting the financing innovation), and
- Progress toward and implementation of the financial innovation (the primary outcome).

Based on the literature, experiences from previous work providing TA and evaluation services, and original program theory for how Bridging for Health would achieve its goals, the GHPC team developed an initial theory of change that guided data collection and ongoing work (see Figure 7.1).

Figure 7.1. Evaluation Questions and Theory of Change



The Local-National Evaluation Team

Each site chose local evaluators, who were then onboarded to the project by the GHPC evaluation lead. These evaluators typically played additional roles in the local initiatives as well:

- Allegheny County — university professor and Plan for a Healthier Allegheny workgroup member.
- Spartanburg/Way to Wellville — university leader and Way to Wellville core leadership team member.
- Bexar County Health Collaborative — program manager.
- Yamhill CCO — program manager.
- Inland Empire — staff evaluator at a stakeholder organization.
- MiHIA — university staff and leader of university center (a collaborative stakeholder).
- NEK Prosper! — university researcher at a university center involved in previous partnerships.

Local evaluators were positioned and equipped to observe and document four key factors:

- How the sites' innovation processes unfolded,
- The contextual factors that influenced the innovation processes,
- The changes that contributed to innovation (e.g., mindset of leaders, commitment of collaborative to stewardship, bringing in new partners, etc.), and
- The role of the GHPC TA.

The local evaluators were much more than local data collectors — they were keen observers with valuable contextual knowledge, partners in tailoring evaluation methods, critical thinkers in sense-making, and articulate co-authors in documenting the work of Bridging for Health.

Local evaluator responsibilities included:

- Maintaining stakeholder connections,
- Joining the “right” meetings,
- Conducting periodic interviews using tailored interview guides,
- Designing and conducting post-meeting reflection forms,
- Participating in monthly calls to refine processes and engage in sense-making, and
- Developing ongoing analytic summaries and authoring case studies.

The GHPC evaluator lead met monthly with the seven site evaluators (either individually or as a group) to share observations and note similarities and differences across sites and to discuss and modify processes for data collection, documentation, site sense-making, and writing.

Data Sources and Data Collection

Data collected and reviewed by both the local evaluators and the GHPC evaluation lead included multiple qualitative data sources:

- Notes. Site evaluators or Bridging for Health staff took structured notes on collaborative meetings, TA calls, and internal meetings, while key meetings were recorded and transcribed. The meeting note templates were based on the realist evaluation framework.
- Interviews. Site evaluators conducted semistructured interviews with key site leaders and stakeholders, with some sites interviewing key project participants multiple times.
- Feedback forms. Participants in collaborative meetings filled out feedback forms.
- Project documents. Site evaluators and Bridging for Health staff made available relevant project-related documents, including email correspondence, strategic reports, formative assessments, and TA plans.
- Reviews. Bridging for Health staff completed before-action reviews and after-action reviews for site visit planning and debriefing.

The semistructured interview guides were tailored for each site and modified over time. Broadly, the questions covered the following topics, which map to the realist framework and use aspects of the “most significant change” approach ⁶:

- Describe the interviewee’s roles in the project and in the broader context.
- Summarize the most significant change in the past six months.
- Describe the overall progress and insights gained, including changes in knowledge, reasoning, or commitment of the collaborative, and other factors influencing progress.
- Analyze the influence of TA, challenges, and sustainability, and share advice with other sites.

The GHPC evaluation lead organized a secure website to facilitate document tracking and sharing. At the evaluation’s outset, recordings and extensive notes were maintained on all meetings — both Bridging for Health project meetings and those peripheral but anticipated to provide important context. Over time, the evaluation team modified the data collection strategy to better meet the developmental evaluation approach’s goals — that is, to support rapid communication, analysis, feedback, and adaptation. The evaluators developed a “timeline” document shared by evaluators and TA liaisons recording brief, reflective notes, observations, and next steps, with links to longer documents as needed. This approach encouraged centralized communication, more timely documentation, and efficient sense-making.

Data Analysis Process, Sense-Making, and Feedback Loops

All interviews and relevant meetings were recorded (with participant permission) and transcribed. Georgia State University Institutional Review Board approved all data collection tools and instruments. Notes, transcriptions, summaries of meeting feedback forms, and documents collected were tracked, organized, and analyzed at timepoints corresponding with project milestones. Analysis began once the first round of interviews and site meetings was completed.

The GHPC team tested themes that emerged from peer debriefings and draft findings against the original Bridging for Health theory of change. Data display analysis techniques, including matrices and theory of change models, were used to organize and condense the qualitative data to facilitate drawing and verification of conclusions during sense-making sessions. The evaluation generated multiple versions of this theory of change and noted differences across sites.

GHPC coordinated periodic sense-making discussions with each site’s evaluator and TA liaisons, across site evaluators, and internally with the GHPC leadership and TA team. These discussions

focused on reviewing progress and challenges, as well as on the role and impact of GHPC TA as identified through data collection and preliminary analyses. Table 7.1 outlines the key evaluation milestones. Findings were also reviewed with the advisory panel and with site leaders during each reverse site visit. Site evaluators also reviewed findings with site leaders and key stakeholders in various ways, including through periodic updates on evaluation, sharing of site-specific summaries, reviewing the cross-site theory of change iterations, and discussing interview results and case study drafts.

Table 7.1. Key Milestones for Evaluation

TIMING	LEAD	MILESTONE	USE
December 2016	Local evaluators	Key stakeholder interviews	Initial feedback on TA
February 2017	GHPC evaluation lead	Site-level summaries and revised program theory	Sense-making at reverse site visit
February 2017	GHPC evaluation lead	Summary of learning module use	Module revisions and TA planning
June-July 2017	Local evaluators	Key stakeholder interviews	Data source in August data review
August 2017	GHPC evaluation lead	Theme summary memo for TA “lessons learned”	Planning TA for two new sites
September 2017	GHPC evaluation lead	Site-level findings and revised program theory	Internal planning for phase 2 of TA and the Innovation-to-Action Cycle
December 2017-January 2018	Local evaluators	Key stakeholder interviews	Sense-making and preparation for February peer learning
February 2018	GHPC evaluation lead and local evaluators	Summary of evaluation progress and interview themes	Reverse site visit presentation and facilitated local evaluator discussion
April 2018	GHPC evaluation lead	Document review focusing on meeting notes and before- and after-action reviews from site visits and peer learning	Debriefing on initial phases of the innovation process to inform TA for remainder of project
May-June 2018	GHPC evaluation lead and local evaluators	Site level document review and thematic analysis	Summarizing themes using matrix of Innovation-to-Action Cycle and realist framework

TIMING	LEAD	MILESTONE	USE
July 2018	Local evaluators	Key stakeholder interviews after stress-testing phase and peer-learning webinar	Debriefing on most recent progress and GHPC planning for implementation phase
August 2018	GHPC evaluation lead and local evaluators	Site and cross-site summaries	Site conference calls with TA liaisons to review, test, and refine themes for case study
September-December 2018	GHPC evaluation lead and local evaluators	Establish process, templates, schedule, and draft for case study writing	Multiple iterations for review and discussion
December 2018		Key stakeholder interviews and/or final sense-making with site leadership	Final case studies and lessons learned

Accomplishments and Outcomes

- Each site evaluator conducted three to five rounds of interviews, with approximately 120 interviews total.
- The evaluation and TA teams codeveloped and evolved processes and tools to support the complex, qualitative, longitudinal design.
- The embedded evaluators — both locally and internal to GHPC — provided ongoing, meaningful, iterative feedback impacting the pace and direction of the site work and the TA approach.
- With the GHPC evaluator, site evaluators from Bexar County, Inland Empire, and Allegheny County presented the project's evaluation design and early learnings at the American Evaluation Association Conference in November 2017.

Key Learnings

The evaluation team adapted to address the challenges of evaluating a complex, evolving initiative:

- The TA approach (the intervention) was different for each site, particularly in early project phases, and
- The site evaluators had varied types of experience and degrees of involvement in the site work.

Given the diversity of the site contexts and initiatives, the team had to hone analytic skills to move beyond site-level learnings and synthesize the work more broadly. Key factors for success included:

- Establishing effective feedback loops,
- Developing efficiencies in dividing the evaluation work, and
- Organizing the local-national partnership, setting expectations, and prioritizing embedded evaluation.

PART II. CASE STUDIES

As Bridging for Health was initiated, both the staff at GHPC and the leaders of the sites were interested in documenting the learnings from the process in a book. An initial outline that included the project process, site-specific stories, and learnings was developed. The evaluation structure that included overall and site-specific evaluators facilitated the writing of the book.

The book includes chapters for each of the seven sites. The local and national evaluators worked together with the editor to develop the outline that site evaluators would use in writing the site-specific chapters. Each site chapter includes:

- A description of the collaborative group and its context, challenges, and opportunities,
- The site's Bridging for Health innovation and the use and outcomes of TA,
- The site's experience with the Innovation-to-Action Cycle, and
- Lessons learned and a look ahead.

Over the course of Bridging for Health, the site leaders, participants, and evaluators participated in a process that included systematic but flexible TA, peer learning, knowledge and mindset modules, and innovation acceleration. Each site had a different cast of partners, a different pace and rhythm to the work, and a different context. A complex set of learnings and perspectives emerged. Site leaders and participants, local site evaluators, the TA providers, and the program leaders were each impacted differently from the process.

The structured evaluation and sense-making created opportunities for project participants to see site specifics and overarching themes. The complexity of an innovative project with emergent learnings required the structured, overarching evaluation process. One high-level theme was the emergence of pooled community funds in each site. This became the headline of the learnings from the project. Throughout these case studies you will see threads of information, actions, and learnings that, woven together with experience and observation, create insights about this process and the funds.

Because the site chapters are written in the authentic voices of the evaluators who were embedded in the sites, you can see the ups and downs and challenges that occurred throughout the process. You can also see the threads of other high-level themes that emerged related to the effectiveness of the TA and the use of the Innovation-to-Action Cycle. Across the site chapters there are also countless site-specific learnings about leadership, stewardship, strategy, financing, and equity. It is also possible to understand the courage and persistence required to pursue innovation when there are only shreds of evidence as to how to effectively proceed. These case studies and the collective learnings from this work provide the basis for the next phase of learning regarding innovations in financing to build a culture of health.

PUBLIC HEALTH IMPROVEMENT FUND: ALLEGHENY COUNTY, PENNSYLVANIA

Steven Albert

Allegheny County is located in the southwestern corner of Pennsylvania near the Ohio and West Virginia borders. It covers a total area of 745 square miles (1,930 km²). With a population of 1,223,048 (as of 2017), it is the second most populous county in the commonwealth. Its capital, Pittsburgh, population 303,000, is a major economic force, with a strong “eds and meds” startup culture emerging from its major universities (University of Pittsburgh, Carnegie Mellon, Duquesne). Yet outside Pittsburgh, the county is mostly rural and sparsely populated in some areas, with an older population and aging infrastructure.

The county is fortunate in that it has a philanthropic community interested in improving population health. Several major philanthropies emerged from the wealth generated by steel and coal production when Pittsburgh served as major center for manufacturing. Their investment in the city and county is long-standing; it has been critical for Pittsburgh’s outsized arts and education community, as well as for innovation in human services and, most recently, community health.

With the appointment of a new director of the Allegheny County Health Department (ACHD) in 2013, the philanthropies came together to form a trust fund to support ACHD infrastructure, which had been neglected over the prior decade. At the same time, the new director initiated a series of steps to redirect ACHD away from its prior relatively narrow focus (infectious disease control) to community health more generally. In addition to building infrastructure (including new deputies, information technology resources, and a new building), ACHD conducted population health surveys, developed a community advisory coalition of organizations that address health, and drew on both to develop “a plan for a healthier Allegheny.”

At this critical point in the reorientation of ACHD, Allegheny County joined the set of communities working with Bridging for Health — Innovations in Financing. The county was represented by the ACHD director and deputies, the community advisory coalition, and the philanthropic community, and later by local health systems. Bridging for Health provided two years of technical assistance through monthly calls, site visits, national meetings, and shared resources to help the county make its planned transition. Among the challenges the county faced were to find ways to:

- Expand the mandate of the blended philanthropic fund, and
- Use these funds to invest in local efforts emerging from a large community coalition.

Innovations that emerged from its Bridging for Health involvement included a new charter for the blended fund and substantial changes in the organization of the community advisory coalition and its relationship to ACHD.

The Allegheny County Bridging for Health effort involves three key partners: ACHD, the community advisory coalition that was organized to implement ACHD's Plan for a Healthier Allegheny (PHA), and the Public Health Improvement Fund (PHIF), a blended philanthropic fund. With guidance from Bridging for Health, the philanthropic community agreed to a change in the PHIF charter that allowed funds to be used to support innovative programs that address population health needs consistent with the PHA, rather than ACHD infrastructure alone.

GHPC's TA liaisons were crucial in helping ACHD recognize that direct efforts to promote PHA goals could be appropriate for PHIF funding. The TA liaisons promoted use of the co-chair steering committee model through consensus building and other participatory exercises. Efforts to implement a broader stewardship model with the entire community coalition proved less successful, however, as the disparate participants were focused on their own agency missions. In the workgroup co-chair meeting settings, stewardship and consensus emerged more readily. Still, a key test remains — that is, it is still unclear whether small PHIF-funded demonstrations emerging from the workgroups can successfully transition to larger, sustainable public health programs.

Allegheny County: Context, Challenges, Opportunities

Allegheny County has a population of 1,223,048 (as of 2017), and Pittsburgh is its county seat. Relative to the rest of the United States, the county's population is old: 18.4 percent are aged 65 or older, compared to 13 percent nationally. The county is largely white but has growing African-American (13.4 percent) and Latino (2.1 percent) populations. The federal poverty rate in the county is 11.4 percent, compared to 12.9 percent statewide (<https://datausa.io/profile/geo/pennsylvania/>). Health insurance coverage is high; in 2017, more than 95 percent of county residents were insured.

Through ACHD efforts, the county has made great strides in addressing the community's health needs, including, for example, increasing rates of insurance coverage and use of preventive services. Allegheny County is part of the Public Health 3.0 program, which "challenges business leaders, community leaders, state lawmakers, and federal policymakers to incorporate health into all areas of governance."⁷ This has led to a health-in-all-policies orientation in city and county legislation. In 2017, ACHD was accredited as a nationally certified health department, and in 2018, it was funded to coordinate a Centers for Disease Control and Prevention REACH program addressing disparities in minority health.

Allegheny County at a Glance

Region: 745 square miles (1,930 km²)

Population: 1,223,048 (as of 2017)

Collaborative: Allegheny County Health Department (ACHD), Plan for a Healthier Allegheny (PHA) Community Coalition, Public Health Improvement Fund (PHIF).

Overall goal: Expand the PHIF mandate to fund community-driven PHA projects with a high likelihood of future funding.

Innovation solution: Revision of PHIF charter; promotion of organizational culture in ACHD and community coalition that supports emergence of competitive PHA projects.

Target "upstream" strategy: PHIF funding of PHA projects across five PHA coalition workgroups: access, chronic disease, mental health/substance abuse, maternal and child health, and environment.

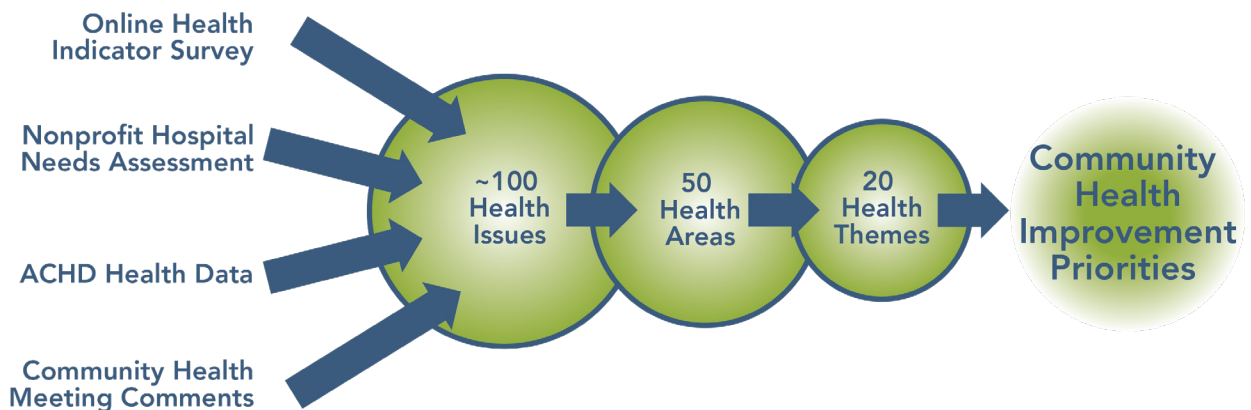
Key Challenges

To identify and address its critical population health needs, ACHD conducted an extensive health needs assessment in April 2016. The effort had three goals:

- Characterize the overall health of Allegheny County residents,
- Evaluate the factors that influence health outcomes, and
- Identify areas in need of improvement.

Figure 8.1 shows how ACHD developed the community health needs assessment. The process identified five key community health priorities: access, chronic disease, mental health–substance use, maternal and child health (MCH), and environment.

Figure 8.1. The Development Process for Allegheny County's 2016 Community Health Needs Assessment



Opportunities

ACHD recruited workgroups from the community coalition to develop projects that would address the five areas of health needs:

- **The Chronic Disease Workgroup** aims to “decrease preventable chronic disease by assuring access to resources, knowledge, and opportunities for residents to adopt healthy behaviors.” To do this, the group focuses on three areas: obesity and poor nutrition, physical inactivity, and smoking and tobacco.
- **The Access Workgroup** “identifies and addresses gaps in and barriers to accessible and affordable, person-centered, high-quality health care.” The workgroup focuses on insurance, oral health, and transportation. Table 8.1 shows an example of one of its PHA targets.
- **The Mental Health–Substance Use Workgroup** aims to “reduce mortality and morbidity related to mental and substance use disorders.” Current efforts revolve around depression, drug and alcohol use, and integration of mental and physical health care in primary care.
- **The Maternal and Child Health Workgroup** works to “improve the health and quality of life of women, infants, children, caretakers, and their families, especially in vulnerable communities.” The workgroup has targeted asthma, breastfeeding, infant mortality and low birth weight, parental support, and safe sleep.

- **The Environment Workgroup** “enhances quality of life by reducing pollution and other environmental hazards using coordinated, data-driven interventions.” This group’s focus areas include air quality, unconventional oil and gas production, and water quality.

Table 8.1. The Access Workgroup’s Example of a Plan for a Healthier Allegheny Target

OUTCOME INDICATOR	BASELINE	PHA IMPACT	PHA TARGET	HEALTHY PEOPLE 2020 TARGET	DATA SOURCE
% Allegheny County Medicaid children less than 5 years accessing preventative dental care	41% received at least one preventative dental service	20% increase	49.2% receiving at least one preventative dental service	N/A	2014 Gateway UPMC, United, Aetna Claims Data

The Organization and Partnerships

Dr. Karen Hacker is director of the ACHD, which led development of the PHA as a road map for addressing the county’s health needs. ACHD works closely with two other organizations: the PHIF and the PHA community coalition.

The PHIF includes local philanthropies (Hillman, Pittsburgh, Staunton Farms, Jewish Healthcare, Heinz, and Buhl) and, more recently, health plans (University of Pittsburgh Medical Center (UPMC) and Highmark/Allegheny Health Network) that have agreed to contribute to ACHD efforts. The Pittsburgh Foundation administers the PHIF, which draws on a model of philanthropy established earlier to support the county’s Department of Human Services, Pittsburgh school district, and Pittsburgh police. The PHIF has attracted approximately \$600,000 over five years and disburses \$60,000 to \$80,000 annually.

The PHA community advisory coalition has more than 100 participants from over 70 agencies, including representatives from advocacy groups, industry, and county and city agencies. The coalition meets annually and advises ACHD on its progress toward PHA population health targets. In a kickoff meeting, the community coalition used a nominal process to prioritize efforts and identified five key areas among the set of PHA goals. Coalition members were then invited to join the five workgroups to collaborate on ways to address each area. Each workgroup has a community and an ACHD co-chair; the workgroups meet quarterly, and a steering committee of co-chairs meets twice a year.

ACHD has designated a staff member to coordinate PHIF-funded projects each year. This person is usually a recent Master of Public Health (MPH) graduate, and many have joined the ACHD staff after the grant period. Each ACHD deputy (including the director) serves as a co-chair for a PHA workgroup. Workgroup membership is open to any county organization involved in the effort. ACHD has tapped some organizations because of their prominence. Community co-chairs are largely self-nominated, and workgroup turnover is an issue, both for co-chairs and members.

Bridging for Health

Allegheny County was among the first five sites funded through the Bridging for Health initiative. The site's broad goal is to mobilize existing resources — including the ACHD PHA, its supporting community advisory coalition and workgroups, and funding available through PHIF — to develop sustainable public health efforts that improve population health.

To launch this initiative, three key challenges had to be met: First, the PHIF charter — which was originally focused narrowly on supporting the ACHD infrastructure — had to be rewritten to align with the ACHD's PHA (see <http://www.achd.net/pha>). Next, the community coalition had to be mobilized to develop a well-functioning co-chair steering committee, along with subcommittees and engaged workgroups that had standardized ways to issue progress reports and stay on track. Finally, the workgroups had to develop proposals for funding that could be presented to the PHIF or other potential funders; they did this by learning from each other and with the help of the steering committee, which meets before each PHIF funding cycle and helps coordinate funding requests.

A key strategy in reaching these goals was to develop the workgroup co-chairs steering committee with the help of Bridging for Health TA. The TA liaisons helped pull the groups together by attending or calling into co-chair meetings to find common purpose and provided various tools to improve workgroup efforts. Workgroup co-chairs had regular contact with TA; other members of the workgroups did not. The monthly TA calls involved ACHD staff, the PHIF director, and the local evaluator. GHPC attended one of the annual full-scale community coalition meetings. Representatives from two different hospital systems each attended one reverse site visit.

By dint of hard-earned experience, workgroups evolved charters, subcommittees, and standardized reporting to ensure progress toward goals. One of the goals for workgroups is to achieve consensus on a proposal to address a health issue, develop the proposal, and submit it to ACHD for review and submission to PHIF. Alternatively, workgroups can launch an effort with an organization's existing resources. The workgroups have already launched several successful efforts:

- The Access Workgroup has completed two pilots — a dental Medicaid pilot and a medical transportation pilot,
- The Chronic Disease Workgroup has launched a school-based obesity pilot,
- The MCH Workgroup started an asthma task force,
- The Mental Health–Substance Abuse Workgroup has launched a naloxone distribution pilot, and
- The Environment Workgroup (which must meet specific regulatory requirements) began work on a climate change initiative in 2018.

The Innovation

Allegheny County's financing innovation was to expand use of PHIF monies to support community-driven projects consistent with PHA targets. These funds cover piloting, needs assessments, and small demonstration efforts. PHIF funding ranges from \$25,000 to \$100,000 for a direct public health intervention. (Some PHIF funds continue to be applied to ACHD infrastructure.) Generally, PHIF disburses funds broadly — an understanding reinforced by ACHD — which gives each workgroup an opportunity to propose a fundable idea. It is unclear whether this level of funding is enough to engage workgroups; yet it is also possible that too much money — and overly grand ambitions — may torpedo workgroup efforts as well.

ACHD and the five workgroups recognize themselves as proving grounds for generating projects to address public health problems, with a focus on pilot-scale PHIF-funded efforts. Although the ultimate goal is larger innovative financing efforts, finding the funding to scale up will be challenging. Success in scaling up to larger efforts depends on demonstrating both feasibility and benefit, as well as identifying external funders or ways to anchor new programs in currently reimbursable services.

Technical Assistance and Support

Through its five-step Innovation-to-Action Cycle, GHPC TA offered crucial support as Allegheny County developed its innovative funding mechanism (see Table 8.2).

Table 8.2. Allegheny County's Innovation Cycle

STEPS	ACTIVITIES	TA SUPPORT PROVIDED	OUTCOMES
Empathy and Mindset	<ul style="list-style-type: none"> Revise PHIF charter to expand funding for community-driven projects aligned with PHA 	<ul style="list-style-type: none"> Helped ACHD promote community organizations in PHIF-funded projects 	<ul style="list-style-type: none"> Revised charter
Define and Agree	<ul style="list-style-type: none"> Include PHIF director in Bridging for Health effort; develop workgroup structure to activate community advisory coalition 	<ul style="list-style-type: none"> Advised on workgroup co-chair organization and reporting during calls and site visits 	<ul style="list-style-type: none"> Well-functioning workgroups in the five areas identified by the community advisory coalition; representation of ACHD and local organizations
Ideate	<ul style="list-style-type: none"> Access Workgroup projects on dental health in county Medicaid clinics and medical transportation 	<ul style="list-style-type: none"> Advised on workgroup dynamics and reporting requirements 	<ul style="list-style-type: none"> Pilots completed; insights on redirection of existing funds, such as Port Authority funds for medical transport
Prototype	<ul style="list-style-type: none"> The Access Workgroup's success led other workgroups to develop their own proposals 	<ul style="list-style-type: none"> Advised on workgroup dynamics and reporting requirements 	<ul style="list-style-type: none"> All five workgroups developed and submitted proposals to PHIF

STEPS	ACTIVITIES	TA SUPPORT PROVIDED	OUTCOMES
Test and Implement	<ul style="list-style-type: none"> Find ways to take PHIF-funded pilots to scale 	<ul style="list-style-type: none"> Linked PHIF projects to larger innovative funding paths, such as a tax referendum movement 	<ul style="list-style-type: none"> In process

Empathy and Mindset

Shifting mindsets to embrace stewardship, health equity, and systems thinking, as well as cultivating relationships and identifying community need.

While the ACHD director views the PHIF as a way “to put public health in the community,” some PHIF foundation representatives found it difficult to move beyond the original, narrower understanding of it. For example, when summarizing the PHIF effort, one PHIF representative asked, “so the function of the PHIF is to build capacity to improve ACHD programming, right?” Such misunderstanding reflects PHIF’s original focus, which was expanded substantially as a result of the Bridging for Health initiative.

Generally, the philanthropy community was comfortable with an expanded PHIF charter that would allow public health funding rather than focusing solely on ACHD infrastructure support. As the amended charter states, the PHIF:

is designated to support and catalyze novel and responsive public health interventions guided by the Plan for a Healthier Allegheny, where other internal and external resources are unavailable. ... The PHA is a guide for countywide health improvement that has engaged multiple partners ranging from organizations to residents. The Plan for a Healthier Allegheny will help guide priorities for the Public Health Improvement Fund agenda.

GHPC technical guidance was important in pushing ACHD and PHIF in this direction, but the effort also required some new thinking from the philanthropic community. The PHIF director’s January 2018 remarks illustrate the residual resistance to change:

The pushing from the Georgia Health Policy Center has been effective. ACHD and the PHA workgroups are more active. However, the pushing is not aligned with PHIF. PHIF is not a public health trust fund. ... Remember, PHIF is not designed for direct contact from workgroups or other groups from the community. The Fund is designed only for addressing pressing current needs of ACHD in the absence of other funding. ... A pooled decision model involving community collaboration is not the current distribution fund.

Still, ACHD appears to recognize the need to make this bridging effort. As the PHA coordinator noted:

We really want to be able to bring more PHA-focused projects to [the foundations] and have them be successful. And really prove to the foundations that this is a sustainable model — that it’s something useful and beneficial — and to encourage them to continue to support it.

Define and Agree

Building a shared vision of the Innovation-to-Action Cycle plan through an innovation agreement between partners.

Prior to the Bridging for Health effort, ACHD was not convinced that PHIF funds could be productively used to promote PHA targets. ACHD was concerned that competition for these funds might intensify rivalries between agencies. By the same token, agencies were not convinced that their agencies would get credit for efforts they made. As one agency head noted, “If we do the work, will we get the credit or will ACHD?” For some agencies, PHA goals did not align with their specific agency missions. For this reason, a direct effort by the Bridging for Health group to promote stewardship at an annual community advisory coalition meeting did not resonate with many advisory coalition members.

Recognizing the unwieldy nature of such a large coalition, ACHD and the Bridging for Health group took a step back and regrouped. Their discussions led to an organizational solution: small working groups jointly chaired by ACHD and community partners.

Ideate and Prototype, Test and Implement

- *Generating ideas that fit the sweet spot of a high-leverage strategy — the intersection of a community’s needs, funding opportunities, and evidence-based strategies.*
- *Pitching a draft of the chosen idea to gain feedback from stakeholders.*
- *Using the philosophy of “investing a little to learn a lot,” sites test a small-scale version of the innovation to prove or disprove key assumptions.*

Bridging for Health resources helped workgroups move toward their first pilot grant proposals to the PHIF. TA focused more on organizational dynamics than financial innovation, since the goal was to access an existing blended fund (see Table 8.3). All five workgroups developed proposals to PHIF.

Table 8.3. Allegheny County’s Blended Fund

	CURRENT STATUS	NEXT STEPS
Funding sources	Nine philanthropies in PHIF; two health systems	Recruit additional health system providers; expand number of contributing foundations
Purpose of funds	Expanded PHIF charter allows funding of community-driven PHA projects as they emerge from workgroups led by ACHD and community partners	Seek ways for PHIF-funded projects to expand and attract outside funding
Fund administration	Pittsburgh Foundation manages fund	Seek to reauthorize PHIF for additional cycles

The goals for the innovation in financing effort in Allegheny County were twofold:

1. Expand the charter of the PHIF to allow public health funding rather than only ACHD infrastructure support, and

2. Ensure that all five ACHD community coalition workgroups successfully develop, submit, and fund public health pilot projects through the PHIF.

The workgroups achieved these goals. The larger goal is to bring successful projects to scale with additional funding.

Following revision of the PHIF charter, four of the five workgroups prepared proposals that were submitted and funded by PHIF, and the fifth workgroup submitted a proposal as the evaluation period was winding down.

Access Workgroup's transportation navigator pilot. In this workgroup pilot's initial (unfunded) phase, the group helped ACCESS Transit — a local medical assistance transportation program — field referrals for unmet medical transportation needs from the East Liberty Family Health Center, a Federally Qualified Health Center (FQHC), that initially referred 206 patients interested in transportation support. Almost all of these patients were successfully referred to transport services, most involving discounts for bus lines. Currently, the clinic refers about three patients per week, which is not enough for ACCESS to justify adding a support person for the program, so the tasks are being absorbed by existing ACCESS/Port Authority Allegheny County staff.

The community co-chair reported that ACHD took the lead on this proposal, but the project itself actually emerged from the workgroup: "The transport pilot started with a concept paper and moved from step to step, and it was ACHD-driven. This is expected; projects need an organizer. However, ACHD involvement did not detract from workgroup." After this trial period, ACHD requested and was granted \$30,000 to hire a 50 percent project manager to develop and disseminate information aimed at educating patients and clinic staff on existing transportation programs for transport to health services, including the navigation service at ACCESS Transit.

Chronic Disease Workgroup's adolescent obesity pilot. The goal of this pilot is to decrease obesity among school-age children by 10 percent over five years, targeting those schools with high obesity rates. It will first do research to understand what other communities (in Allegheny County and nationally) have done to reduce obesity among school-age children. Using the information collected, the workgroup will consider and implement intervention tailored to the needs of the highest-risk communities and schools.

MCH Workgroup's asthma pilot. This pilot seeks to bring together community asthma treatment and prevention efforts and three managed care organizations (MCOs) — Highmark, Gateway, and UPMC — to reduce emergency department visits for children with asthma. The group plans to collect the MCOs' claims data and clinical data from the county's emergency department and hospital data systems as well as from Children's Hospital in an effort to understand obstacles to effective asthma care by census tract. To officially launch the project, the workgroup is seeking funding for a 60 percent project coordinator with data skills.

Mental Health–Substance Abuse Workgroup's naloxone distribution pilot. Prevention Point Pittsburgh's current naloxone dissemination efforts are limited to site-based distribution through its three syringe-exchange locations. This workgroup pilot requested \$20,000 (of a proposed \$50,000) to launch a second model of distribution: community-based peer outreach workers. The goal of the pilot is to put naloxone "in the hands of people most likely to witness an overdose, but who may not be able to access a needle exchange or who may not feel comfortable doing so." This pilot is now sustained by a state naloxone fund, with ACHD serving as the coordinating entity.

Lessons Learned

The Allegheny County coalition learned several lessons that may be useful for other communities seeking innovative health funding:

Study ideas carefully — before developing proposals. Although the workgroups met with success on several proposals, others — including proposals related to safe sleep, school-based mental health intervention, breastfeeding, and behavioral health advocacy — failed to reach maturity. Some failed because they were not aligned with PHIF priorities, while others lacked sufficient discussion and planning. Also, some of the efforts that emerged from the workgroups, including a children's oral health initiative and the initial phase of the medical transportation pilot, did not require PHIF funding.

Technical assistance has its limits. Although the TA was useful in providing tools and helping workgroups organize, many of the workgroups found that it was focused at too high a level, emphasizing work with the ACHD rather than getting involved in project development. One workgroup community chair echoed the sentiment of others when she noted that, "the TA was probably more helpful to ACHD staff than to workgroups. I didn't see any amazing change." One issue that several co-chairs also agreed upon was that while GHPC "does a good job of pushing people," it was involved with the workgroups only through large convenings. Many noted that the TA would have been more helpful if it had been more involved in each workgroup's progress and how its work fit into larger efforts across workgroups and at other Bridging for Health sites. Some participants also wanted more clarity on how the tools and competences introduced through the TA connected to their group's actual work.

Tensions can arise between short- and long-term goals. Because PHA does not stress financing — or the need for innovative financing — to address public health challenges, participants deemed the push in this direction appropriate. However, the tension between identifying new pilot projects and seeking large-scale funding for their full realization was never fully resolved. ACHD put development of projects first, financing was secondary, and PHIF funding was reserved for pilot efforts only. At the same time, GHPC stressed thinking about financing first and aiming for large-scale efforts through a braiding of funding sources. This disparate focus created tension. The ACHD director was quite forthright in viewing the PHIF as a reservoir of seed funding for pilot efforts to get things moving immediately. Thus, she did not view the absence of innovative funding of large-scale public health projects as a sign of failure: "It is not ACHD's responsibility to develop proposals and local coalitions. ACHD is the catalyst and data source. Communities must step up to the plate and build partnerships." The director viewed getting the workgroups to develop proposals and tap PHIF funds that support the PHA as a success in itself. Further, she noted that, "the most important outcome is cross-sector partnerships. Moving forward, even if not efficient, is the right metric. Planning will break down along different stakeholder areas of expertise, which is OK, so long as efforts move forward."

Looking Ahead

Workgroup participants recognized that something new was in the air with the PHIF as a resource for PHA-related projects. They also recognized the challenges of making good use of this opportunity. As one community workgroup co-chair noted, "we haven't had our 'aha' moment yet" in terms of how best to marshal workgroup talent to develop a common project. Another co-chair noted that the new partnerships that have emerged among workgroup members may "allow us to do something no one else is doing." One task for future work may be to track these emerging partnerships and how they impact workgroup productivity.

Allegheny County focused more on developing collective action — that is, on using PHIF funding to spur efforts from coalition workgroups — than on direct financing efforts. This focus arose mainly from PHIF constraints, PHA priorities, and the ACHD director's appraisal of the state of the community coalition. Collective action did emerge, and organizations participating in the community coalition ramped up their efforts. In addition to working with new partners, they expanded their mandate to work in new communities and with new populations and began to draw on each other's expertise. The PHIF focus allowed the organizations to cooperate without competing; however, its narrow focus also dissipated some of the enthusiasm of participating organizations.

Promising next steps were discussed in recent PHIF meetings. Among these was an offer from the Hillman Foundation to award a prize to local organizations to promote the PHA. Further, ACHD has collaborated with an Allies for Children referendum to introduce a new tax, based on assessed property values, to invest in early education, child food security, and after-school programming. This is a local property tax, not a social bond (which would require state approval). The initiative received the required 40,000 signatures and was on the November 2018 ballot; unfortunately, it did not pass. Given the efforts completed through the Bridging for Health project, ACHD is well positioned to help steward these and other projects in Allegheny County.

Acknowledgments

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CHAPTER

9

PATHWAYS COMMUNITY HUB: BEXAR COUNTY, TEXAS

Caroline Bergeron

The Bexar (pronounced *Bear*) County Community Health Collaborative (The Health Collaborative) is a nonprofit organization in San Antonio dedicated to improving community health through collaborative efforts.

The Health Collaborative conducts the county's community health needs assessment (CHNA) and the community health improvement plan (CHIP) every three years. It serves as the backbone organization for several community coalitions, such as the San Antonio Health Literacy Initiative (SAHLI), recently renamed the Health Literacy Collaborative, which has been focusing on removing barriers to achieving health for the past 20 years. The Health Collaborative serves as an AIDS Education and Training Center for the South Central Region, providing education and training opportunities to reduce stigma and institutional barriers for people living with HIV. It also provides health education programming in the community. As a nonprofit organization, it relies heavily on grants to support its staff and operation. Program funding is limited and may not be sustained over time.

In early 2016, the Health Collaborative was selected as one of the first sites for Bridging for Health because of its work throughout Bexar County to foster connections across multiple sectors to impact health. The key challenge targeted was: *How can we look beyond grants to find larger, more sustainable funds that will have a measurable, lasting impact on population health?*

To address this, the Health Collaborative planned, designed, and implemented the first Pathways Community HUB in Texas to be supported with a blending and braiding of funds. Key partners

The Health Collaborative at a Glance

Region: Bexar County, Texas (southwestern U.S.)

Population: 1.96 million

Collaborative: Bexar County Community Health Collaborative, a nonprofit organization, with an 18-member board of directors.

Overall goal: Invest and intervene upstream in population health to address the social determinants of health.

Innovation solution: Develop and implement the Pathways Community HUB model supported by the blending and braiding of funding sources.

Target "upstream" strategy: Grow Healthy Together Pathways Community HUB.

include members of the HUB Community Advisory Board, care coordination agencies (CCAs) and their community health workers (CHWs), health plans, city and county governments, and foundations.

The Organization

The Health Collaborative is a 501(c)(3) nonprofit in San Antonio, Texas, that serves the county of Bexar. It was launched informally in 1997, when the county's four major health systems agreed to set competition aside and conduct a countywide health needs assessment in a collaborative fashion. Three years later, the Health Collaborative was formally incorporated, with the goal of decreasing services duplication and promoting coordinated efforts for the best possible outcome for the community.

For the past 20 years, the Health Collaborative has been recognized not only as a leader and as a partner in community health efforts, but also as a trusted neutral convener of a strong network of organizations, businesses, and residents collaborating to improve the community's health. The Health Collaborative's board of directors consists of 18 members representing all community sectors, including residents, businesses, universities, government, nonprofits, faith communities, health systems, and health plans. The organization has four staff members and serves as a learning center for more than 20 undergraduate and graduate student interns each year.

True to its mission statement, the Health Collaborative does everything in collaboration with stakeholder partners. Its list of existing partnerships is exhaustive and comprises all sectors of society including health care, government, education, and nonprofits.

The Health Collaborative: Context, Challenges, Opportunities

Bexar County, located in South Texas, has a population of 1.96 million residents, of whom 60 percent are Hispanic. It is the 17th most-populous county in the United States and the fourth most-populated county in Texas. Bexar is home to the city of San Antonio and 20 other incorporated cities.

Key Challenges

According to the County Health Rankings & Roadmaps, and compared to the 100 most-populous U.S. counties, Bexar ranks among the worst for social determinants of health and disease including access to healthy foods, health insurance rates, children living in poverty, college education rates, health status, low birth weight, teen pregnancies, diabetes, obesity, and premature mortality. Organizations have sought to address these social influencers of health and health outcomes through short-term funding, but Bexar County needs access to sustainable funds to achieve long-term population health improvement and impact.

Data from the 2016 CHNA, which the Health Collaborative shared throughout the community, showed the urgency of focusing upstream to address social influencers of health. The CHNA clearly revealed a 20-year difference in life expectancy between residents living in the north of the county versus residents living in the south. Compared to their northern counterparts, residents in south Bexar County have lower education, higher unemployment rates, lower incomes, more crime, and higher rates of diabetes and other chronic conditions, which can ultimately result in up to 20 years of life lost.

Opportunities

In collaboration with the San Antonio Metropolitan Health District, the Health Collaborative conducts the CHIP to address needs identified by the CHNA. Involving more than 200 community stakeholders, the CHIP focuses on five priority areas: behavioral and mental well-being, healthy child and family development, healthy eating and active living, safe communities, and sexual health. A key theme that emerged from the CHIP workgroups is that while Bexar County is rich in resources, it is poor in connecting residents to them. A plan to improve coordination of services and care was in the works.

While historically known mainly for its work with the CHNA and the CHIP, discussions began to change in late 2014 when the Health Collaborative's vice board chair introduced the idea of investing funds into prevention. In February 2015, he presented to the board the concept of Pennies for Prevention, which focused on making more funding available for health rather than almost exclusively funding traditional healthcare delivery. In April 2015, the board created the Pennies for Prevention Taskforce to investigate this issue, which also coincided with the beginning of the Health Collective's involvement with Bridging for Health.

Bridging for Health

The Health Collaborative decided to engage in Bridging for Health to better identify financing innovations so as to secure sustainable funds to invest upstream for improved downstream community health. The Health Collaborative was also interested in investing further upstream to prevent diseases and conditions that burden the community; the goal was therefore to innovate both in population health strategies and financing mechanisms.

The first priority was to find potential sustainable funds to be invested upstream in prevention; the second priority was to determine how those funds could be used to improve the community's health. To help meet these goals, the Health Collaborative chose the Pathways Community HUB model, which is an evidence-based model of community-based care coordination to address the social determinants of health for at-risk populations. The model also has an integrated financing innovation, in which payers — such as health plans — contract with the HUB to pay for achieved outcomes.

The HUB could receive various sources of funds, including contracts with managed care organizations and non-health partners such as schools, employers, or the judicial system whose performance outcomes are likewise impacted by social influences. In addition to these contract sources of funds, other sources could include grants, hospital community benefits, and social impact bonds. Blending and braiding these funds could help to create diversified sources of fund for the HUB program, ultimately improving its sustainability over time.

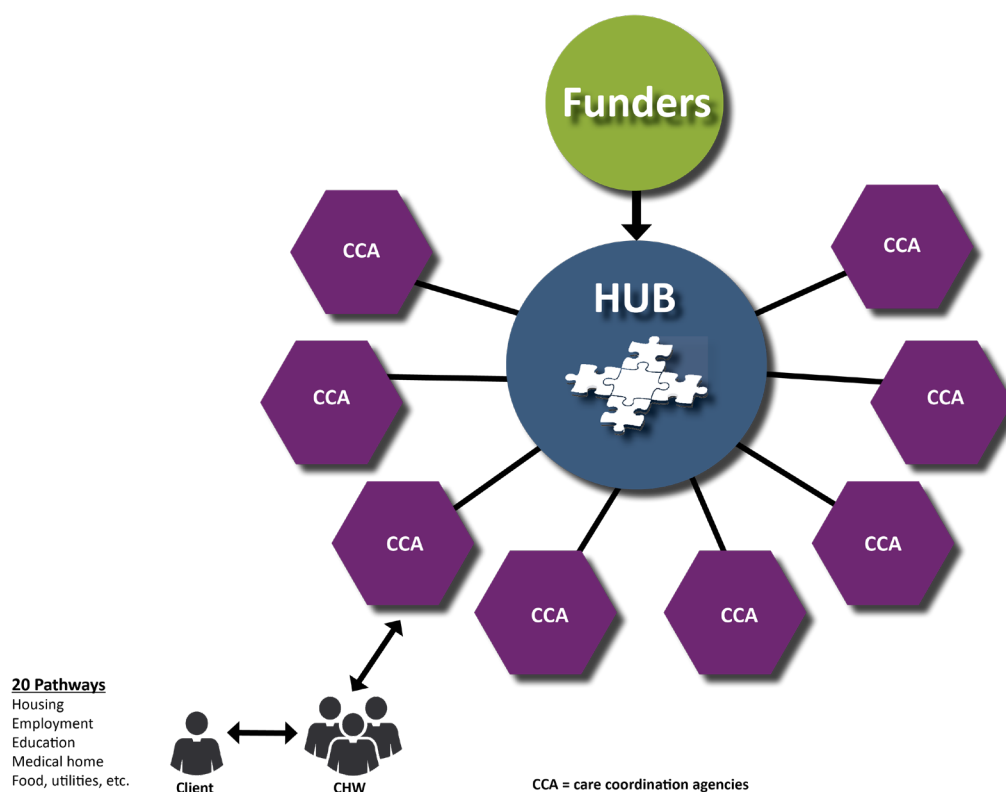
The Innovation

The Health Collaborative's financing innovation is embedded in the Pathways Community HUB model. The Health Collaborative acts as the HUB entity. It contracts with 10 care coordination agencies (CCAs) who employ community health workers (CHWs) to work with the payers' at-risk clients. Simultaneously, the HUB contracts with payers who are at financial risk for their clients. These funders pay the HUB for completed pathways that address basic social needs. Such needs include a list of 20 pathways such as:

- Housing (e.g., the client is in stable housing for a minimum of two months),
- Adult education (e.g., the client completed an education goal, such as graduating from high school), and
- Employment (e.g., the client has been employed for at least three months).

Once these outcomes have been achieved by reaching and executing the “completion step”, the payer is invoiced by the HUB for the CHW’s efforts on each completed pathway. The payer then reimburses the HUB, which then distributes a portion of this payment to the CCAs for their work in executing the HUB model (see Figure 9.1). As existing HUBs across the country show, this financing innovation can help sustain the CCA organization, as well as provide continued funding for CHWs who execute the HUB model, and whose salaries otherwise depend on grants.

Figure 9.1. The Financing Structure of the Pathways Community HUB Model



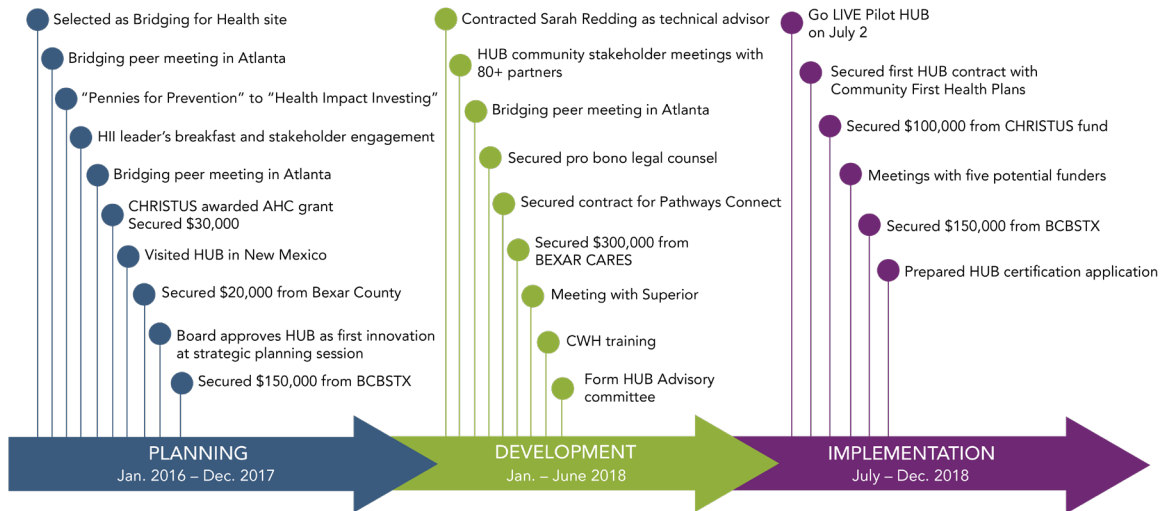
Technical Assistance and Support

Over the past three years in Bridging for Health, our process in Bexar County reflected each step of the innovation adoption cycle at one point or another (see Table 9.1). Because our process was nonlinear, it included months of back-and-forth between different cycle phases; we also worked in more than one phase at the same time — such as simultaneously raising awareness of the need for the financing and strategy, exploring partners, and developing prototypes and stress tests to potential payers.

As Figure 9.2 shows, we conducted the Bridging for Health work in three phases:

- The planning phase (January 2016–December 2017),
- The development phase (January–June 2018), and
- The implementation phase (from July–December 2018).

Figure 9.2. Bexar County's Bridging for Health Milestones 2016–2018.



Throughout the project, GHPC:

- Guided us and encouraged us to move forward as a thought partner in our local process,
- Shared tools such as the Bridging for Health workbook and webinars,
- Connected us to experts, and
- Helped us design and facilitate meetings, including our leadership breakfast meeting in September 2016 and our strategic planning session in October 2017.

In the following sections, we describe general activities that, as we noted, often overlapped with other phases.

Table 9.1. The Health Collaborative's Innovation Cycle

STEPS	ACTIVITIES	TA SUPPORT PROVIDED	OUTCOMES
Empathy and Mindset	<ul style="list-style-type: none"> Organized the Leaders' Breakfast in September 2016 	<ul style="list-style-type: none"> Helped organize and facilitate meeting 	<ul style="list-style-type: none"> Increased understanding of health impact investing Created a call for action
Define and Agree	<ul style="list-style-type: none"> Identified the HUB model as a potential innovative financing and population health strategy 	<ul style="list-style-type: none"> Offered feedback from the Bridging for Health advisory panel Organized a journey-mapping session to identify our strategy Attended the Communities Joined in Action meeting 	<ul style="list-style-type: none"> Learned more about the HUB model Considered the HUB model as our strategy
Ideate	<ul style="list-style-type: none"> Visited the New Mexico HUB Held a teleconference with the Northwest Ohio HUB Compared existing and similar models in Bexar County Contracted Sarah Redding as technical advisor 	<ul style="list-style-type: none"> Provided contact information for HUB directors across the country 	<ul style="list-style-type: none"> Obtained tools and templates from other HUBs to develop our local model Educated the board of directors on this complementary community model Selected the HUB as first innovation solution for population health through strategic planning session
Prototype	<ul style="list-style-type: none"> Educated a variety of stakeholders on the HUB model Made formal presentations to health plans Secured a contract with Bexar CARES for CHW stipends 	<ul style="list-style-type: none"> Learned from Bridging for Health advisory panel how to diversify funding sources 	<ul style="list-style-type: none"> Obtained community buy-in Launched the program in July 2018

STEPS	ACTIVITIES	TA SUPPORT PROVIDED	OUTCOMES
Test and Implement	<ul style="list-style-type: none"> Enrolled HUB clients Actively worked on addressing their needs Secured first contract with Community First Health Plans for payment for outcomes 	<ul style="list-style-type: none"> Helped the team think through progress and achievements Awarded additional funding from GHPC to cover return on investment (ROI) analysis costs 	<ul style="list-style-type: none"> Launched the first HUB model in Texas Working toward national HUB certification

Empathy and Mindset

Shifting mindsets to embrace stewardship, health equity, and systems thinking, as well as cultivating relationships and identifying community need.

We dedicated the first year of this project to engaging with the community on health impact investing. In September 2016, the Health Impact Investing (HII) Taskforce organized a leaders' breakfast with 76 attendees and organized several individual stakeholder meetings with foundations, businesses, health plans, and other community partners.

The purpose of these meetings was to challenge the status quo, shift mindsets, and motivate the community to "invest now to save later" — that is, by investing dollars in health and prevention now, we could achieve savings that would otherwise be spent later in health care and treatment. In general, community partners responded favorably to health impact investing; however, they wanted a concrete example of what they would be investing in and how their investments would be used toward prevention.

Define and Agree

Building a shared vision of the innovation-to-action plan through an innovation agreement between partners.

The Health Collaborative set out to find population health interventions worthy of the community's investments. During several months, we considered existing interventions that could help address the main health issues identified in our CHNA, including diabetes and obesity. We then reviewed previous and potential projects such as the health department's Partnerships to Improve Community Health – San Antonio (PICH-SA), to consider focusing further upstream to make policy, systems, and environmental changes that would support healthy eating and physical activity, and ultimately reduce the incidence of chronic disease in San Antonio. After considering several options, we identified the Pathways Community HUB as a possible candidate.

We first learned about the HUB model through Soma Stout, a member of the Bridging for Health advisory panel, who told the team about it at the February 2017 Bridging for Health peer-to-peer meeting in Atlanta. The HII Taskforce members discussed it as an option the following week during a journey-mapping session with their TA team in San Antonio; they also compared it to the

Accountable Health Communities project that the Health Collaborative would be implementing in collaboration with CHRISTUS Santa Rosa Health System. The HII Taskforce members learned more about the HUB model at the annual Communities Joined in Action meeting.

Ideate

Generating ideas that fit the sweet spot of a high-leverage strategy — the intersection of a community's needs, funding opportunities, and evidence-based strategies.

As we were exploring whether the Pathways Community HUB model would be a great fit in Bexar County, we wanted to learn as much as possible about the model and its financing innovation. Our TA team shared contact information for a few HUB directors across the country. In June 2017, the HII Taskforce members visited the Pathways to a Healthy Bernalillo County in Albuquerque, N.M., where they learned about that program's primary funding source, a county level property tax levy, which provided \$800,000 per year for eight years to sustain the HUB. We also reviewed several of their reports, which showed impressive return on investment results. In addition, we held a teleconference with the Northwest Ohio Pathways HUB, which explained its financing through contracts with Medicaid managed care organizations. We were interested in building these different types of funding mechanisms (e.g., tax levy, payer contracts) in our own local HUB.

As we were exploring the HUB care coordination model, we held important discussions about its similarities and differences with other existing models in Bexar County, including TXServes, Autism Lifeline Links, and the Southwest Texas Regional Advisory Council's new model focusing on super utilizers. It was important that we regularly showed our board of directors and various community stakeholders that our proposed HUB model did not duplicate current and somewhat similar care management models, but rather complemented them. The HUB model also removes silos and fragmentation, improving how we use community resources for upstream prevention. During the October 2017 strategic planning meeting facilitated by GHPC, the Health Collaborative's board of directors approved the HUB model as its first innovative solution for investing upstream for population health.

In one of our Bridging for Health webinars, Pamela Russo from RWJF shared the contact information for Brenda Leath, who oversees the national HUB Certification Program at the Rockville Institute in Rockville, Md. Brenda Leath put us in contact with Sarah Redding, the co-founder of the HUB model. In January 2018, we contracted the professional services of Redding through her Pathways Community HUB Institute.

Redding has been instrumental in our local journey, helping to educate the community about the model — including its relationship with CHWs, CCAs, and payers — providing us expertise and resources for all HUB operations including securing contracts, forming the HUB advisory board, collecting and reporting data, and HUB certification.

Prototype

Pitching a draft of the chosen idea to gain feedback from stakeholders.

The development phase began in January 2018, when the Health Collaborative contracted with Redding and the Pathways Community HUB Institute to meet with more than 80 stakeholders — including potential funders, CCAs, and CHWs — to educate the community about the model and its value and fit in Bexar County.

In February 2018, the Bexar HUB obtained more guidance from the Bridging for Health advisory panel on how to diversify funding sources for the HUB. The Health Collaborative pitched the

idea of the HUB through formal presentations and discussions with several potential funders, including Community First Health Plans, Superior Health Plan, and Aetna Better Health. The Health Collaborative officially secured a \$300,000 contract with Bexar CARES, the local authority for children's mental health, to provide stipends for up to 20 CHWs engaging in the HUB model of care coordination. This funding, which was to be used by September 2018, significantly accelerated our development of the HUB; we identified, recruited, contracted, and trained 10 CCAs, including 20 CHWs and 10 supervisors, using the Pathways Community HUB model. In July 2018, we launched our one-year pilot of the first Pathways Community HUB in Texas: the Grow Healthy Together Pathways Community HUB.

Test and Implement

Using the philosophy of "investing a little to learn a lot," sites test a small-scale version of the innovation to prove or disprove key assumptions.

With its 20-plus years of experience in the community, the Health Collaborative set out to educate the team, the board of directors, and the community-at-large on:

- Health impact investing,
- Evidence-based interventions focused upstream on population health, and
- Implementing a model that would be true to Bexar Country's strengths and reality.

Accomplishing these tasks using a grassroots collective impact approach was key to ensuring that the final outcome would meet the community's needs.

Since the beginning of the implementation phase, we have collected a considerable amount of data on the economic, social, and medical needs of the community and the barriers that exist to addressing those needs. More importantly, HUB-trained CHWs are helping community residents enrolled in the HUB to resolve their basic social and medical needs every day, resulting in improved health outcomes for the community.

In November 2018, we secured our first official HUB contract for payment for outcomes with Community First Health Plans, a Medicaid managed care health maintenance organization (HMO). We are also in discussions and negotiations with several other managed care organizations and payers to truly blend and braid funds and ensure the HUB's sustainability. Finally, we are working on our application for certification to become a nationally recognized HUB through the Pathways Community HUB Institute. Table 9.2 shows the HUB's status and next steps.

Table 9.2. The Health Collaborative's Pathways Community HUB

	CURRENT STATUS	NEXT STEPS
Funding sources	<p>Contracts:</p> <ul style="list-style-type: none"> Community First Health Plans Center for Health Care Services/ Bexar CARES <p>Grant funding:</p> <ul style="list-style-type: none"> Blue Cross and Blue Shield of Texas Bexar County General Funds CHRISTUS Fund CHRISTUS Santa Rosa Health System's Accountable Health Communities grant 	<ul style="list-style-type: none"> We are developing contracts for outcome payments with other Medicaid managed care organizations in the Bexar service area, including Superior Health Plan. We are holding discussions with other sources of funds, including health systems, and the employment and housing sectors.
Purpose of funds	<p>Initial use:</p> <ul style="list-style-type: none"> Payment for outcomes for checklists, pathways, and tools completed through the Pathways Community HUB model. Funding currently for a one-year pilot period, with opportunity for renewal. Stipends for CHWs doing the work of identifying and addressing the social determinants of health (funded for one year). 	<ul style="list-style-type: none"> We are primarily seeking to blend and braid funds to cover outcome payments for the HUB program. We are also seeking ways to elevate the CHW workforce and ensure sustainable funding for those positions.
Fund administration	The Health Collaborative's executive director is managing the funds, with oversight from the Health Impact Investing Taskforce and the executive committee of the Health Collaborative (board chair, board vice chair, and treasurer), which work under authority delegated by its governing body, the board of directors.	We are looking forward to completing an ROI analysis by the end of the one-year of operation (i.e., July 2019) to use this information to attract more funders (contracts and grants) for the HUB.

Community and community partners were involved in each phase of the HUB-development process. We deliberately sought their feedback to ensure that the Pathways Community HUB model was the right fit for our community. Contracting with 10 different CCAs to implement the HUB model changed our existing relationships. The Health Collaborative oversees all HUB operations, including quality assurance and quality improvement, grant and contract management, data reporting, and invoicing. All involved partners are key stewards in ensuring that the HUB model is faithfully implemented and that we are improving community health.

Lessons Learned

Our previous experience in the community led us to anticipate three main challenges early on in our journey; we also experienced and learned from many challenges that we did not expect.

Collaboration is hard and requires time and patience. Our plan to address this expected collaboration challenge was to be open and transparent. We continually reminded partners that we do not have all the answers and that we are learning alongside them. Our established trust in the community, and our previous work toward its greater good, helped to bring partners together and sustain patience and excitement about the work ahead.

Educating diverse stakeholders and community members requires lots of effort. Educating various audiences about health impact investing and the Pathways Community HUB model was challenging because each audience — whether it be the HII Taskforce, the board of directors, community partners, potential payers, or the community at large — has varying levels of knowledge, understanding, readiness for change, and engagement.

To address this, we learned to be proactive in communicating, to repeatedly explain the same message in different ways, to share regular updates (such as at the monthly board meetings), and to ask for feedback. This process helped us identify the skeptics or late adopters early on and address their concerns, which in turn helped us persuade them to join the effort. Regarding the board of directors, we realized that the leadership team sometimes leads and sometimes follows.

Projecting financial outcomes requires data, which takes time to accumulate. We identified early on the importance of running financial projections to identify the point at which the HUB would be self-sustaining. This analysis has begun and continues to remain a challenge. However, as we gather operating results on a monthly basis regarding client needs, achieved outcomes, operating expenses, and invoices incurred and paid, HUB management will be in a better position to forecast financial results by month for 36 months or more into the future. These actions remain an important task to complete in order to ensure the Grow Healthy Together Pathways Community HUB's financial sustainability.

Financing innovations require everyone — including payers — to shift their perspective. We counted on funding for planning and developing the HUB and on receiving payment for outcomes, but several of our proposals were not funded. This was a disappointment, but it reflects the fact that some payers have a traditional mindset in terms of health programming and prefer to measure outreach to a larger number of unduplicated clients of all categories of risk, rather than to a smaller number of high-risk clients for whom the majority of medical claims are incurred. Several funders also continue to focus on clinical outcomes versus prevention which can be done through the HUB's approach of identifying and working to moderate and eliminate clients' social determinants of health. Health impact investing and the Pathways Community HUB model require a shift in mindset for all involved, including potential funding sources.

Move quickly, but do your homework. We had to be well versed in health impact investing and the HUB model, but we also had to act fast. For example, we had to quickly reserve our HUB geography (as per HUB certification standards), take our place in the market, and take advantage of specific opportunities (such as Texas House Bill 13 and Bexar CARES funding).

Celebrate success, be persistent, and stay positive. To better deal with progress-stalling obstacles and to balance acting with required research, we celebrate our successes, regardless of their size.

After all, we are making progress, and we focus as much as possible on the positive. We have also learned how important it is to have grit, be flexible, be persistent, and adapt to new opportunities and circumstances.

Take advantage of external experts. Seeking external expertise has helped us to address some of our limitations in structure, capacity, and skills. We hired many external experts; examples include hiring our director of programs and community engagement, who helped manage the HUB's development and operation; and Redding, who offered technical expertise on HUB planning, development, operation, and certification.

Acknowledge your strengths. Contending with unexpected challenges helped us confirm that the Health Collaborative can do this work. We can be strategic in identifying payers who understand health impact investing and are ready to make this type of investment. We can adapt to changing circumstances and let go if a partner is not ready to engage in the HUB. We continue to learn and are becoming quicker to act. We also continue to progress in developing the right structure and staff capacity for the financing innovation.

The power of self-help. We initially misunderstood the role of our GHPC TA team, expecting it to disclose its "set of tools," including which resources (experts, documents) we could access. We eventually realized, however, that the TA team was not there to lead us or give us answers, but rather to encourage us and support our own journey. In turn, this pushed us to do a lot of research to educate ourselves on key concepts, such as health impact investing, health impact assessments, social impact bonds, population health interventions to address social determinants of health, and ROI analyses. It also motivated us to seek external expertise for our project.

Build on existing trust. The time was right for Bexar County partners to start working smarter rather than harder to improve the community's health. It was their trust in the Health Collaborative's work and history that made this journey possible. Because of this trust, all stakeholders were more open to learning about financing upstream investments for population health, which led to their buy-in in these fundamental concepts — and ultimately to the development and implementation of the Pathways Community HUB.

Looking Ahead

This project's most gratifying result is to know that strong collaborations can help secure long-term investments and significantly improve population health. As a result of this project, the Health Collaborative adopted a new pillar in its strategic plan that focuses on innovative solutions for population health. Its first solution, the Pathways Community HUB, is funded through a blending and braiding of funds. This financing innovation represents the first of many possible solutions for sustainable upstream investments in population health.

The Health Collaborative now has a somewhat different type of relationship with its partners. Because it oversees all HUB operations — including payment for outcomes — the Health Collaborative has greater responsibility to ensure that the CHWs are well trained and that we collect quality data on our community. In contrast, its partners, including CCAs and their CHWs, continue their work of addressing at-risk populations' unmet social needs, while also using a systematic approach to collecting data across the county, playing a key role in describing the context and its barriers, and applying the model to fidelity. All parties involved are strong stewards of the HUB model and the community they serve.

Through this project, we have gained a greater appreciation for creativity in financing innovation. Our Health Collaborative team learned to think outside the box in terms of financing mechanisms and to not be shy about reaching out across sectors to find investors in the HUB. In addition, our partners are collecting invaluable data on the community's health status, which will certainly help attract more payers.

These outcomes can significantly impact our community in the future. On a programmatic level, we expect to see significant changes in our community's social makeup, such as having more food-secure households, higher graduation rates, higher employment rates, less homelessness, higher health insurance rates, and more residents seeing primary care providers, which will significantly impact our community's health. Addressing all of these social influencers of health can lead to a decrease in several health issues impacting our community, including diabetes, obesity, substance use, and teen pregnancy. We are already expecting to see some initial changes in our next CHNA.

From a financing point of view, these outcomes will help to sustain this evidence-based program and the workforce of CHWs who do this hard work in community. Sustainable funding ensures continuity of the program and long-term community health improvements. This first example of health impact investing in Bexar County can also result in future innovative financing mechanisms for population health.

Among its next steps, the Health Collaborative plans to:

- Use existing HUB data to conduct a break-even analysis and financial projections, which will provide key assumptions around the HUB's sustainability,
- Secure additional payer contracts for the HUB,
- Conduct an ROI analysis with the one-year pilot data,
- Incorporate HUB data in the Bexar County CHNA to assess initial population health changes,
- Explore how to further develop and strengthen stewardship for financing innovations,
- Assess how to incorporate lessons learned from the HUB throughout the Health Collaborative's structure and programming,
- Expand the HUB model beyond Bexar County, and
- Collaborate with future HUBs in Texas to advocate for necessary health policy changes at the state legislature in support of the HUB model.

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PROSPERITY FUND: INLAND EMPIRE, CALIFORNIA

Kimberly Morones and Glenn Landers

Southern California's Inland Empire is a large region of pocket communities across Riverside and San Bernardino counties. These planned communities emerged due to rapid growth and urban expansion, yet their disconnectedness makes it difficult for residents to access healthy foods and health care. It also creates challenges for agencies providing preventive services that cross county lines and have a sustainable source of funding — both of which are essential to achieving long-term improvements in health outcomes in this region.

This disconnectedness exacerbates some of the region's most prevalent challenges, which include access to fresh fruits and vegetables, social services, and health care. For example, in Riverside County's Coachella Valley Region, the hospitals serve some communities that are at least a 30-minute ambulance ride away, and it can take even longer to get to a specialist. Fast food outlets are abundant and significantly outnumber grocery stores. Further, access to preventive care services across both counties is widely dispersed, and the problem is exacerbated by a disjointed public transportation system.

To address these geographic and cultural challenges, collaboration among community stakeholders is essential. Although many collaborative partnerships exist in each county, few existed across county lines and covered

Inland Empire at a Glance

Region: Riverside and San Bernardino counties in southeastern California

Population: Approximately 4 million

Collaborative: The group, originally led by Inland Empire Health Plan, consists of several community-based organizations, the local United Way, the two county public health departments, the Riverside Community Health Foundation, Impact4Health (a health care innovation consultant), and the Hospital Association of Southern California.

Overall goal: Bridging for Health Inland Empire seeks to create initiatives that promote a culture of health in Riverside and San Bernardino counties using innovations in financing.

Innovation solution: The collaborative chose to blend and braid sources of funding together to create a wellness fund that captures and reinvests dollars as the group's upstream target strategies change and evolve over time.

Target "upstream" strategy: The group's initial upstream target strategy is the Centers for Disease Control and Prevention's Diabetes Prevention Program, with enhanced features to target higher-risk minority groups.

the entire region prior to the Bridging for Health project. Today, multiple partnerships have been developed as a result of this project, as many sectors came together to address population health.

As the largest provider of Medicaid coverage across the two counties, the Inland Empire Health Plan (IEHP) was a natural choice to convene the Bridging for Health cross-county collaboration. As at the other program sites, the goal was to build an innovative financing mechanism (here, the Prosperity Fund) and a program delivery model to improve regional health outcomes. Other charter members of the region's Bridging for Health collaboration included:

- Both county public health departments,
- Several local nonprofits, including Partners for Better Health,
- Impact4Health, a health care innovation consultant,
- Arrowhead United Way,
- The Hospital Association of Southern California, and
- The Riverside Community Health Foundation.

Inland Empire: Context, Challenges, Opportunities

The U.S. Census Bureau defines California's Inland Empire as the Riverside-San Bernardino-Ontario metropolitan area, comprising Riverside and San Bernardino counties and covering approximately 27,000 square miles.

Key Challenges

Due to a rapidly growing population — fed by families migrating in search of affordable housing — the region's residential, industrial, and commercial development has surged in the last 30 years. This rapid growth and urban sprawl have contributed to poor access to coordinated health care and fresh foods. Many of the residents commute long distances to work or work in large industrial distribution centers.

In general, Riverside County's health fares somewhat poorly compared to other counties' health in California. According to the County Health Rankings, it is 25th out of 57 California counties for health outcomes and 39th for health factors. Rates of diabetes, sexually transmitted disease, and asthma all vary slightly by community. Heart disease remains the leading cause of death among Riverside County residents, while chronic obstructive pulmonary disease (COPD), which is largely attributable to smoking, has climbed to the third-leading cause of death.

San Bernardino County's issues are more severe. It ranked 41st out of California's 57 counties overall — an improvement over last year's ranking of 46th. The county's mortality rates for coronary heart disease and diabetes rank third- and sixth-highest in the state, respectively.

Opportunities

IEHP has always been highly integrated in community projects and has often played the role of sponsor for various community initiatives. Serving almost half of the Medicaid population in the

region, IEHP is strongly mission-driven around giving back to community efforts. Its deep involvement in the collaborative and many connections to various stakeholders in the community initially provided a strong foundation for the project's success. Riverside County's SHAPE initiative and San Bernardino's Community Vital Signs collaborative provided the core networks on which to build this stakeholder group.

The Organization

The Inland Empire Bridging for Health site has a unique organizational structure in that three partners make up the backbone of the group's functionality and organization. IEHP was chosen as the primary grant recipient based on its service area — which covers both counties — as well as its work in the community and the existing relationships that it could leverage. With a network of more than 5,000 providers and more than 1,800 employees, IEHP serves over 1.2 million residents. Although IEHP was a natural choice to lead the effort, it recognized its limited capacity to manage and execute the grant. It therefore brought in two groups to help run the project: Partners for Better Health (PBH) as project manager and Impact4Health as a consultant and co-facilitator.

The Inland Empire collaborative consists of two committees. The steering committee manages the initiative; it was tasked with identifying both a key health need and innovative financing to support its successful launch. The steering committee monitors and reviews the project status and is overseeing the project's rollout and implementation. The steering committee meets monthly and developed a charter that outlines membership expectations. The committee members all hold high-level leadership positions and have decision-making power in their respective organizations.

The *stakeholder committee* focuses on community buy-in for collective impact. The committee has been meeting quarterly since the project started in July 2016 and includes representatives from nongovernmental organizations, community-based organizations (CBOs), public health departments, school board officials, offices of elected officials, hospitals, foundations, investment firms, and health insurance providers from both counties.

The initiative also leveraged two other key partnerships to fulfill important roles and objectives. First, the Riverside Community Health Foundation is the collaborative's fiscal sponsor and will be managing the dollars that will be blended and braided from various sources. Second, the Hospital Association of Southern California (HASC) is developing Communities Lifting Communities, a business venture that is examining innovative financing streams and that is a potential resource-sharing partnership for the Bridging for Health initiative. HASC's involvement has also resulted in the organic formation of a hospital workgroup that has served as a platform for the Bridging for Health group to practice and refine its pitch with hospital representatives.

Finally, the collaborative includes three workgroups — financing innovations (sources), intervention (uses), and policy — that meet as needed. Each workgroup has a different leadership team and focus, and each is given tasks by the executive steering committee and reports back to the committee regarding its progress and recommendations. The intervention and financing innovation workgroups are the most active and have been managing some of the project's core components.

Bridging for Health

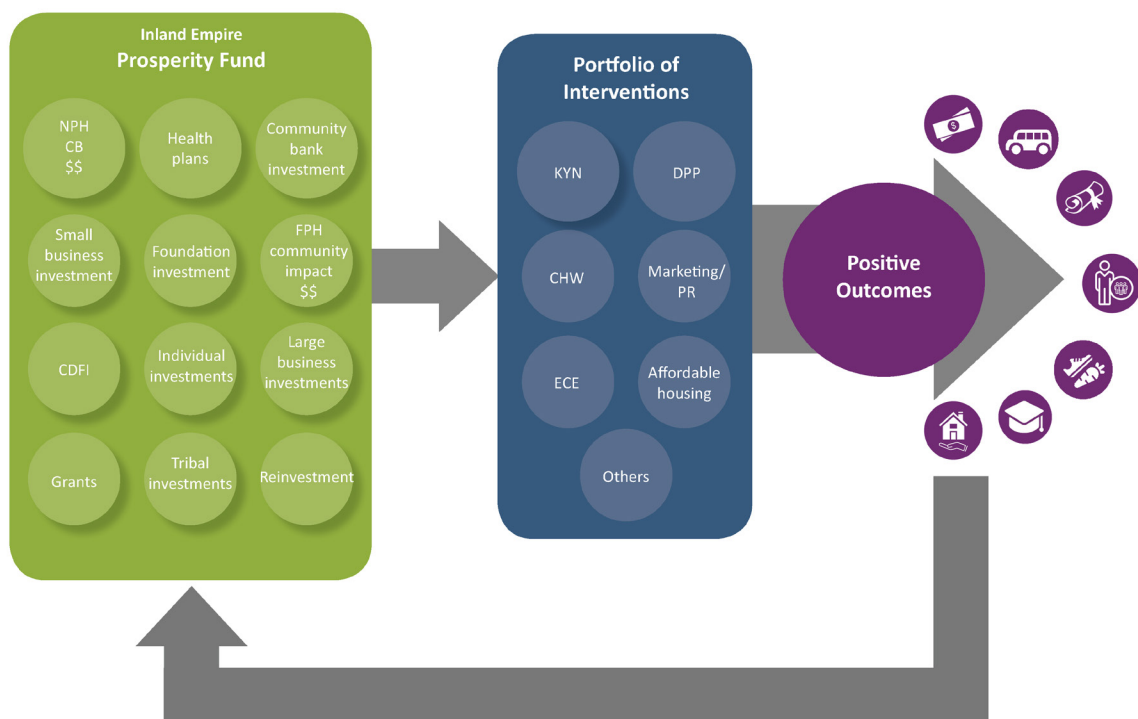
IEHP and the Inland Empire collaborative became engaged with Bridging for Health in July 2016, building on both the community's growing interest in innovative financing and two existing county collaboratives. The effort had a specific goal: to identify financing beyond traditional grant mechanisms and grant dollars. Stakeholders from both counties had identified issues around restricted funding and the detrimental impacts to sustainability that occur when grant dollars drop off or political agendas change. As the group matured, the accountable communities of health (ACH) model appeared to be a vehicle for health improvement in the region. The Prosperity Fund was envisioned as the engine that would fuel the ACH.

The Innovation

The executive steering committee and finance workgroup primarily determined the financing innovation. To begin the search, the finance workgroup first examined literature related to various financing models and real-world examples in other communities and states. It then brought this information to the executive steering committee, which weighed the pros and cons of each model.

It was soon evident that to ensure the flexibility that the group wanted in terms of accepting and leveraging dollars, the funds would have to be blended and braided from multiple sources. This would create a diverse stream of financing that would be much more sustainable and resilient to changes in grant and public funding (see Figure 10.1).

Figure 10.1. The Inland Empire Prosperity Fund: Funding and Reinvestment



Restricted dollars make it difficult to sustain the overhead costs, infrastructure, and day-to-day management needed to achieve large collective impact efforts. The group thus aimed to create a prosperity fund that was diverse, flexible in how the funds could be spent, and that would “reseed” itself by investing in whatever intervention or prevention programs the community agreed on as the focus. The collaborative also sought an ROI-type measure that could be built and pitched to potential investors based on intervention outcomes.

The ACH model met these needs. As generally defined by the Center for Health Care Strategies:

The ACH model facilitates cross-sector collaboration to address the full range of factors that influence health, including access to medical care, public health, genetics, behaviors, social factors, economic circumstances, and environmental factors.⁸

There are seven core elements to consider when designing an ACH:

1. Geography,
2. Mission and vision,
3. Governance,
4. Multisector partnerships,
5. Priority focus areas,
6. Data and measurement, and
7. Financing and sustainability.

ACHs are founded on the idea that there is a shared responsibility for the health of a community or population across health sectors. Their focus is on aligning clinical and community-based organizations, and they offer an integrated approach to the preventive health, traditional health care, and social services needed by individuals and communities to achieve better population health outcomes, reduce costs, reach a higher quality of care, and achieve equity.

Technical Assistance and Support

Through its five-step Innovation-to-Action Cycle, GHPC TA offered crucial support as the collaborative developed its innovative funding mechanism (see Table 10.1).

Table 10.1. The Inland Empire's Innovation Cycle

STEPS	ACTIVITIES	TA SUPPORT PROVIDED	OUTCOMES
Empathy and Mindset	<ul style="list-style-type: none"> Received buy-in from both county leadership and the area's largest insurer (IEHP) Decided that the stewardship and financing modules should be completed hand in hand 	<ul style="list-style-type: none"> Delivered the stewardship model that helped get the group in the correct organizational mindset 	<ul style="list-style-type: none"> Created workgroups to address the collaborative's various goals, which was extremely beneficial in dividing the effort into reasonable workloads
Define and Agree	<ul style="list-style-type: none"> Selected the intervention and the financing strategy Shared learning around financing mechanisms Uncovered work aligns with the HASC 	<ul style="list-style-type: none"> Used calls and facilitation at quarterly stakeholder meetings to help target the information and gather stakeholder input 	<ul style="list-style-type: none"> Selected an ACH fueled by a prosperity fund based on their learnings about various financing mechanisms
Ideate	<ul style="list-style-type: none"> Developed a clearer vision of the fiduciary and the ACH, and of how to refine the intervention Packaged an intervention and financing plan pitch to take to stakeholders 	<ul style="list-style-type: none"> Offered access to resources around strategic thinking Assisted in the development of an innovation agreement to garner stakeholder commitment 	<ul style="list-style-type: none"> Developed cost estimates for the intervention and integrator overhead Identified an ACH structure with a prosperity fund as the financing innovation

STEPS	ACTIVITIES	TA SUPPORT PROVIDED	OUTCOMES
Prototype	<ul style="list-style-type: none"> Developed the “pitch deck” – a presentation slide deck of the prototype – and presented it at the reverse site visit Committed, along with the two counties, to investing funds to get the integrator organization up and running during the pitch period Presented the pitch deck to Dignity Health 	<ul style="list-style-type: none"> The reverse site visit helped the core team identify areas that needed development prior to stress testing and also helped the team gain clarity on the difference between the intervention and the financing innovation The innovation work helped the team better understand the financing piece and how it could be structured 	<ul style="list-style-type: none"> Focused again on the distinction between the financing innovation and the intervention Engaged in work on what the governance, integrator, and fiscal agent would do as the scope began to formalize
Test and Implement	<ul style="list-style-type: none"> Invested in building the governance, fiduciary, and integrator simultaneously to ensure that they work together Presented the pitch deck to HASC, which led to a \$15,000 contribution from Loma Linda Hospital 	<ul style="list-style-type: none"> Offered an outside perspective when the group was stuck in the ACH design Offered key support during changes in leadership and organization Offered valuable insights during the stress-testing debrief 	<ul style="list-style-type: none"> The group is not ready to implement ACH as it adds overhead to what others might already be doing Decided to build prosperity fund using an existing foundation as the fiscal agent

Empathy and Mindset

Shifting mindsets to embrace stewardship, health equity, and systems thinking, as well as cultivating relationships and identifying community need.

At the very early stages of the collaborative, a large stakeholder meeting was held. In that meeting, the TA team led participants through a stewardship module presentation that helped to solidify the way in which the group would function as a larger collective body. Many of the stakeholders were drawn to the project because of its focus on innovative financing — but they were not well versed in it. Many stakeholders came from a traditional grant and categorical funding perspective; this made thinking about financing complex. The GHPC team offered coaching and examples of strategies developed in other communities to finance health initiatives as a springboard to conversations about what might be possible in the Inland Empire. The team also presented a module on stewardship that helped the group create a vision of what the collaborative would look like and understand how much commitment would be required to achieve that shared vision.

Because many of the stakeholders were initially drawn to the financing component, the group decided that both the stewardship and financing innovation should be developed simultaneously. To achieve this, it established several workgroups to address the various goals; this proved extremely beneficial in that it broke up the work into reasonable chunks and kept stakeholders engaged. The collaborative was also divided up into an executive steering committee and three workgroups — one each on finance, intervention, and policy.

Define and Agree

Building a shared vision of the Innovation-to-Action Cycle plan through an innovation agreement between partners.

The financing group led a shared learning process to examine various streams of financing, as well as what it would take to build an ACH. Through this process, the executive committee began to identify some of the barriers and challenges to financing that must be addressed in order to get the collaborative moving toward implementation. It also identified the required minimum investment for the group to get the initiative up and running.

To determine which population health challenge would be the focus of the first intervention, the steering committee reviewed all data available to both county public health departments. It identified several large health disparities in the region — including obesity and diabetes — and took the information to the larger stakeholder meeting for feedback. The GHPC TA team helped lead the discussion with the stakeholder group around the social determinants of health, stewardship, and the region's health disparities. The stakeholders chose diabetes as the focus.

Ideate

Generating ideas that fit the sweet spot of a high-leverage strategy — the intersection of a community's needs, funding opportunities, and evidence-based strategies.

A Bridging for Health conference midway through the initiative's second year served to cross-pollinate ideas among the various Bridging for Health sites. This led the Inland Empire team to explore similarities between what it hoped to accomplish and what was happening in the Michigan Health Improvement Alliance project. Taking real-world examples back to the steering committee helped the collaborative maintain momentum and morale, as well as generate new conversations about the Inland Empire project.

To fund the ACH and build an innovative financing model, the Inland Empire Bridging for Health collaborative decided to start with the national Diabetes Prevention Program (DPP), which is reimbursable by Medicaid. It also aligns with a program developed in San Bernardino County called Know Your Numbers, which uses a community health worker model to screen participants and walk them through test results. Through this screening, participants with body mass index and A1c values eligible for participation in DPP are identified. To finance the DPP intervention, the collaborative approached investors to chip in to the collective pot of blended and braided funds.

Prototype

Pitching a draft of the chosen idea to gain feedback from stakeholders.

Following the second reverse site visit, GHPC facilitated a call with Dignity Health, which has a community investment arm and a hospital in the Inland Empire. The call focused on the "pitch deck" — a presentation slide deck of the prototype — that the collaborative had created based on feedback during the second reverse site visit. The call was very influential; the Dignity Health representative had

some technical critiques of the pitch deck that the group was not expecting to hear — such as asking about the ROI and how the project differed from one that was currently underway at a local Dignity Health hospital. This feedback challenged some of the group’s forward momentum, forcing it to address other aspects and issues in order to achieve its vision.

Test and Implement

Using the philosophy of “investing a little to learn a lot,” sites test a small-scale version of the innovation to prove or disprove key assumptions.

To implement the innovation, the team planned to use the ACH to build out a robust structure to house and govern the blended and braided dollars. This would include:

- A fiscal intermediary to house the Prosperity Fund,
- An integrator organization to implement the work and manage the day-to-day activities, and
- A governance board to lead the collaborative’s strategic mission and provide governance and approval for fund disbursement.

The blended and braided dollars would come from grants; contributions from local investors, health plans, health care organizations, and local health departments; and from reimbursable interventions such as DPP. Table 10.2 summarizes the status of the model and its funding approach.

Table 10.2. The Inland Empire’s Prosperity Fund Model

	CURRENT STATUS	NEXT STEPS
Funding sources	Several funders are potentially onboard: two county health departments, Loma Linda University, and potentially other hospitals via the HASC.	The group is currently in a reframing process but will be looking for more private- and financial-sector partners in the future.
Uses of funds	The DPP was never fully funded and, given the group’s current status, it may choose to go in another direction.	The group is currently in a reframing process, which could lead to a very different direction in terms of projects in the near future.
Fund administration	The Riverside Community Health Foundation has initially agreed to house the fund.	The ultimate goal for the structure is to have a fund housed within a fiscal agent and a governing board to help guide the project. To achieve this, the group will need to resecure a fiscal agent and find a new organization willing to take on the integrator role.

Outcomes

In summer 2018, IEHP lost its internal Bridging for Health champion, and the priorities of the remaining administrators were not aligned with the project’s direction. As the project drew to a close

in fall 2018, leaders within the county health departments were poised to step up — one to move the financing forward and one to focus on further developing the diabetes program.

Lessons Learned

Challenges in this type of work are always expected; following are some of the lessons learned in addressing both expected and unexpected issues.

Names matter. Several of the committee members have organizational-level experience with managing funding streams, which helped us understand that even the name of a fund may have legal ramifications. For example, calling a fund a “wellness trust” versus a “wellness fund” entails different regulations around how the dollars can flow in and out. Thus, based on the ACH model and the desire to focus beyond health over time, the Inland Empire collaborative landed on the label “Prosperity Fund” and the decision to house it within a fiduciary organization.

Caution can hinder progress. Deciding on the level of detail during the design process proved challenging. The Inland Empire collaborative faced a constant push-pull between setting up structures based on granular-level decisions and simply starting something and iterating as the process grew and changed. This push-pull greatly affected the group’s speed, and periods of overanalyzing details and erring on the side of caution sometimes hindered progress. Much of the problem resided in a knowledge gap around financing legalities and regulations. The risk-averse nature of the public service and nonprofit sectors (where most stakeholders were from) also made it difficult to get buy-in to “just try something” and then course-correct as the process unfolded.

Leadership changes are inevitable. PBH, which was managing the project and was in line to take the role of integrator organization for the larger governance structure, opted out of the latter role in summer 2018. This considerably shifted momentum, as the collaborative had chosen PBH for its deep knowledge base. Further, the organization’s deputy director, who was the project management lead for the collaborative, left PBH in July 2018. The Inland Empire collaborative therefore had to onboard a new person and divide up the tasks. This leadership change reaffirmed the fact that dedicated project management is essential to maintaining project momentum and focus. Then, in August 2018, the director of health administration at IEHP left the organization. At that point, two county leaders reaffirmed their commitment to the project, as did several other stakeholders, helping to stabilize the situation.

Capitalize on stakeholder knowledge. The unexpected, organic development of a hospital workgroup as a source of constructive feedback during pitch-deck development led to better pitches. This was a huge morale boost for the collaborative and spoke volumes about the amount of work invested in the pitch deck.

Big change is challenging. As this project shows, cross-county collaboration and systems-level change is challenging, both in terms of funding streams and program delivery. The Inland Empire is a large, diverse area working with limited funding streams, yet the idea of creating a prosperity fund made cross-county coordinated services a goal that is both worthy and achievable. Further, the shared learning that occurred during the project strengthened the community, and the Inland Empire collaborative members’ deeper knowledge of financing outside of the traditional systems will only spark more ideas and possibilities for the future.

Looking Ahead

IEHP's role in the project is now changed, from one of leader and hub of the project to being one among many stakeholders at the table. The collaborative is now searching for a new lead organization. The University of California Riverside's Center for Social Innovation is a possible fit for this position and has expressed interest in taking on the role. To facilitate this transition, the collaborative may engage a regional expert in collective impact to assist with a hard reset, building on the information and partnerships established thus far.

In addition to the contributions from the initial presentation of the pitch deck, plans are in motion to identify a structure to house the Prosperity Fund and to find an organization to assume the role of integrator following PBH's decision to leave that role. We are currently identifying and evaluating other organizations to take on the integrator role and assessing their capacity and willingness to do so. In the interim, the group is continuing to present the pitch deck to different stakeholders and expanding the collaborative's partnerships.

Building on these partnerships could serve as a basis for further exploration around innovative financing in the future. The concept of investing in ROI models is of great interest to many of the partners at the table; the challenge is in measuring and calculating the return. A strong jumping-off point has been established for those conversations and partnerships.

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CHAPTER

11

REGIONAL HEALTH & WELL-BEING FUND: MIDCENTRAL MICHIGAN

Alison Arnold

Founded in 2007, the Michigan Health Improvement Alliance (MiHIA; pronounced ma-high-ah) is a formal multistakeholder collaboration pursuing a vision “to achieve a community of health excellence” for a 14-county region in midcentral Michigan. MiHIA’s work varies, but its primary aim and all initiatives are focused on the “Quadruple Aim,”⁹ which targets health factors defined into four broad areas at the regional level:

- Population health,
- Quality of care and patient experience,
- Cost of care, and
- Health care providers’ well-being.

MiHIA seeks long-term sustainability in how it designs its programs and initiatives, which focus on improving these four facets of health outcomes. At the individual level, this translates into good or better health, high-quality care, and good value. To fulfill its vision and mission, MiHIA serves as the regional hub for:

- Sharing health information,
- Implementing sustainable, evidence-based practices focused on system change, and
- Setting the stage for learning and collaboration among multiple sectors.

By producing a call to action across organizations, MiHIA can position the region to become a national leader and a model for health that leads to positive impact.

In summer 2017, MiHIA was selected by GHPC as one of seven Bridging for Health sites, providing a valuable opportunity to expand MiHIA’s knowledge and capacities for addressing upstream drivers of health through the development of innovative strategies and financing mechanisms. Through this work, MiHIA learned from national thought leaders, further leveraged its own collective impact model to produce sustained system improvements, and developed a better understanding of which action agendas will produce the greatest impact on health outcomes.

The funding mechanism MiHIA chose to create and implement is a Regional Health & Well-Being Fund. MiHIA convened a steering team composed of representatives from a broad base of sectors to guide the Bridging for Health work. The steering team worked with GHPC to develop the concept and implement the fund through a phased approach, building investments across stakeholders

and funding streams that will help expand a preventive care portfolio over time, allowing the region to better address gaps and needs. MiHIA also chose to innovate and expand one of its existing successful initiatives, the Diabetes Prevention Program (DPP), as the initial intervention strategy. It plans to develop and implement a Virtual DPP option to expand regional access to residents in MiHIA's 14-county service area with a focus on rural communities and the 19- to 26-year-old age group.

Over an 18-month period, MiHIA's steering team participated in monthly peer learning and TA calls. Members of the team included the health officer at the Bay County Health Department, the dean of the College of Health Professions at Central Michigan University, the director of the Interdisciplinary Center for Community Health & Wellness at Central Michigan University, the trustee and treasurer at the Charles J. Strosacker Foundation, the MiHIA board chair, the DPP coordinator at MiHIA, and MiHIA's chief executive officer.

The totality of MiHIA's engagement in the Bridging for Health national pilot has not only informed this single funding innovation and intervention strategy, but has also propelled other significant multisector collaborations for improving health and the economy. Knowledge gains and useful tools from MiHIA's Bridging for Health efforts will help create a comprehensive financing strategy that will support a broad portfolio of interventions and lead to transformational change in the region.

MiHIA: Context, Challenges, Opportunities

The 14-county region served by MiHIA includes urban and rural populations across multiple jurisdictions that are served through a diverse continuum of health care resources. Additionally, the region is supported by four large health systems, robust federal qualified health clinics, a medical school, multiple physician residency training programs, and many health professions and community-based programs. Yet even with these many regional strengths, partnerships, and assets, data continues to indicate gaps in access and health outcomes.

MiHIA at a Glance

Region: 14 counties in Central Michigan

Population: 760,000

Collaborative: Health systems, universities, public and behavioral health agencies, nonprofits, foundations, employers, community volunteers, economic development organizations, and payers/insurers.

Overall goal: Align diverse stakeholders and target their investments into upstream initiatives focused on chronic disease prevention that will improve population health outcomes in the region.

Innovation solution: The funding mechanism MiHIA chose to implement is a Health & Well-Being Fund, which is a funding pool raised and set aside specifically to support prevention and wellness interventions that improve health outcomes. The fund will bring together multiple streams of investment funding from community foundations, public health departments, employer health plans, regional health plans, hospital employee benefit programs, and community benefit dollars. The fund may include capturing savings from interventions to reinvest in other evidence-based interventions.

Target "upstream" strategy: MiHIA will expand one of its successful prevention programs, a widely received, evidence-based Diabetes Prevention Program (DPP) and increase capacity to bring that program to currently unserved age groups and geographies by deploying a virtual delivery model aimed at enhancing engagement in diabetes education and prevention. Virtual DPP delivery will remove barriers to access and let residents in rural areas more easily participate in the program.

Key Challenges

Compared to both state and national levels, the 14 MiHIA counties have higher rates of diabetes, obesity, unemployment, poverty, and food assistance; they also have lower per capita income levels and access to health care. Further, the region has skyrocketing rates of preventable, chronic illnesses, is battling epidemics in opioid use, has systemic problems with access and delivery of mental health care services and treatment, and is increasingly experiencing deteriorating health outcomes and preventable mortality, especially among the most vulnerable underserved communities. The magnitude of these challenges demands engagement of all forces, as well as a regional view and approach to innovation.

Based on a recent regional health needs assessment, MiHIA identified chronic disease as a problem area to be addressed. The rates of diabetes, hypertension, and heart disease within the region are higher than both the state and national averages. Indeed, based on recent data, one in three residents in the MiHIA region are likely prediabetic, yet the Behavioral Risk Factor Surveillance System found that only 10 percent have been told by a provider that they are prediabetic. Similarly, a survey by MiHIA found multiple gaps in diabetes prevention within the region, including limited access to prediabetes programs or prevention programs in some communities, if such programs are available at all.

Opportunities

In 2016-17, regional leaders used local funding and a donation from the Fannie E. Ripple Foundation to engage ReThink Health to facilitate stakeholder engagement as part of a two-year strategic planning process. The goal was to develop a regional master plan consisting of a portfolio of high-leverage interventions that will transform health and the regional economy. As an outgrowth of this endeavor, a broad-based regional initiative was formed. Transforming Health Regionally in a Vibrant Economy (THRIVE) is a collaborative effort that recognizes that a population's good health and a robust economy are intertwined.¹⁰

Community leaders are determined to both improve the general health of the region's population and to deliver sustained economic growth. This expansive cross-sector collaboration has gained the active attention of the U.S. surgeon general and other national thought leaders. THRIVE is the partnership of MiHIA and the Great Lakes Bay Region Alliance (GLBRA). MiHIA specializes in working to improve the health of the region's population, while GLBRA works to enhance the area to make it a magnet for new businesses and for people to both stay in and relocate to the region.

In 2017, during the first year of THRIVE, MiHIA and GLBRA engaged 80-plus local stakeholders through group and individual interviews, and conducted mapping sessions to identify key levers or strategies to improve the regional ecosystem. The planning process compiled thousands of data points and deployed system modeling to ensure interventions were data-driven, impactful, and sustainable. THRIVE's regional priorities are as follows:

- Build health provider capacity,
- Facilitate preventive care, mental health and well-being
- Invest in the social determinants of health,
- Invest in regional attractiveness, with a focus on cost, quality, and access to care, and
- Create jobs.

These five priority areas led to the build out of the ALL THRIVE Portfolio of Interventions for community investment. ALL THRIVE will guide the region to produce high-value impact and benefit to citizens, regional health systems, and businesses. As the THRIVE strategic planning process evolved, MiHIA's leaders and staff interfaced with ReThink Health as the organization built a structure for stakeholder engagement and research.

As it was implementing the THRIVE initiative, MiHIA joined the Bridging for Health project; this created unique opportunities and challenges. Among the challenges were MiHIA's operational and staffing capacity to incorporate two major initiatives and TA support. However, integrating the two initiatives also yielded ripe opportunities, including:

- A rich transfer of learning about financing mechanisms derived from MiHIA's Bridging for Health initiative, and
- The identification of the region's readiness to build funding capacity to address a portfolio of health and economic priorities developed through THRIVE.

The Organization

MiHIA's board of directors is its primary authority and represents a broad spectrum of stakeholders, including hospital systems, independent providers, universities, public and mental health organizations, consumers, health plans, and employers. The board's 15-23 members oversee MiHIA's affairs and business, fully support its vision and mission, and are committed to its success.

MiHIA's board is responsible for ensuring progress on the organization's mission through the effective oversight of MiHIA's CEO, two full-time employees and several contractors, programming contracts, budget, and operations. MiHIA also has a variety of steering teams and working committees to address improvement in the Quadruple Aim. In addition, it has a long-standing Population Health Strategy Team with more than 65 multistakeholder/multisector members who represent all 14 counties. As an outgrowth of the Population Health Strategy Team, MiHIA recently formed the Regional Community Health Needs Assessment Project Team with the main objective to achieve the Regional Community Health Improvement Plan's goals and strategies.

Bridging for Health

In summer 2017, MiHIA engaged with GHPC as a Bridging for Health site. MiHIA's stated goal for Bridging for Health was to "foster alignment among diverse stakeholders and target their investments into upstream initiatives that will ultimately improve population health outcomes in its region." The steering committee worked with GHPC to establish a sustainable financing mechanism to achieve decreased rates of preventable health conditions, reduce costs, reduce health inequities, and create environments that support health and safety with the aim of improving population health in MiHIA's 14-county service region. Further, MiHIA recognized the need to harness regional capacity.

To deliver inclusive growth strategies and initiatives across jurisdictions and sectors, MiHIA would need to develop and pursue longer-term financing strategies for improved health regionally. MiHIA's financing innovation would need to involve and equip multisector partners to steward a long-term sustained focus on addressing chronic disease prevention.

In the initial phases of GHPC's TA, the MiHIA collaborative's self-assessment identified opportunities to improve MiHIA's stewardship mindset around the purposes, people, and structures that could sustain optimization of positive population health outcomes in the region. The assessment feedback revealed that MiHIA's track record of innovation included numerous high-impact initiatives. MiHIA's successful evidence-based DPP has demonstrated positive health impacts for individuals and the community and delivered value for employers, hospital systems, providers, and other stakeholders by reducing the duplication of efforts, increasing regional efficiencies, and leveraging total dollars to support health-related initiatives. The top three strategies initially identified for the Bridging for Health focus were to:

- Reduce the chronic disease burden,
- Take a systems approach to addressing regional opioids, and
- Forge systems improvements in mental health access and resources.

However, even with many established successes and targeted metrics, MiHIA's self-assessment revealed some challenges across the region where MiHIA's organization could offer cohesive support. Stakeholders who provided assessment feedback noted that regionally, some community needs were not being adequately addressed because stakeholder initiatives and strategies are not always comprehensive and evidence-based. The self-assessment also indicated that misaligned financing may be:

- Targeting needs without addressing the evidence basis for the intervention, or
- Disconnected completely from needs and strategy.

In MiHIA's initial site visit with GHPC, MiHIA's Bridging for Health team also discussed priority areas for interventions — the top two being to reduce the chronic disease burden and forge systems improvements in mental health access and resources.

The Innovation

The innovative funding mechanism that MiHIA chose is a Regional Health & Well-Being Fund. This fund will interweave multiple funding streams, including funding from area community foundations, public health department employee health plans, regional health plans, and hospital employee benefits programs and hospital community benefit dollars. Once fully implemented, the Health & Well-Being Fund will provide a funding pool for the region.

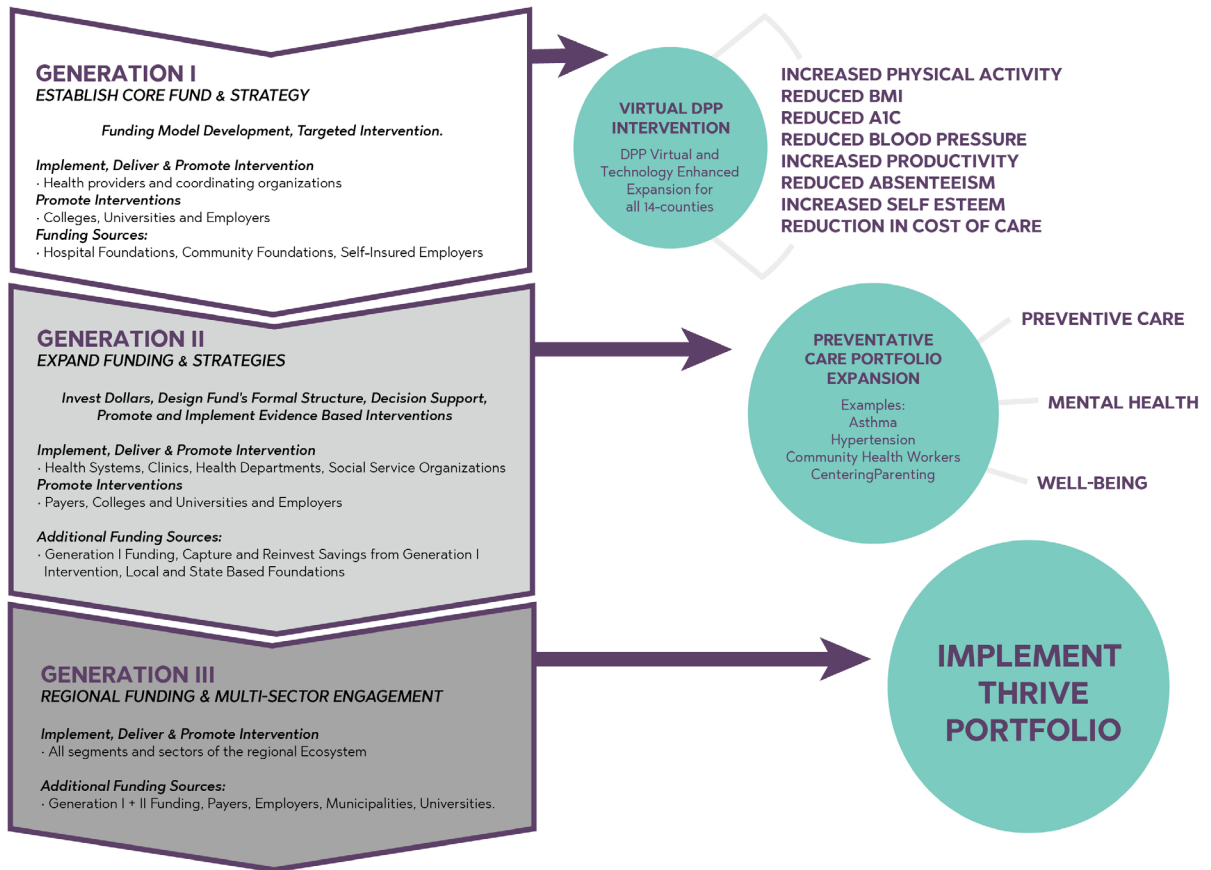
MiHIA will build and develop this fund in a three-phase process, with planned additions of funding investment sources and streams through 2020:

- The first generation of work established the core fund and its initial investments and implemented the Virtual DPP,
- The second generation will involve further investments from other sources, formalization of organization and operational structures, and expanded strategies of prevention intervention, and
- The third generation will attain broad multisector engagement and investments, combining strategies that address prevention and social drivers of health.

Building on each phase, the Regional Health & Well-Being Fund will develop investments across stakeholders and funding streams to expand a preventive care portfolio that addresses the region's

needs and priorities; it will be a key financing strategy within a comprehensive regional financing plan (see Figure 11.1).

Figure 11.1. The MiHIA Regional Health & Well-Being Concept Model and Phased Implementation



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The initial prevention strategy MiHIA chose to innovate expands on a successful, existing prevention intervention: a widely received evidence-based DPP initiative supported by 19 partners, including health systems, public health departments, employers, payers, and community-based organizations. The DPP initiative is currently delivered in five of MiHIA's 14 counties and has trained more than 30 lifestyle coaches. The program, now in its third year of implementation, increased its focus on sustainability and regional expansion in 2017. MiHIA has provided consultation to various employer organizations in — and beyond — the 14-county region. The program has already resulted in more than \$1 million in health care savings (estimate based on Medicare pilot data) and, as program participants remain free of a diabetes diagnosis, estimates predict \$3,286,400 in health plan savings annually.¹¹

MiHIA's Virtual DPP strategy gives underserved age groups (19- to 26-year-olds) and people living in rural geographies greater access to diabetes education and prevention support; it also offers

convenient access for people whose alternative work or family schedules make it difficult for them to attend in-person meetings.

The DPP program helps individuals make positive changes in their eating and exercise behavior. It is particularly effective for people with prediabetes who also have one or more other complicating medical conditions. Participants in Virtual DPP receive one-on-one support from their CDC-trained lifestyle coach, a clinician (such as a registered dietitian or certified diabetes educator), and other group members who support each other as they work on nutrition, physical activity, stress management, and weight loss. The sessions are offered as an online group video at set times; the sessions are also available as asynchronous online courses. Sessions are weekly for the first 16 weeks and gradually taper to monthly sessions in the last six months of the program year.

Technical Assistance and Support

Through its five-step Innovation-to-Action Cycle, GHPC TA offered crucial support as MiHIA developed its innovative funding mechanism (see Table 11.1). MiHIA joined the Bridging for Health initiative nearly a year into the national initiative's implementation. This resulted in a faster pace for MiHIA's project implementation and TA support. The compressed timeline for an 18-month project implementation — compared to the standard minimum of two years — required rapid learning on MiHIA's part and adjusted TA on the part of GHPC and the ability and agility of both MiHIA and GHPC to work through ambiguities. It also required MiHIA to learn to trust in the process that was already well underway across the Bridging for Health network.

Table 11.1. MiHIA's Innovation Cycle

STEPS	ACTIVITIES	TA SUPPORT PROVIDED	OUTCOMES
Empathy and Mindset; Define and Agree; and Ideate	<p>Conducted MiHIA self-assessment sharing and group reflection</p> <p>Learned about landscape of innovative funding mechanisms</p> <p>Visualized and clarified MiHIA's ideas:</p> <ul style="list-style-type: none"> • Creating value propositions for key stakeholders • Examining assumptions • Preparing initial elevator speech and outreach interviews to get feedback • Continued to learn about similar innovation models for the wellness trust and the Virtual DPP 	<ul style="list-style-type: none"> • Conducted initial site visit with stewardship and strategy modules, then a second visit with financing and innovation cycle workshops • Provided workbook modules, tools, and TA consults for exploring financing options and choosing domain and innovation ideas • Offered a structured process and pacing to help MiHIA's core team get into the work • Engaged in a thought partnership with MiHIA's core team to help with identification of knowledge • Provided stewardship, in-the-moment sense-making, and thoughtful connections of MiHIA with resources 	<ul style="list-style-type: none"> • Core team members reported their own broader understanding and new ideas about innovative funding mechanisms • Over time, team members noted how the work and team learnings were transferring into board conversations about financing opportunities moving away from securing grants to questions of how to create long-term, sustainable funding

STEPS	ACTIVITIES	TA SUPPORT PROVIDED	OUTCOMES
Prototype and Stress Testing	<ul style="list-style-type: none"> Created a concept model of MiHIA's prototype strategy and funding innovation Participated in the initial walkthrough, workshopping, and peer-review discussions at the reverse site visit Conducted exploratory interviews with prospective partners and investors to stress-test the prototype and get feedback Fine-tuned the prototype, concept model, and communications 	<ul style="list-style-type: none"> Held a reverse site visit workshop including pre- and post-TA consultations Facilitated connections so MiHIA could consult with experts 	<ul style="list-style-type: none"> Resequencing investment sources Increasing confidence among team members as vision becomes real Creating a structure for the Health & Well-Being Fund Finding increasing clarity regarding the alignment between the Health & Well-Being Fund and the ALL THRIVE portfolio

STEPS	ACTIVITIES	TA SUPPORT PROVIDED	OUTCOMES
Test and Implement (currently underway)	<ul style="list-style-type: none"> Engaging in tactical planning processes and shaping roles for fund development and outreach Setting up the Virtual DPP program with Good Measures (it is poised to go live once funding is secured) Continuing to refine communications to articulate the unique value propositions for businesses and health plans 	<ul style="list-style-type: none"> Provided technical support to diversify funding sources (such as small and medium-sized businesses and health plans) 	<ul style="list-style-type: none"> Initiating broader outreach to local community foundation, including grant submissions, presentations, and tailored value propositions focused on specific foundation funding interests Beginning to tailor the concept to meet emergent and potential opportunities (such as transitioning the Public Health Department Employee Health Plan to the fund)

Empathy and Mindset

Shifting mindsets to embrace stewardship, health equity, and systems thinking, as well as cultivating relationships and identifying community need.

During the early phases of MiHIA's innovation cycle, sense-making steps were intertwined to cultivate the necessary mindsets that would serve as the underpinning for the project. MiHIA was forming its core leadership team, developing a shared understanding of the financing landscape, and generating ideas for its innovation project. GHPC's early TA support provided tools and facilitation for MiHIA to conduct a self-assessment.

This process activated stakeholders, engaged their perspectives, and provided shared learning and discussion opportunities for gaining a deeper understanding of innovative financing strategies in relation to the context, regional funding landscape, and MiHIA's role in serving the region. GHPC's TA team provided empathetic guidance that helped MiHIA team members reflect more deeply based on stakeholder input.

One MiHIA steering team member observed that coming from MiHIA's self-assessment through Bridging for Health, "We've seen real value and gained much more clarity about the work of MiHIA, as our organization matures, and the shared recognition that innovative financing was a weak spot for us that we want to shore up. Those of us involved have really captured a lot of learning so far." This early stewarding provided by GHPC strengthened MiHIA's work by providing both a process to follow and a thought partnership that brought in new knowledge regarding financing.

Define and Agree

Building a shared vision of the innovation-to-Action Cycle plan through an innovation agreement between partners.

Moving through the innovation cycle involved iterative communications processes with many team and TA interactions and discussions to distill ideas and form agreement on courses of action. Initially, the MiHIA core team worked through planning modules with TA guidance to identify stakeholders, examine assumptions about the regional financing landscape of opportunities, and consider how MiHIA's new knowledge about and insights into both financing and strategy concepts might provide potential value propositions for different stakeholder groups. Core team planning meetings were scheduled two to three weeks apart. GHPC stewarded the process and provided support for using tools.

Ideate

Generating ideas that fit the sweet spot of a high-leverage strategy — the intersection of a community's needs, funding opportunities, and evidence-based strategies.

Initial perceptions about financing innovations among MiHIA's team members began to change as a result of GHPC's site visits, financing workshops, and TA support; this laid a foundation for ideation. One team member observed a significant shift in MiHIA's view of the funding landscape:

In our conversations around project-based initiatives, we used to focus on how to go get grant dollars. Now we are really looking at the question of how do we create a long-term, sustainable mechanism for funding population health. I feel this paradigm shift is huge.

At this stage of the innovation cycle, GHPC's "in the moment sense-making" helped MiHIA's team:

- Consider and prioritize opportunities for pilot strategies and financing mechanisms, and
- Pragmatically think about the need to differentiate the concept development work for both financing and intervention strategies.

The structure and process that GHPC provided were very important; according to one MiHIA team member, "It's really essential that we are clear with our strategy before we can apply the funding mechanism. The TA support has been very methodical, taking piece-by-piece at a time so they do not overwhelm our group — just having us work on pieces as we build our concept."

The support provided by GHPC also facilitated continuous learning about innovation models, which in turn helped MiHIA shape its vision for the concept of a Regional Health & Well-Being Fund that would pilot a Virtual DPP intervention. GHPC's TA guidance to keep things focused and start small, and its thoughtful connecting of resources to inform MiHIA's work, were invaluable. This information helped MiHIA team members build clarity and confidence that their concept vision was possible. One MiHIA team member summed up the ideation work, which led to MiHIA's vision for a Health & Well-Being Fund for prevention care regionally:

When we got involved with the Bridging work, it encouraged us to open our minds to a lot of different funding avenues that maybe we hadn't explored. We tried not to bite off too much, and I think that's a good thing. Let's do something we know best, try to figure out how to fund it, and then that led to the discussion of what I think will eventually sell for us more broadly, which is just a prevention care portfolio.

MiHIA's core team members and board finance committee members were aware of the concept of the wellness trust fund based on work in Massachusetts. However, the Bridging for Health project offered the focus and opportunity to examine how such a financing option might be highly leveraged to address key priorities in MiHIA's region. GHPC financing workshops and resource connections with other wellness trust innovation models provided great insights. For MiHIA to put a vision into action, it was critical to learn from others who were doing the same work so they could understand that the result of this process was movement — from an initial view (prior to trying tools and practices) to new ideas. Moreover, it was crucial for MiHIA to examine lessons learned from others further along in implementing wellness or prevention trusts. *What were the lessons? How did their plans work out?* MiHIA also explored ideas that emerged from actively thinking and reaching out about how best to engage Michigan's State Innovation Model initiative dollars.

Prototype

Pitching a draft of the chosen idea to gain feedback from stakeholders.

As the project moved into prototyping, MiHIA's questions and technical support needs shifted based on the core team's need to find working models and connect with expertise; doing both would help the team better understand the anatomical structure, operation, and governance of wellness and prevention funding mechanisms.

MiHIA's progress and prototype was strengthened through the stress-testing phase, which provided key stakeholder input for truly fine-tuning and ultimately forming the Regional Health & Well-Being Fund and Virtual DPP implementation. GHPC's TA support was especially crucial as MiHIA socialized and stress-tested its concept in conversations with regional community foundation leaders. MiHIA had targeted these funders as potential early investment partners who could help generate broader support for a health and well-being fund that would focus on prevention care (and affirm MiHIA's prototype strategy for expanding Virtual DPP regionally).

From these meetings, the team gleaned valuable feedback suggesting a resequencing of its initial investment sources. For its first-generation funding, MiHIA had targeted foundations and hospital community benefit dollar sources as key early investment opportunities. However, after closely listening to stakeholder feedback and reflecting on the context and dynamics in the foundation arena, MiHIA refined the fund's value proposition to address benefit opportunities for foundations, health plans, regional employers, and self-insured plans that focus on providing DPP benefits to workers. By investing in a resource that offers preventive care for their employees, for example, small and medium-sized businesses derive the value of healthier employees, increased productivity, and reduced absenteeism. As these examples show, MiHIA's team gained important insights during this stress-testing process that will help it further fine-tune the concept and various phases of fund implementation.

To help MiHIA design an architecture for its Regional Health & Well-Being Fund, GHPC helped connect MiHIA with the Pittsburgh Foundation, the Center for Community Investment, California Accountable Communities of Health Initiative (CACHI), and other experts to gain insights about constructing and operating a fund. However, both MiHIA and GHPC encountered limits in the ability to connect with specific expertise that could provide concrete templates for how to structure, govern, and operate a wellness fund. MiHIA's regional focus for building funding capacity was unique compared to other prevention trust funds, which were largely county-based or served a single jurisdiction.

Additionally, as MiHIA's THRIVE initiative progressed, it generated a portfolio of regional health strategic priorities that identified opportunities for prevention care investment that aligned with MiHIA's vision for the Regional Health & Well-Being Fund and its purposes. Moreover, the broad-based community engagement generated through the THRIVE initiative opened up conversations about the region's capacity and readiness for creating a comprehensive financing plan. MiHIA's prototype for a Regional Health & Well-Being Fund provided a viable and timely strategy option for funding some of the portfolio interventions proposed as the fund develops over time. So, while the overlap of Bridging for Health's TA support and the THRIVE initiatives provided capacity challenges (as mentioned earlier), this convergence of knowledge, rapid learning, simulation modeling, and stress-testing across both initiatives provided a flywheel effect that continues to inform and advance the work of improving the region's investment in population health priorities.

Test and Implement

Using the philosophy of "investing a little to learn a lot," sites test a small-scale version of the innovation to prove or disprove key assumptions.

As Table 11.2 shows, MiHIA is proactively securing commitments for generation 1 of the regional Health & Well-Being Fund. As of the first quarter of 2019, funds have been secured for an initial small-scale implementation of the Virtual DPP intervention, which is now fully developed through a partnership with Good Measures. Initial funding sources include a hospital system and the expressed commitments of local health plans. Investment commitments are being finalized — with a target to raise \$125,000 to expand Virtual DPP regionally — as MiHIA continues to pursue additional funding sources, including small to medium-sized businesses and health plans. By working with employers to offer a tailored Virtual DPP benefit for employees, MiHIA can enhance the value proposition to businesses with the potential to increase productivity, reduce absenteeism, and help workers overcome obstacles to healthy living.

Table 11.2. MiHIA's Health & Well-Being Fund as of January 2019 (Generation 1)

	CURRENT STATUS	NEXT STEPS
Funding sources	Generation 1 of MiHIA's Health & Wellbeing Fund is underway, with one funder confirmed, five pending, and two in initial vetting stages.	Active recruitment of contributors is underway, targeting health plans (public and private) and employers. Unique opportunities are also being identified and pursued through an accelerator project with GHPC.
Purpose of funds	Initial use of generation 1 investment funding will support the launch of a Virtual DPP regional intervention. To date, the Virtual DPP implementation is funded to 20 percent of its projected cost of implementation.	In the third generation of the fund, additional chronic disease and prevention interventions, aligned with a regional portfolio of funding priorities, will be added to expand the fund's scope.
Fund administration	An advisory board (a subcommittee of the MiHIA board of directors) oversees the work of the Health & Well-Being Fund. The advisory board provides fiduciary capacity with respect to a prevention-focused portfolio and is accountable to MiHIA's board for overseeing the investment of all assets distributed into the fund.	Funds are intended to be disbursed in full (or, in some instances, replenished by the funders when spent down) to support prevention interventions in the 14-county region. The advisory board will engage contributors and beneficiaries to establish and communicate purposes, procedures, and the progress of the fund-supported activities and will distributes periodic financial and programmatic reports, including recommendations for the allocation of funds.

Lessons Learned

The Bridging for Health process has increased knowledge and skills among MiHIA's team members, which in turn has helped them make iterative refinements and pivots in establishing the Health & Well-Being Fund.

MiHIA's team recognized its capacity and knowledge thresholds, especially in the context of simultaneously driving two significant, overlapping regional health initiatives. MiHIA greatly values the tools, TA, and cross-site and expert resource connections GHPC has provided.

MiHIA's learnings from the Bridging for Health Initiative are ongoing and include the following:

Regional perspectives for improving population health are a challenge but are key to cultivating long-term funding capacity. One Bridging team member summed up the essence of this challenge:

Out there in the community, there are certain projects and things we need to work on that transcend borders, whether it's a physical border, a county line, a city line, what have you.

They really need to be worked on as a whole. ... I think we have started to crystallize and get people focused around the kinds of issues that we can work on together through this fund. ... There are still a lot of parochial interests, “So what’s this going to do for my county?” ... Well you know, chronic disease still has no borders.

As an outgrowth of MiHIA’s iterative outreach and stress testing of the Health & Well-Being Fund concept, a range of expected and unexpected communication and perception challenges surfaced. Some challenges underscored the need for specificity and clear, targeted communications. The team also needed to tailor and refine the description of the fund’s benefits for different stakeholders. For example:

- Foundations needed to clearly understand that the fund was not a “trust” or an endowment,
- Community foundations want to know how their citizens and geographies will benefit,
- Funders want to know how their dollars will benefit their stakeholders, and
- Some communities may be resistant to engaging in regional approaches or to working with organizations that may not have a strictly local or county focus.

MiHIA has recognized learning opportunities for increasing resident engagement in local communities, focusing on equity and equipping people to use their power and privilege in a positive way. To address social drivers of health across the greater community, it will take both local and individual engagement — as well as a collective vision, imperative, and resources — to transform health regionally in a vibrant economy.

All of these examples underscore the importance of crafting a clear value proposition for the Regional Health & Well-Being Fund that both makes the case for improved health outcomes and aligns with the specific priorities of specific stakeholders. Moreover, lessons learned are important for looking ahead as MiHIA fulfills a leadership role in the development of a comprehensive regional financing plan.

TA capacity for translating prevention fund models into MiHIA’s context and regional funding landscape is limited. As the dynamic nature of MiHIA’s Bridging for Health work evolved within GHPC’s national pilot and MiHIA’s regional setting, both partners recognized that timing and context factors required tailored TA support. For instance, MiHIA’s team members wish they had invited more finance-minded stakeholders and experts to the table earlier to provide insights about specific sources and streams of funding. In retrospect, the team wondered if some project learning gaps might have been filled if MiHIA had participated in the first year of Bridging for Health, which would have included an earlier reverse site visit. The February 2018 reverse site visit was incredibly enlightening and helpful for MiHIA in making connections with other experts. As a result of these connections, MiHIA realized that a playbook for developing prevention funds does not yet exist. Accepting this general knowledge gap in the field was frustrating at first, but it eventually strengthened MiHIA’s resolve to pioneer its prototype concept, which incorporates facets of other models reshaped to suit MiHIA’s regional context.

Finally, as the overall Bridging for Health project wound down, MiHIA’s team members believed they may have benefited from a final GHPC site visit to facilitate additional mapping of funding streams in their particular funding landscape and context.

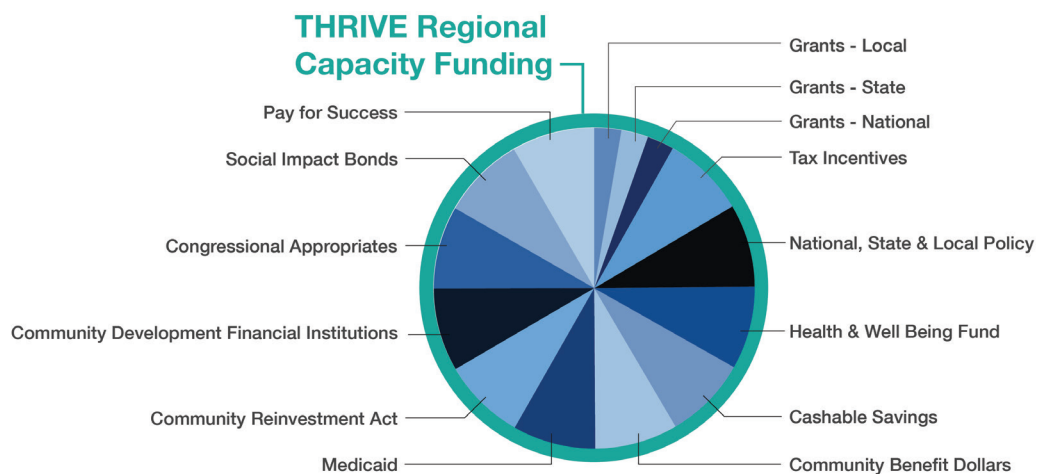
Looking Ahead

MiHIA plans to implement cycles of innovation and refinement to further cultivate and build on broad multisector engagement to fully maximize the Health & Well-Being Fund's potential benefits for the region. Many aspects of the Bridging for Health learnings and tool sets will support MiHIA's continued implementation of the fund and its integration with THRIVE; in this process, it has two goals in mind:

Optimize community investments and partnerships. MiHIA plans to continue expanding its working knowledge here in two key ways. First, it plans to focus on learning how to better utilize community investment dollars (such as by partnering with the banking community). Second, it needs to increase partnerships with business communities (such as chambers of commerce, business coalitions, and economic development corporations).

Share and transfer knowledge. MiHIA sees high value in continuing the partnership learnings to share progress, resolve barriers, and learn together with other communities (within the Bridging for Health network and beyond). There is currently no playbook for developing prevention funds. MiHIA's creation of a Health & Well-Being Fund will serve as a cornerstone piece and key driver of the region's future funding capacity. As MiHIA continues to build up investment in the fund, with a focus on prevention, the model will also serve as a key financing strategy within a comprehensive regional financing plan that is being developed through the THRIVE initiative (see Figure 11.2).

Figure 11.2. The Regional Comprehensive Financing Plan: Funding Capacity Opportunities for THRIVE

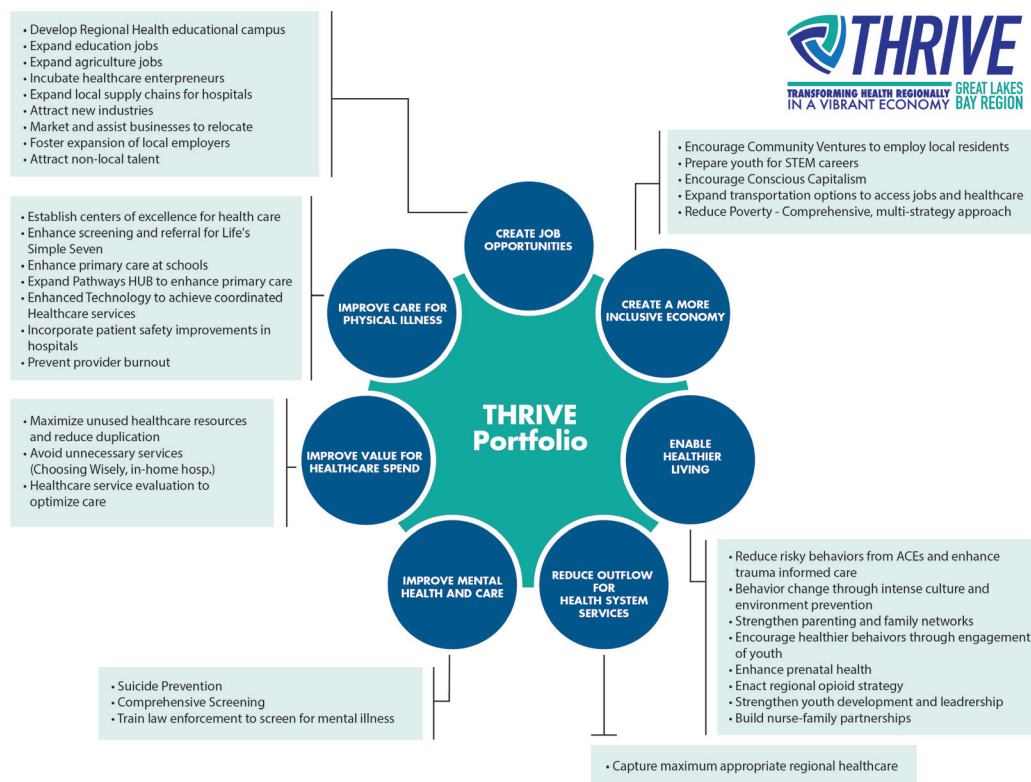


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Identified priorities in the ALL THRIVE Portfolio integrate 35 interventions into seven clusters of interrelated outcomes for improving regional health and the economy (see Figure 11.3). Clusters of potential projects to enable healthier living may involve preventive care focused on prenatal populations, asthma prevention, mental health, and reduction of illnesses caused from adverse childhood experiences, trauma, and toxic stress. THRIVE, the Health & Well-Being Fund, and other funding mechanisms will strategically align with projects in the regional community health needs

assessment (CHNA) and community health improvement plan (CHIP) for addressing chronic disease prevention.

Figure 11.3. ALL THRIVE Portfolio of Regional Health Priorities



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With an ever-changing population health context and a financial landscape from federal and state sources resulting in significant decreases in the size of grants and subsidies, MiHIA will need to continuously rethink and adjust the Health & Well-Being Fund based on how and where funding streams and sources flow. The region's ongoing THRIVE implementation work will need to fully consider the true cost of services beyond a fee-for-service world and evolve to become more innovative in financing/paying for health care.

It will be essential to develop a long-term inclusive strategy for the Health & Well-Being Fund that investigates and works to secure as many viable sources as possible throughout the fund's generations. This will also be important as the fund integrates into a comprehensive regional financing plan that will use all viable sources of community support and funding capacity to build out a sophisticated financing strategy.

As the Regional Health & Well-Being Fund grows, continued learning is needed to fill gaps related to various financing mechanisms. Further, MiHIA must develop operational processes for maintaining connections to the advisory panel and translating its members' experiences and expertise into

regional efforts. MiHIA has also identified several specific areas for growing the Health & Well-Being Fund:

- Use community reinvestment dollars (such as partnering with the banking community),
- Leverage state or federal appropriations,
- Support a collective community benefit approach with the four health systems, and
- Increase partnerships with the business communities (such as chambers of commerce, business coalitions, and economic development corporations).

Key learnings derived from MiHIA's involvement with Bridging for Health have continued to validate the need for regionalization of financing strategies to build long-term sustainable funding capacity to support population health.^{12, 13}

MiHIA is deeply grateful for the profound learning it has gained through its Bridging for Health partnership and the TA from GHPC. The opportunity to learn from and connect with other progressive communities has created synergies that will continue to propel transformative work in MiHIA's region for improving health outcomes and reducing the overall health care cost burden through sustained investment.

Acknowledgments

The following people and partnerships were essential to MiHIA's conceptualization and building of its Health & Well-Being Fund. Under the leadership and direction of MiHIA's board of directors, the following committee members dedicated their energies and spirit of collaboration, and aligned with the region's shared vision for transforming health in a vibrant economy: Beth Roszatycki, MBA, MiHIA chief executive officer; Catherine Baase M.D., MiHIA board chair; James Borin, MiHIA board of directors and treasurer; Thomas Masterson Jr., Ph.D., MiHIA board of directors and dean of The Herbert H. & Grace A. Dow College of Health Professions at Central Michigan University; Joel Strasz, M.P.A., MiHIA board of directors and health officer, Bay County Health Department; Beth Pomranky, B.S., MiHIA operations manager; and Alison Arnold, Ed.D., project evaluator and director, Central Michigan University Interdisciplinary Center for Community Health & Wellness. MiHIA wishes to acknowledge the following partners who contributed to these learnings and their integration with MiHIA-led initiatives: THRIVE Steering Team: ReThink Health, Fannie E. Ripple Foundation, and Michigan Health Endowment Fund.

PROSPERITY FUND: NORTHEAST KINGDOM, VERMONT

Kelly Hamshaw

Vermont's Northeast Kingdom (NEK) is a rural region of vast contrasts: while the bucolic landscapes are dotted with pastures, farms, and forests, many families and individuals struggle with the impacts of persistent poverty in their daily lives. Recognizing the complexity of addressing persistent poverty and the related negative health outcomes, a cross-sector group of nonprofit community organizations initiated the Caledonia–Southern Essex Accountable Health Community (CAHC) in 2014. Now known as NEK Prosper!, the organization's new name reflects both the region (the Northeast Kingdom) and the goal of creating a more prosperous community for all who call it home.

NEK Prosper! has a mission “to improve the health and well-being of the people in the Caledonia and southern Essex Counties by integrating our efforts and services with an emphasis on reducing poverty in our region.” It has eight members:

- The regional hospital,
- A local, federally qualified health center network and home health organization,
- A designated mental health service agency,
- An affordable housing provider,
- A community action organization,
- A council on aging,
- The regional United Way organization, and
- The statewide food bank.

In May 2017, NEK Prosper! officially became a Bridging for Health pilot site. Its goal was to create an innovative financial mechanism for generating sustainable funds for upstream interventions to address social determinants of population health. Although NEK Prosper! partners had already successfully secured grant dollars to support their collective impact efforts on the ground, they lacked sustainable, locally based funding sources to expand their collaborative efforts.

Working with GHPC TA providers, NEK Prosper! partners created the NEK Prosperity Fund to generate upstream funds for interventions. Previous initiatives focused on identifying the most vulnerable households in the community, such as female-led households with young children and households with grandparents raising grandchildren. Given this, as its first upstream strategy, NEK Prosper! chose to collaborate on an existing Northeast Kingdom Community Action agency

microbusiness development program that supports female entrepreneurs in launching or scaling up their businesses.

NEK Prosper! Context, Challenges, Opportunities

NEK Prosper! serves Caledonia County and the southern portion of Essex County — two of Vermont's most rural counties, which are home to an estimated 30,000 residents. The region reflects the Northeastern Vermont Regional Hospital (NVRH) service area, which includes 19 separate municipalities — almost all of which are home to fewer than 2,000 residents.¹⁴

Key Challenges

The most recent community health needs assessment report highlighted a variety of health trends in which the region falls behind the balance of the state. These areas include adults with a depressive disorder, suicide deaths, adults considered obese and overweight, and lack of physical activities for both adults and youth. The report also identified low-income families and older adults as the region's vulnerable populations.

Opportunities

NEK Prosper! members embrace the collective impact model as the foundation of their work to create a community that is financially secure, physically healthy, mentally healthy, well nourished, and well housed. A key attribute of collective impact is an understanding among participants that complex issues cannot be solved by individual organizations alone. Initiatives using this model thus bring together individual organizations from different sectors that commit to a common agenda for addressing a specific problem in ways that each individual organization is best positioned to undertake.¹⁵

In NEK Prosper!'s case, member organizations are dedicated to collaboratively addressing persistent poverty as a root cause of negative health and social outcomes. NEK Prosper! seeks to address these challenges and create a more prosperous and healthy future for the whole community by:

NEK Prosper! at a Glance

Region: Caledonia County and Southern Essex County of Vermont

Population: Approximately 30,000

Collaborative: The Leadership Team is composed of eight organizations: the regional hospital, the local federally qualified health center network and home health organization, the designated mental health service agency, the regional affordable housing provider, the regional community action organization, the regional council on aging, the regional United Way organization, and the statewide food bank. The hospital is the backbone organization; the local community bank, regional community development financial institution, and regional economic development agency joined the collaborative for the Bridging for Health initiative.

Overall goal: Improve community health and well-being through collective impact to ensure that the community is physically healthy, mentally healthy, well nourished, well housed, and financially secure.

Target "upstream" strategy: Invest in female entrepreneurs through the regional community action agency's microbusiness development program.

- Engaging in cross-sector collaborations,
- Using data to inform interventions and decisions, and
- Emphasizing the importance of listening to voices from the community.

Organizational Structure

NEK Prosper! was formed as an Accountable Health Community — that is, “an aspirational model where partners are accountable for the health and well-being of the entire population in its defined geographic area and not limited to a defined group of patients.”¹⁶ This structure requires member organizations to seek and support communitywide interventions that can address health and well-being disparities.

Figure 12.1 illustrates the organizational structure. Eight organizations constitute the Leadership Team, which operates as the decision-making body. To enable decision-making about program and resource alignment, each Leadership Team member has executive decision-making power at his or her home organization.

Figure 12.1. The Structure of NEK Prosper!



The larger NEK Prosper! collaborative has more than 40 member organizations representing diverse community interests such as education, human services, health care, transportation, food security, domestic violence, youth services, and arts and culture. NEK Prosper! meets monthly at the NVRH

to coordinate and collaborate on issues of shared interest. The team has heavily invested in building trust and developing an organizational culture that enables transformative change.

To promote positive change, NEK Prosper! created five collaborative action networks (CANs) in five key outcome areas: Well-Nourished, Well-Housed, Mentally Healthy, Physically Healthy, and Financially Secure. The CANs aim to enact small, place-based community interventions that address specific outcomes by engaging residents and front-line staff from member organizations. To fund these interventions, CANs have used grant dollars from various sources with matching funds from member organizations. Prior to its involvement in Bridging for Health, NEK Prosper! had no sustainable financing mechanism to implement upstream strategies beyond those funds.

Bridging for Health

In May 2017, two-and-a-half years after first forming its organizational structure using the collective impact model, NEK Prosper! was invited to join the Bridging for Health initiative. At that point, NEK Prosper! was ending a two-year grant with a family foundation to develop the five CANs, and it had made substantial investments in establishing shared processes, norms, and trust.

The timing of the invitation to join the Bridging for Health initiative was fortuitous as members were eager, if not impatient, to make tangible changes on the ground following the closing of the earlier grant, which was used to build the team's capacity. Two members of the NEK Prosper! Leadership Team were designated as "co-shepherds" of the Bridging for Health work to ensure an interface for the TA activities and local capacity for pushing the work forward.

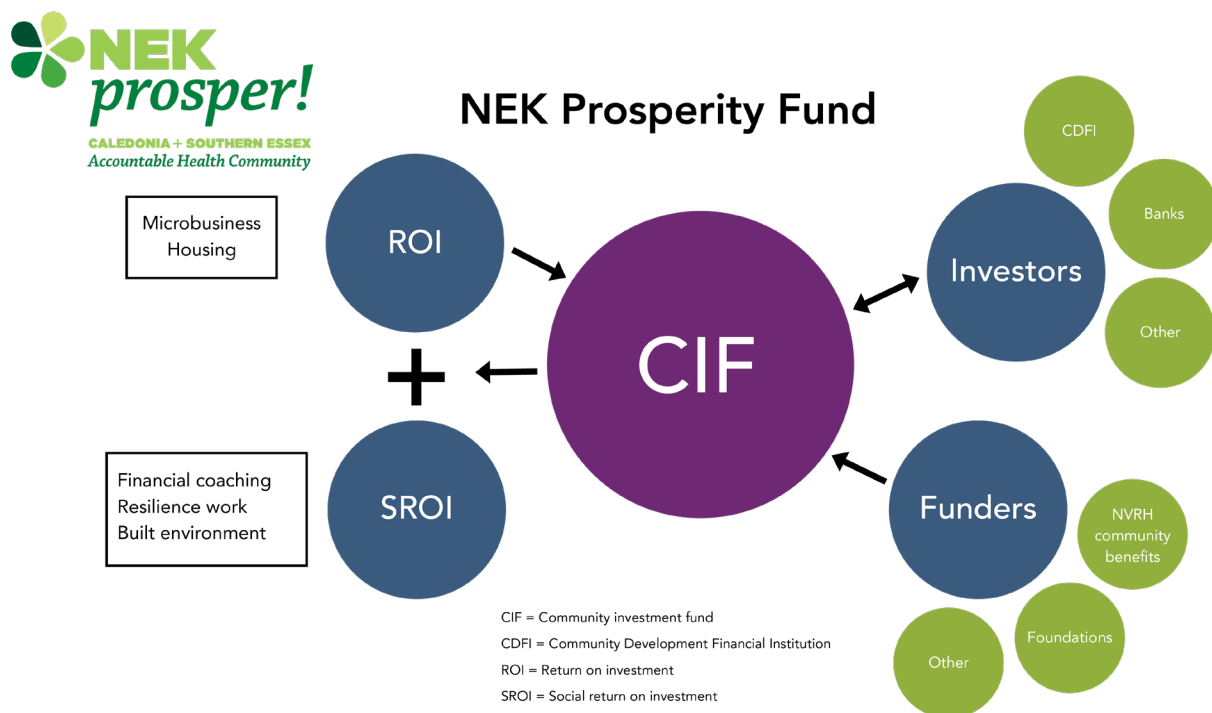
Many viewed the Bridging for Health work as a chance to delve into an action-oriented process that held the potential, if successful, to create a consistent, sustainable source of funding for NEK Prosper!'s work through the newly formed CANs. It also represented a strategic opportunity to engage local stakeholders from the economic development, financial, and business sectors that were not yet heavily involved in NEK Prosper! but had expressed support for its work to address social determinants of health.

The Innovation

With the support and structured process led by GHPC's TA providers, NEK Prosper! decided to create a community investment fund as its financial innovation. The NEK Prosperity Fund offers the CAHC a flexible, locally controlled mechanism for funding upstream interventions to address social determinants of health.

Figure 12.2 shows the NEK Prosperity Fund's conceptual framework. The fund is housed within the regional community development financial institution, Northern Counties Investment Corporation (NCIC). An NCIC staff member stewards the fund and the work with the advisory committee, which is comprised of three of NEK Prosper!'s Leadership Team representatives, the executive director of the local economic development agency, and a community member with small business experience. The committee's purpose is to review and provide recommendations on fund applications, reporting back to the NEK Prosper! Leadership Team.

Figure 12.2. The NEK Prosperity Fund's Conceptual Framework



As envisioned, the NEK Prosperity Fund is a mechanism that lets local banks, philanthropic organizations, member NEK Prosper! organizations, and others (including individuals) invest dollars to fund upstream strategies such as supporting entrepreneurship for lower-income households, affordable housing development, and resilience-informed systems. The NEK Prosperity Fund is designed to be flexible in terms of the dollars it awards to recipients, depending upon the type of request; it offers options for loan repayment, forbearance, or forgiveness if the recipients achieve key social return-on-investment criteria. The NEK Prosperity Fund's ultimate goal is to create a more prosperous region in which all community members have tangible improvements in their quality of life that in turn improve population health.

Technical Assistance and Support

Through its five-step Innovation-to-Action Cycle, GHPC TA offered crucial support as NEK Prosper! developed its innovative funding mechanism (see Table 12.1).

Table 12.1. The NEK Prosper! Innovation Cycle

STEPS	ACTIVITIES	TA SUPPORT PROVIDED	OUTCOMES
Empathy and Mindset	<ul style="list-style-type: none"> The Leadership Team embraced participating in Bridging for Health as a way to move to action It convened a roundtable to introduce the Bridging for Health initiative to a diverse range of local, regional, and state stakeholders, including financial institutions 	<ul style="list-style-type: none"> Introduced key concepts of the Bridging for Health initiative to the community Guided NEK Prosper! to invite economic development and financial stakeholders from the onset 	<ul style="list-style-type: none"> The roundtable highlighted strong interest and support for the work Financial and economic development stakeholders were engaged in the earliest conversations
Define and Agree	<ul style="list-style-type: none"> The collaborative established a small work team (Team Finance) that included three champions — one each from the local community bank, the regional community development financial institution, and the regional economic development agency It identified existing financial resources within the community 	<ul style="list-style-type: none"> Provided examples of communities engaged in similar work to help NEK Prosper! stakeholders understand the range of possibilities 	<ul style="list-style-type: none"> The collaborative identified a lack of financing opportunities for local entrepreneurs in the “higher-risk/higher-reward” category Three champions of this work emerged from the local community bank, the regional community development financial institution, and the regional economic development agency

STEPS	ACTIVITIES	TA SUPPORT PROVIDED	OUTCOMES
Ideate	<ul style="list-style-type: none"> Each collaborative action network was asked to generate a list of upstream strategies for consideration NEK Prosper! participated in a strategy-narrowing webinar to identify three strategies for deeper consideration Consensus was reached to build a community investment fund as the financing mechanism during a site visit with GHPC TA The regional community development financial institution offered to be the fund's administrative home and fiscal agent 	<ul style="list-style-type: none"> Facilitated the strategy-narrowing webinar to assist the NEK Prosper! team in thoughtfully selecting three upstream strategies to consider Facilitated a process during a site visit to help the NEK Prosper! Leadership Team determine the best match between an upstream strategy and financing mechanism 	<ul style="list-style-type: none"> NEK Prosper! selected a community investment fund as its financing mechanism and supported the regional community action agency's microbusiness program as the upstream strategy for the pilot initiative The regional community development financial institution became the administrative home and fiscal agent for the fund.

STEPS	ACTIVITIES	TA SUPPORT PROVIDED	OUTCOMES
Prototype	<ul style="list-style-type: none"> • A core team was designated to develop and participate in the presentation for the reverse site visit • Co-shepherds confirmed broader support for the community investment fund through conversations with community members and leaders • During the reverse site visit, the core team identified key assumptions and next steps for the stress-testing phase 	<ul style="list-style-type: none"> • Provided examples of other community investment funds as the core team investigated governance structures, the legal process, and funding sources • Facilitated the reverse site visit, which provided the core team with key action items to move forward • Hosted a cross-site call between NEK Prosper! and Yamhill to share experiences about innovative uses of Medicaid funds for upstream work 	<ul style="list-style-type: none"> • The collaborative developed a continued appreciation of the iterative nature of the innovation process • It found increased momentum and energy for moving the work forward • It also identified five key goals for the stress-test phase: <ul style="list-style-type: none"> ○ Develop a minimum viable product ○ Understand the supply side ○ Understand the demand side ○ Identify legal and regulatory requirements ○ Determine measures of success

STEPS	ACTIVITIES	TA SUPPORT PROVIDED	OUTCOMES
Test and Implement	<ul style="list-style-type: none"> • The collaborative hosted a focus group with local female entrepreneurs to understand the demand for financing • It used key assumptions to organize efforts to develop a structure and process for the pilot • It engaged in fundraising for the pilot effort of funding the microbusiness program • The NEK Prosperity Fund advisory committee was created to review applications • A dedicated staff member was designated to steward the fund at the regional community development financial institution 	<ul style="list-style-type: none"> • Offered ongoing monthly coaching and support to monitor progress during the stress-testing and implementation phases 	<ul style="list-style-type: none"> • The collaborative successfully raised funds for the initial pilot effort from the local community, bank, regional hospital, council on aging, regional United Way organization, statewide food bank, and community members • It developed key documents and processes for operating the fund • \$10,000 successfully flowed into the NCIC fund and the community action agency to fund four female-led enterprises • Strong partnerships developed between NEK Prosper! and its financing and economic development partners

Empathy and Mindset

Shifting mindsets to embrace stewardship, health equity, and systems thinking, as well as cultivating relationships and identifying community need.

With guidance from GHPC's TA, NEK Prosper! closely followed the innovation adoption cycle throughout the 15-month timeline. As described earlier, NEK Prosper! members laid the groundwork for collaboration prior to joining the Bridging for Health initiative. This enabled the team to quickly move through the Empathy and Mindset phase of identifying community needs, convening existing partners, and inviting key stakeholders from the financial and economic development sectors at the

very beginning of the work. The NEK Prosper! Leadership Team also identified trusted members to co-shepherd this work, serving as the primary interface between NEK Prosper! and GHPC.

Define and Agree

Building a shared vision of the innovation-to-action plan through an innovation agreement between partners.

Led by the co-shepherds, NEK Prosper! quickly began the Define and Agree phase. NEK Prosper! members were challenged to generate lists of viable ideas for upstream strategies and innovative financial mechanisms. Given the team's focus on addressing the social determinants of health, there were many ideas for potential upstream strategies, but it was initially more difficult to identify financial mechanisms that were truly innovative. However, the participation of financial and economic development stakeholders early in the process — beginning with the GHPC team's very first site visit — revealed a gap in the local/regional financing landscape for entrepreneurs through an assessment of the risk and reward spectrum.

Ideate

Generating ideas that fit the sweet spot of a high-leverage strategy — the intersection of a community's needs, funding opportunities, and evidence-based strategies.

The Ideate phase generated many ideas for NEK Prosper! to consider, and GHPC introduced the critical concept of having a pipeline of strategies for future work — beyond the pilot program — just as the group was feeling great pressure to meet key milestones on the Bridging for Health timeline. GHPC's assistance during the strategy-narrowing webinar and the second site visit in December 2017 resulted in the selection of the NEK Prosperity Fund as the financial innovation; as its upstream strategy, NEK Prosper! chose the regional community action agency's microbusiness program specifically to support female entrepreneurs. The December site visit further solidified team members' shared understanding that this project experience would give them new skills that they could apply after the grant ended to continue with further strategies and innovations.

Prototype

Pitching a draft of the chosen idea to gain feedback from stakeholders.

The team's preparation for the February 2018 reverse site visit marked the beginning of the Prototype phase. A smaller team of NEK Prosper! Leadership Team members, along with the local community bank president and the CEO of the regional community development financial institution, NCIC, further developed the NEK Prosperity Fund concept. The reverse site visit enabled the team to dive into the financing mechanism's details as the team embraced the purpose of the Prototype phase as building sufficient structure for the fund in order to move forward with the innovation process. One of the co-shepherds later reflected that the reverse site visit was an important experience that confirmed "our focus on embedding economic development and banking partners into the work from the very beginning as a major factor in our success and has allowed the team to hone our messaging on the financing mechanism."

Test and Implement

Using the philosophy of "investing a little to learn a lot," sites test a small-scale version of the innovation to prove or disprove key assumptions.

The team returned from the reverse site visit with a list of critical assumptions to test and a list of tasks to launch the Stress Test and Implement phase. The reverse site visit boosted the team's

confidence as it set out to create a minimum viable product, assess the demand for financing among local entrepreneurs, begin conversations with potential investors in the community, and determine potential metrics for gauging community impact.

NEK Prosper!’s vision for the NEK Prosperity Fund became clearer as it tested the critical assumptions, and key pieces began falling into place in the months following the reverse site visit. NCIC offered to serve as the administrative home and fiscal agent for the prosperity fund, as the fund aligns with the NCIC mission and fills a gap in the community’s financial landscape.

From June to December 2018, NEK Prosper! fully engaged in testing and implementing the innovation and the related strategy. GHPC TA liaisons encouraged the co-shepherds through monthly telephone calls; they also connected NEK Prosper! to valuable resources, including examples of other community investment funds’ governance documents.

NEK Prosper! designated an advisory committee that draws from its Leadership Team members, a representative from the local business community, and the executive director of the regional economic development authority. The president of Passumpsic Bank committed \$5,000 as an initial investment into testing the NEK Prosperity Fund. Another \$5,000 was sought to match the bank’s commitment and enable a \$10,000 investment in supporting four women-led businesses in the community action agency’s microbusiness program. This amount was exceeded in a limited solicitation; five organizations and six private individuals invested an additional total of \$8,500 in the fund. Table 12.2 shows the status and next steps for the NEK Prosperity Fund.

Table 12.2. The NEK Prosperity Fund

	CURRENT STATUS	NEXT STEPS
Funding sources	<ul style="list-style-type: none"> The local community bank, the regional hospital, a federally qualified health center, regional United Way, council on aging, statewide food bank, and private individuals in the community 	<ul style="list-style-type: none"> Investigate other potential investors, including local residents, businesses, and organizations Explore potential for funding from the Medicaid Transformation Project
Purpose of fund	<ul style="list-style-type: none"> Funding the launch or expansion of four female-led enterprises 	<ul style="list-style-type: none"> Continue to raise funds for investment in local enterprises Consider grant avenue for nonprofit organizations

	CURRENT STATUS	NEXT STEPS
Fund administration	<ul style="list-style-type: none"> • The NEK Prosper! Leadership Team is the primary governing body • The NEK's community development financial institution serves as the fiscal agent and administrative home • An advisory committee of NEK Prosper! members, the regional economic development agency, and a local business owner was formed to review fund applications 	<ul style="list-style-type: none"> • Formalize policies, procedures, and documentation • Develop and track metrics for assessing social ROI • Launch marketing and outreach efforts to connect with aspiring entrepreneurs • Cultivate and support potential fund applicants

Lessons Learned

This pilot initiative has already resulted in several important outcomes for the community. Perhaps most importantly, participating in the Bridging for Health initiative gave NEK Prosper! the opportunity to put ideas and energy into action with GHPC support. After years of investing in the groundwork of collective impact, this opportunity helped the team gain new knowledge in financing innovations, meaningfully engaging financial and economic development partners, and realizing tangible results.

The team members especially appreciated the focus on learning from the site's innovation process experiences rather than focusing solely on outcomes. This focus was refreshing and empowered the team as it progressed through the cycle. Additionally, several team members said that their experience with Bridging for Health has also benefited the Medicaid Transformation Project. NEK Prosper! members, led by the regional hospital and federally qualified health center organization, are working with Medicaid and the state's sole Accountable Care Organization to align the Accountable Care Organization and the Accountable Health Community models. They are specifically looking at alternative ways to attribute people based on where they live, regardless of their health insurance and where they receive their health care. Through the GHPC support and resources, the team has gained greater confidence in its ability to work on financial mechanisms, and it is now partnering with state agency officials to push ahead with bold changes on an aggressive timeline.

Valuable learning has occurred throughout the NEK Prosper! experience with the Bridging for Health initiative.

Prepare to learn. When team members started this work, they were concerned about their lack of familiarity with the language of the financial and economic development sector. The resources that GHPC provided boosted their knowledge and confidence, while also providing a platform to develop working relationships and a common language with stakeholders in this sector.

Anticipate changes in leadership. Leadership changes within the core group of agencies that constitute the NEK Prosper! Leadership Team occurred throughout the timeline. Fortunately, NEK Prosper! has cultivated a strong culture within the collaborative that enabled interim and newly installed leaders alike to contribute and commit to the initiative.

Combat inertia. As one team member described it, for NEK Prosper!, the greatest challenge is “combatting the tremendous inertia in the system as communities, local governments, organizations, and institutions try to address social determinants of health. It takes time to combat the institutional resistance to shifting how we serve the communities we’re in and addressing complex issues.” The support, structure, and encouragement offered by the Bridging for Health initiative helped the team accomplish ambitious goals on a relatively short timeline.

Build on established processes. The NEK Prosper! adoption of the collective impact approach in the years prior to engaging in the Bridging for Health initiative proved to be a valuable asset. Having established protocols for working together on the shared vision for a prosperous, healthy community helped the team to move forward quickly. The aggressive timeline focused the team on quickly moving from planning to action, thus addressing the strong NEK Prosper! desire to make tangible changes in the community.

Engage key partners. NEK Prosper! was very successful at engaging local financial and economic development partners at the start of the project and sustaining their involvement by choosing a strategy that maximized their role by aligning the community’s social and financial needs. NEK Prosper! members noted that the enthusiasm of the financial and economic development partners has been an influential factor in energizing other members and the larger community.

Nurture cooperation. The community’s collaborative, cooperative nature was an important enabling factor. Indeed, a key financial stakeholder conveyed that, “the hallmark of this project is the cooperative nature of the organizations and people involved. I’ve been around long enough to be able to see many projects start and few successes, and usually it’s because organizations are, if you will, selfishly trying to make their own accomplishments rather than work cooperatively to make a community impact.”

Looking Ahead

Participating in the Bridging for Health initiative empowered NEK Prosper! to make transformative changes to its organization and forge new community collaborations. From creating the new, community-friendly identity of NEK Prosper! (formerly the Caledonia–Southern Essex Accountable Health Community) to partnering with key financial and economic development stakeholders in the community, the organization made significant strides in creating a sustainable financial mechanism for achieving greater community health and opportunity across the region within a 15-month timeline. The leadership organizations’ sustained investment in the collective impact approach paid dividends throughout the Bridging for Health initiative, and NEK Prosper! will continue to reinforce its commitment to this approach.

Indeed, the NEK Prosperity Fund will continue well beyond the Bridging for Health initiative timeline. NCIC committed to be the fund’s fiscal agent and administrative home beyond the pilot phase, and planning is underway to attract investments from the community. NEK Prosper! leaders are also aware of the need to track and communicate outcomes from NEK Prosperity Fund investments. Sharing these stories is important not only for attracting greater investment in the fund, but also for changing the dominant narrative that the region offers little in the way of opportunities.

Finally, potential cross-pollination with the Medicaid Transformation Project could lead to even greater transformative changes and improvements in quality of life at a time when there is considerable unease about federal health care policy and funding. With strong partnerships and

cultivated excitement in the broader community, the NEK Prosperity Fund is well positioned to become a fixture of hope and opportunity for the whole region for years to come.

Acknowledgments

Reflecting the collaborative nature of NEK Prosper!’s collective impact approach to improving population health, many organizations and individuals contributed to the success of this pilot effort. The organizations that constitute NEK Prosper!’s Leadership Team fully embraced the opportunity to engage in this work: Northeastern Vermont Regional Hospital, Northeast Kingdom Community Action, Northeast Kingdom Council on Aging, Northeast Kingdom Human Services, Northern Counties Health Care, Rural Edge, Green Mountain United Way, and the Vermont Foodbank. Critical to this effort were the financial partners who served as champions of this work: Jon Freeman and Aaron Krone of Northern Community Investment Corp., Jim Kisch of the Passumpsic Bank, and David Snedeker of the Northeastern Vermont Development Association. Finally, Laural Ruggles and David Reynolds served as the dedicated, skillful co-shepherds of NEK Prosper!’s Bridging for Health work — convening key stakeholders, interfacing with GHPC TA staff, and moving this important work forward.

SPARTANBURG WELLVILLE EXCHANGE: SPARTANBURG, SOUTH CAROLINA

Kathleen Brady

While not every community has the necessary mix of leadership and courage to tackle its biggest, most bedeviling health issues, Spartanburg, S.C., is an exception. As one of the five winners of the 2014 national Way to Wellville challenge, issued by the Health Initiative Coordinating Council (HICcup), Spartanburg was recognized for being highly collaborative and data-informed around population health. As a Wellville community, Spartanburg embarked on a 10-year process to move the needle on health outcomes crucial to its physical, social, and economic well-being. HICcup committed to provide support through both TA and connections to other potential investors in the work.

A Core Team of partners — Spartanburg Regional Health System, the Mary Black Foundation, city government, and the University of South Carolina Upstate — coordinates Spartanburg's Way to Wellville, meeting every week, setting goals and priorities, monitoring outcomes, and engaging in continuous course correction. Although they have shifted somewhat since the outset, Spartanburg's Way to Wellville launched with five primary goals:

- Increase access to care for the uninsured,
- Promote health for the insured,
- Prevent obesity,
- Increase kindergarten readiness, and
- Improve community pride.

The primary challenge for the Core Team members is to remain deeply engaged in the work while also working their regular full-time jobs. Further, this work's inherent challenge — moving the needle on deeply entrenched population health problems — is also real. The team knew that to address this challenge, the work would have to focus on upstream drivers of health outcomes and would also have to engender highly innovative approaches to funding and programming. Over time, Spartanburg's Wellville became engaged in five primary activities:

- **The Hello Family intervention** promotes school readiness based on feasibility studies and follows a pay-for-success model. It includes multiple wraparound services for all babies born in Spartanburg City, as well as for their families.
- **Neighborhood listening campaigns** in six neighborhoods promote local leadership and address long-standing challenges.

- **Healthy Food and Active Living** initiatives map safe places to be active, ensuring access within a half-mile radius for each resident; they also map outlets for fresh food to ensure access within that same distance.
- Wellville Talks include videos and discussions on issues related to population health that are free and open to the community.
- The Wellville Exchange, which the team chose as the Bridging for Health intervention for small employers.

When Bridging for Health launched in 2015, Spartanburg's Way to Wellville was among the communities selected. Many small employers do not provide health insurance; moreover, having health insurance, in and of itself, does not predict positive health behaviors such as accessing care and prevention services, eating a healthy diet, exercising, or managing stress. Because small employers have fewer resources to invest in employee health programs, the Core Team targeted its innovation as a partnership with small employers in the community to deliver impactful programming at a low cost through innovative financing. The Wellville Exchange is the realization of this goal.

Wellville Exchange: Context, Challenges, Opportunities

Spartanburg County, population 294,229, is located in the upstate region of South Carolina. Like it did in many areas across the South, the decline of the textile industry brought with it high poverty, low educational attainment, and population health challenges that persist to this day. On the positive side, Spartanburg has reinvented itself, becoming a hub for advanced manufacturing and a home to internationally known companies such as BMW Manufacturing, Milliken and Co., and Michelin North America. In fact, Spartanburg is home to more per capita international investment than any place else in the country. It is also a college town, with seven institutions of higher learning. However, many Spartanburg residents have not experienced the positive impact of this economic and educational investment.

Wellville Exchange at a Glance

Region: The city of Spartanburg, with the goal of expanding throughout the county and potentially across the 10-county upstate region.

Population: The city of Spartanburg has approximately 37,000 residents. Spartanburg County has approximately 300,000 residents, and the Upstate region has approximately 1.5 million residents.

Collaborative: A Core Team of partners representing Spartanburg Regional Health System, the Mary Black Foundation, city government, and the University of South Carolina Upstate coordinates Spartanburg's Way to Wellville.

Overall goal: Provide access to comprehensive wellness services and primary care to employees of local small businesses through a model that is affordable to both employers and employees.

Innovation solution: The financing innovation supporting the Wellville Exchange has evolved to a 65 percent employer contribution and 35 percent employee contribution model, with many of the exchange services provided at low or no cost.

Target "upstream" strategy: The intent of the strategy — which was initially conceived as a co-op that became the final Wellville Exchange — was to improve health outcomes in a wide segment of Spartanburg's population: employees of small businesses.

Key Challenges

A 2010 public health needs assessment for Spartanburg County showed that it was one of the unhealthiest counties in one of the unhealthiest states in the country. Those data electrified the community, and partnerships were formed to identify the most pressing community health needs and to align resources to address them. Spartanburg's application to become a Wellville community grew out of this unique spirit of collaboration — a testament to the realization among community leaders and residents that population health in Spartanburg must improve.

As the Core Team recognizes, Spartanburg's health challenges developed over a long time, and it will take patience, determination, and focus to improve them. It will also take innovation, attention to upstream predictors, continuous evaluation and improvement, and collaboration among all sectors. There is no one "silver bullet" to improve a community's health. Resources are finite, and financing must be innovative to accomplish this work as traditional funding from local foundations and external grants is insufficient.

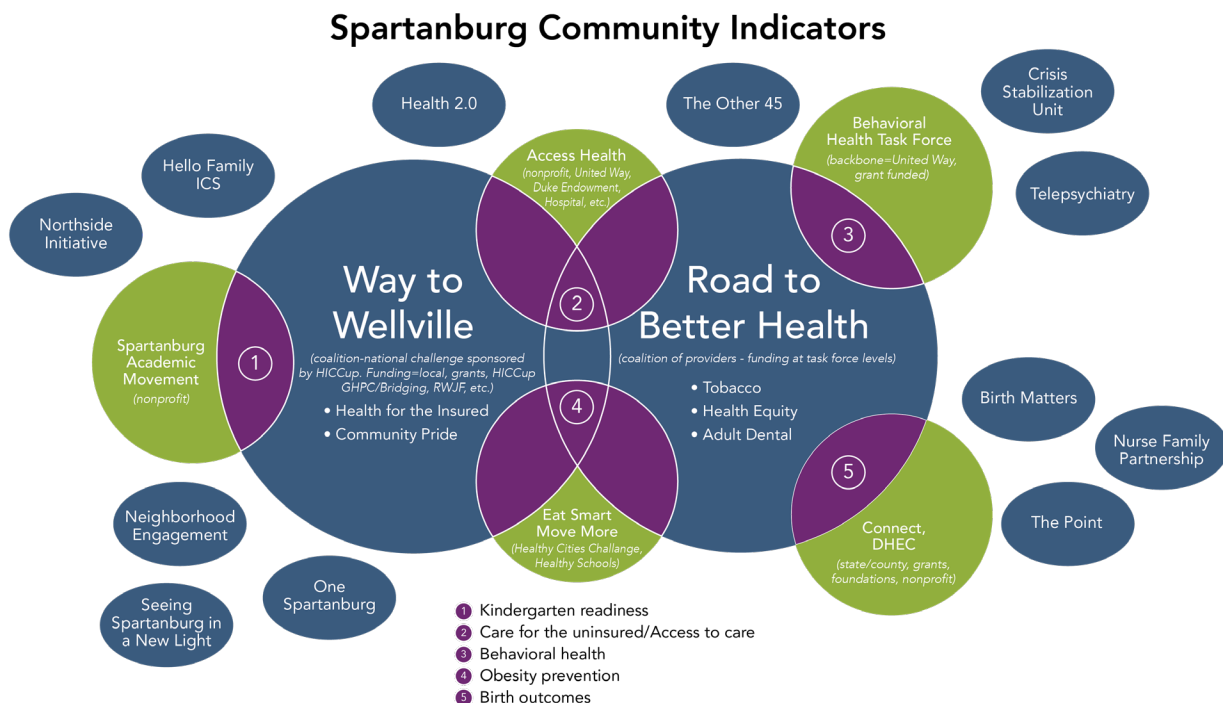
Opportunities

Although the population health work going on in Spartanburg is wide-ranging, none of it immediately focuses on the needs of the working insured or employees of small businesses — many of whom are, in fact, uninsured. Small employers report that comprehensive health and wellness plans are expensive; thus, they experience high employee turnover because larger companies can offer benefits that smaller businesses cannot afford. Further, even when employees have basic health insurance coverage, they frequently do not have access to employee assistance programs, stress management, behavioral health care services, financial well-being services, and other supports. The bottom line is that this is both an economic and a population health challenge for Spartanburg.

A significant portion of Spartanburg's workforce comprises workers employed by small companies. Clearly, if these individuals gain access to primary care, prevention services, and comprehensive well-being services that address their needs, the needle really will move on health outcomes in Spartanburg. And this is not only about health outcomes — the Chamber of Commerce is heavily invested in the Wellville Exchange as a support to small business and as an innovative way to keep Spartanburg's workforce healthy, lowering absenteeism rates and increasing "presenteeism" rates.

Spartanburg's Way to Wellville is a coalition of committed individuals from the local hospital system, a local health foundation, Spartanburg City administration, and the local university. These partners have met weekly since the beginning of Wellville in 2014. Other partners have participated periodically, including United Way of the Piedmont, the Spartanburg Housing Authority, and the Chamber of Commerce. Other partner organizations are also involved in Wellville committees that focus on each goal. Many community organizations and leaders play some role in the work of Wellville, as Figure 13.1 shows.

Figure 13.1. Community Involvement in Spartanburg's Way to Wellville



In addition to the Core Team, primary partners in this work include AccessHealth Spartanburg, Edward Via College of Osteopathic Medicine, United Way of the Piedmont, and Partners for Active Living. Further, national Wellville provides a coordinator dedicated to Spartanburg who is extremely engaged in all of the work. Finally, as described below, the Chamber of Commerce and the South Carolina Hospital Association Working Well program have been deeply involved in the Wellville Exchange design.

Bridging for Health

Through the Bridging for Health initiative, Spartanburg's Way to Wellville partnership with GHPC began in February 2015. The core Spartanburg team knew that innovative financing would be necessary to accomplish the long-term deep work underway; however, the partners knew little about financial innovations.

The initial goal was to learn about funding options that might work in Spartanburg, but the Core Team was soon committed to crafting one of the Wellville interventions around innovative funding while also fulfilling the original goal of improving health for the insured. As described below, after much study, the team decided to apply an innovative funding approach to an intervention for small employers and their employees. Ultimately, the team determined that a three-share funding model, along with blended and braided funding from philanthropists and grantors, offered a viable strategy.

The Innovation

The Wellville Exchange will follow a co-op model to bring in-demand services to small-business employers and employees. Services will focus on:

- Direct primary care,
- Employee assistance and financial wellness,
- Workplace wellness, and
- Education and connection to resources.

The Core Team and the employer partners understood from the outset that traditional co-op financing — that was also affordable to small employers — would be insufficient to develop the Wellville Exchange programming and to nurture the model to sustainability. GHPC and the Bridging for Health initiative helped the Core Team identify financing strategies tailored to local needs and conditions.

The Wellville Exchange will act as a health “catalyzing entity” for small employers in Spartanburg. The exchange’s programming particulars have morphed over time and continue to do so as models are investigated and feedback is obtained.

A physical location for the exchange will provide employees of participating companies access to primary care and telehealth services. These services will rely on partnerships with a local hospital system and/or a local concierge physician. Other services will include a “digital storefront” to connect individuals to care, a navigator, and a Wellbeing Academy offering programs to promote behavioral health, health education, financial health, stress management, and so on, possibly in partnership with the South Carolina Hospital Association’s Working Well program.

The Core Team conceptualized the Wellville Exchange through a collaboration with a working group of small employers; that group included manufacturing and distribution industries, a law firm, a church, a public relations company, and a counseling center. Technical support was provided by national Wellville (HICcup) advisors and the South Carolina Hospital Association’s Working Well staff. The Spartanburg Area Chamber of Commerce became involved in the work shortly before prototyping, and it now plays the lead role in designing the programming and the financing model and in recruiting employer participants. The Mary Black Foundation has provided financial support during the design phase, as has GHPC through Bridging for Health and the \$40,000 implementation funding.

The innovation was redesigned as a 65 percent employer contribution and 35 percent employee contribution model, with many exchange services provided at low or no cost. Initially, the Core Team designed based on a “well-being umbrella” financing innovation that assembled different forms of capital to constitute a three-share model in which costs would be borne by employers and employees and underwritten by philanthropic investment. The intent was to create nimble financing through diversified revenue streams. Seed capital for phases 1 and 2, primarily through the Mary Black Foundation and GHPC, funded a staff member to do the feasibility study and business plan, and to establish the Wellville Exchange within the Chamber of Commerce. Over time, it became clear that philanthropy was not a realistic source of support for the exchange, even in a three-share model.

The exchange programs address a need for comprehensive health interventions that small employers are unable to provide for their employees. In fact, some are unable to provide health insurance at all,

and this co-op model would allow them to do so. Upon full implementation, the Wellville Exchange will give individuals working for small employers access to:

- Primary prevention and treatment,
- Health information,
- Discounts and support for healthy behaviors, and
- Resources to promote behavioral and financial well-being.

In so doing, the exchange will give these small-business employees the same opportunities for maximum health available to employees of larger companies with more resources. Further, small employers will be able to maintain their workforce by providing comprehensive and affordable health services.

Team Roles and Employer Participation

Initially, several Core Team members — Mary Black Foundation, the city of Spartanburg, and the University of South Carolina Upstate — were involved in this project. As the project progressed, other people and organizations also became involved:

- National Wellville consultants connected the project with subject matter experts for programming,
- A working group of local small employers helped explore needs in programming and offered input on financing, and
- The Chamber of Commerce was asked to get involved and took the lead on prototyping; it then committed to lead the project and hire the coordinator.

With the exception of the national Wellville consultants, all relationships pre-existed this work. However, constructing the exchange altered relationships with the Chamber of Commerce; it is now in a direct business relationship with the Core Team.

Technical Assistance and Support

The birth of the Wellville Exchange closely followed the innovation and adoption cycle outlined by GHPC (see Table 13.1). Although some progress was natural — such as the evolution of the programmatic interventions through its small-employer working group — other progress was due directly to the GHPC process.

Table 13.1. The Wellville Exchange Innovation Cycle

STEPS	ACTIVITIES	TA SUPPORT PROVIDED	OUTCOMES
Empathy and Mindset	<ul style="list-style-type: none"> • Participated in initial reverse site visit • Held numerous discussions with Core Team and national Wellville • Partners and their organizations widely embraced and studied issues around equity to move the community forward 	GHPC modules and TA site visits and calls	<ul style="list-style-type: none"> • Team consensus that Bridging for Health is a good fit for Wellville • Committed to Health for the Insured as Bridging project
Define and Agree	<ul style="list-style-type: none"> • Recruited small-employer working group participants • Launched working group meetings • Completed financing and stewardship module • Identified local innovative financing projects • Engaged South Carolina Business Coalition on Health for capacity-building 	<ul style="list-style-type: none"> • GHPC modules and TA site visits and calls • National Wellville TA, including small group facilitation and connection to South Carolina Business Coalition on Health 	<ul style="list-style-type: none"> • Formal project proposal submitted to GHPC • Engaged and released South Carolina Business Coalition on Health • Booklet produced on local innovative financing projects for use in communications

STEPS	ACTIVITIES	TA SUPPORT PROVIDED	OUTCOMES
Ideate	<ul style="list-style-type: none"> • Participated in second reverse site visit • Engaged Working Well to assess needs and assist with intervention design • Conducted small-business well-being assessment • Completed health equity module • Completed innovative financing module 	<ul style="list-style-type: none"> • GHPC modules and TA site visits and calls • Working Well small-business employee wellness assessment 	<ul style="list-style-type: none"> • Team gained wider understanding of financing options • Small businesses brainstormed and prioritized exchange services
Prototype	<ul style="list-style-type: none"> • Drafted prototype • Presented prototype at final cross-site visit • Revised the first financing model • Ongoing refinement of financing model with assistance from national experts 	<ul style="list-style-type: none"> • HPC prototyping business consultant and prototyping worksheets • Opportunity to pitch to peer communities • Connection to financing experts 	<ul style="list-style-type: none"> • First draft of Wellville Exchange presented to the community, including services and financing models • Ongoing model refinement

STEPS	ACTIVITIES	TA SUPPORT PROVIDED	OUTCOMES
Test and Implement	<ul style="list-style-type: none"> • Hired coordinator • Interviewed small employers and employees to further determine needs • Designed program and services • Secured contracts with providers • Obtained sufficient pilot sample (n = 500) 	<ul style="list-style-type: none"> • Phase 2 grant from GHPC of \$40,000 to test and implement Wellville Exchange • Ongoing TA 	<ul style="list-style-type: none"> • Partners secured for medical, behavioral health, financial stability, and navigation services • A realistic funding model established • Moving to pilot in June 2019

Empathy and Mindset

Shifting mindsets to embrace stewardship, health equity, and systems thinking, as well as cultivating relationships and identifying community need.

As with most communities, Spartanburg tended to default to traditional funders when looking for support for programming to improve social and health outcomes. Initially, the Core Team anticipated looking to local foundations and nonprofits to fund the Wellville Exchange, supplementing their support with grants from national organizations. However, when the national Wellville team suggested looking at innovative funding opportunities through Bridging for Health, the team became energized around the idea.

Although Spartanburg was deeply engaged in population health work prior to Wellville and Bridging for Health, the Bridging team brought fresh ideas and concrete examples around stewardship, health equity, and systems thinking. They asked the team to compile examples of innovative financing that had already occurred in Spartanburg, combined them in a document, and used them as a reminder that innovative financing is possible, and had, in fact, already proven feasible in Spartanburg.

Discussions with the Bridging staff around health equity also prompted the Wellville team to embed equity as a pillar of its work. As a result, partner organizations began conversations around equity and produced a Racial Equity Index demonstrating extensive race-based inequities across seven domains, including health. These data provoked a significant response from Spartanburg City Council, which committed to becoming the first municipality in South Carolina to join the Government Alliance on Racial Equity (GARE), looking at all policies and systems through an equity lens.

This initial phase of the Bridging work continues to grow and to embed itself across sectors, opening eyes and changing mindsets throughout the community.

Define and Agree

Building a shared vision of the innovation to action plan through an innovation agreement between partners.

The Wellville Core Team did not have a relationship with the Spartanburg Area Chamber of Commerce prior to its involvement in the Wellville Exchange. In fact, the chamber had announced publicly on several occasions that population health was outside of its scope, and it had been vigilant in avoiding “mission creep.” However, with GHPC’s assistance and a focus on creating a business plan prior to prototyping, it became clear to the partners and the small-business working group that the Wellville Exchange would attract and maintain talent in Spartanburg County. The chamber was thus the ideal partner and needed to be at the table.

The addition of the chamber prompted the Core Team and small business representatives to focus on building a feasible intervention that focused on the primary needs of employers and employees. Possible services that appealed to the health and human services partners were questioned by the chamber and the business partners, and the chamber brought business and financial skills to the group, rounding out the business plan.

Discussions around the financing of the exchange and the programmatic offerings evolved over several meetings, with strategic guidance from the national Wellville team and Working Well consultants. The final prototype was constructed out of these discussions by a small group — the national Wellville consultant, the Working Well consultant, a Core Team member, and the chamber partner. Exchange offerings were prioritized around small-employer needs, and funding was prioritized around feasibility.

It was essential to the process and the outcome that the Core Team enlist assistance from:

- Working Well, which had subject matter experts in employer-based health interventions;
- The national Wellville team, which had expertise in facilitation; and
- The Chamber of Commerce, which had expertise in local business development.

The team learned to pivot quickly as ideas morphed and developed. For example, it became clear that the initial subject matter experts in employer-based health did not grasp the vision for the project; their contract was terminated in short course and Working Well was brought on. Also, it became clear early on that the three-share funding model was not feasible, so the team moved quickly to another financial model.

Ideate

Generating ideas that fit the sweet spot of a high-leverage strategy — the intersection of a community’s needs, funding opportunities, and evidence-based strategies.

The whole concept of Wellville is entrepreneurial and innovative; thus, the Core Team found the idea of financing innovations for the work comfortable and appealing, even though none of the members were well-versed in financing. GHPC not only showed the Core Team the financing models that were possible, but it also held a mirror up to the team, demonstrating that several innovative financing projects were already in place locally. The cross-site visits in Atlanta were extremely helpful as they provided the opportunity to meet and learn from experts in financing population health projects. Some projects were extremely bold, and some were small but scalable, but all provided some vision for what was possible in Spartanburg with the Wellville Exchange.

Now it has become routine for the Core Team to brainstorm financing innovations for other Wellville projects.

Prototype

Pitching a draft of the chosen idea to gain feedback from stakeholders.

Prior to the prototyping phase, the exchange's design process was characterized as "meandering." Many partners thought it was taking too long to unfold; however, in retrospect, the Core Team feels that the process unfolded organically and could not have been rushed. When GHPC brought in the business consultant to lead the prototyping phase, the pace picked up. Specific expectations were issued, and the process for fulfilling those expectations, along with sufficient and thoughtful guidance, was provided.

At that point, the team had completed the Bridging modules and began to complete the worksheets that led to the prototype. In December 2017, the small-business working group met for a half day and amassed all the information from the previous year, organized it, and prioritized it so it would be ready to prototype. The prototype would address four key factors:

1. Focus — the content of the exchange,
2. Fulfillment — defining the expected outcomes,
3. Funding — general as well as funding for sustainability and innovation, and
4. Framework — the agreements needed to make it happen.

The GHPC team visited Spartanburg in January to review the draft prototype and helped further refine it.

When the team presented the prototype at the cross-site visit in February 2018, teams from other communities and the subject matter experts challenged the feasibility of the three-share model for funding; there was broad consensus that a two-share model was more feasible, with employers and employees being the primary investors in the exchange. Further, it became clear that a person would have to be hired to lead the work after stress-testing through implementation. The team adjusted the financing plan to secure \$60,000 in seed money to hire a program coordinator housed within the Chamber of Commerce.

Test and Implement

Using the philosophy of "investing a little to learn a lot," sites test a small-scale version of the innovation to prove or disprove key assumptions.

The exchange was stress-tested in May 2018 at the Chamber of Commerce's annual meeting. There was almost unanimous consensus that the exchange would greatly benefit small employers and their employees, and that it would be a boon for economic development across the county. At that point, phase 1 commenced, with the chamber leading the process to finalize the financial model and the programming. This phase continued for the remainder of 2018, with the plan to move to full implementation with an initial cohort of 500 in early 2019 (see Table 13.2).

Table 13.2. Spartanburg's Wellville Exchange

	CURRENT STATUS	NEXT STEPS
Funding sources	There are currently four primary funders of the exchange: GHPC (\$40,000 grant through Bridging for Health for startup), the city of Spartanburg, the Spartanburg Area Chamber of Commerce (through the One Spartanburg initiative), and the Mary Black Foundation. Funding requests have been approved for phase 2 (feasibility study) and phase 3 (completion of business plan and go-live for a six-month pilot).	The Spartanburg Wellville Core Team and its stakeholders have agreed that the Spartanburg Area Chamber of Commerce will absorb the Wellville Exchange as one of its own programs and will roll it out with other talent-retention tools. The exchange will be funded via its own revenue stream. Recruitment of employers and 500 employees is underway for the initial pilot.
Purpose of funds	GHPC funds received for phase 2 of the project were used to pay for an external consultant to complete a feasibility study and provide recommendations on next steps as related to overall goals of Spartanburg Wellville. The funding provided a road map to expand the project from providing essential health benefits (initial strategy) to providing additional wraparound services in all five domains of well-being: financial, physical, social, career, and community.	There are no plans to fund additional projects at this time; however additional fundraising will be necessary to ensure sufficient startup capital is secured to allow for successful completion of the six-month pilot. Additional accelerator funding will ensure that the Wellville Exchange pushes toward a mid-2019 go-live pilot to provide services to 500 covered employees in Spartanburg County.
Fund administration	Fund management is currently overseen by both the Mary Black Foundation (the backbone of Spartanburg's Wellville) and the Spartanburg Area Chamber of Commerce.	If the project reaches all milestones and implements a go-live, all fund administration will be handled by the Spartanburg Area Chamber of Commerce.

Lessons Learned

The Wellville Exchange stakeholders — including Core Team representatives, national Wellville consultants, small employers, and the Chamber of Commerce — are unanimous in their appreciation for GHPC's TA. This assistance included many elements:

- Education on financing models,
- Connections to various resources and best practices,

- Site visits, which brought clarity to the process,
- TA calls for check-ins and course corrections,
- Introducing processes, such as the innovation cycle, which moved the work along, and
- Cross-site meetings.

From the outset, the Core Team members had a nebulous sense that there would be challenges in designing programs that met small employers' needs, as well as in financing the intervention; however, they had insufficient expertise to identify those potential challenges going in. Following are some of their lessons learned.

Seek outside help in choosing a financing model. The team had no idea how challenging it would be to design the financing model. Initially, a traditional co-op seemed like a viable solution, but research showed that it was a naïve approach. To address this challenge, the team:

- Involved small employers in identifying needs for programming,
- Brought in programming experts to help craft deliverables, and
- Looked to the Bridging for Health work for financing solutions.

All of this worked, although it did require a few pivots: the first set of consultants did not “get” the intent of the programming; the process required more work than anticipated, and the team had to hire a paid coordinator; and the Bridging work did not offer a single easy solution.

Sustainability is challenging. Generally, the funding challenges were more difficult than the team expected. The work required quick seed funding to hire the paid coordinator to take on more funding work, as well as many other tasks. Even now, additional funding challenges are emerging. The Core Team is looking to GHPC and its TA to keep the project on track and identify further funding options.

Small employers are enthusiastic partners. The team found that small employers were very eager for this intervention to help their employees, and they put a great deal of time and effort into providing feedback to the team over their two-year tenure as a working group.

Unexpected partnerships can change everything. The Spartanburg Area Chamber of Commerce became a significant advocate for this work, and it came to view employee health as integral to economic development — so much so that this project is now a “crown jewel” of the chamber's work. This experience taught the Core Team that unanticipated partners can be eager to do the work of health promotion in the community.

Innovative financing is difficult. The biggest surprise the team faced was the difficulty of innovative financing. Rather than a “negative,” the Core Team viewed this challenge as a wakeup call and a learning experience; going in, the team knew little about financing health interventions outside of the traditional models. Exploring approaches beyond those standard models required commitment, expert involvement, time, and a willingness to pivot.

The right innovation can change a community. Spartanburg's Way to Wellville now plays a significant role in the community. Indeed, it has become the go-to collective for bold, upstream impacts on community health — and, more recently, for working knowledge of innovative financing models. The Wellville Exchange has gained significant traction among small employers, and even some larger employers. Further, the Chamber of Commerce and other organizations whose missions are to advance the local economy view the Wellville Exchange as a potential economic engine for

Spartanburg. However, the project's most gratifying result will be when uninsured employees have access to care and all employees are able to access a wider scope of well-being interventions — that is, when the funding model has sufficient investors and is sustainable.

Looking Ahead

Process outputs for implementation are measured through the evaluation process — site timelines, end-of-meeting feedback, and other documentation. TA calls and evaluator meetings also serve this purpose. At this point, there are no implementation outcomes to measure; however, the expected outcome is a sustainable, affordable financing model that draws good participation by local small employers. Programmatic outcomes are relative to employee participation across program options, including preventive care, accessing educational and support programming, and accessing primary care. Upon full implementation, data will be kept and tracked for analysis.

The Wellville team expects the Wellville Exchange to offer more people access to care and to well-being opportunities. Employer participation in the exchange will reduce absenteeism and turnover for Spartanburg's small employers and will ultimately undergird the community's culture of health and positively impact overall county health measures.

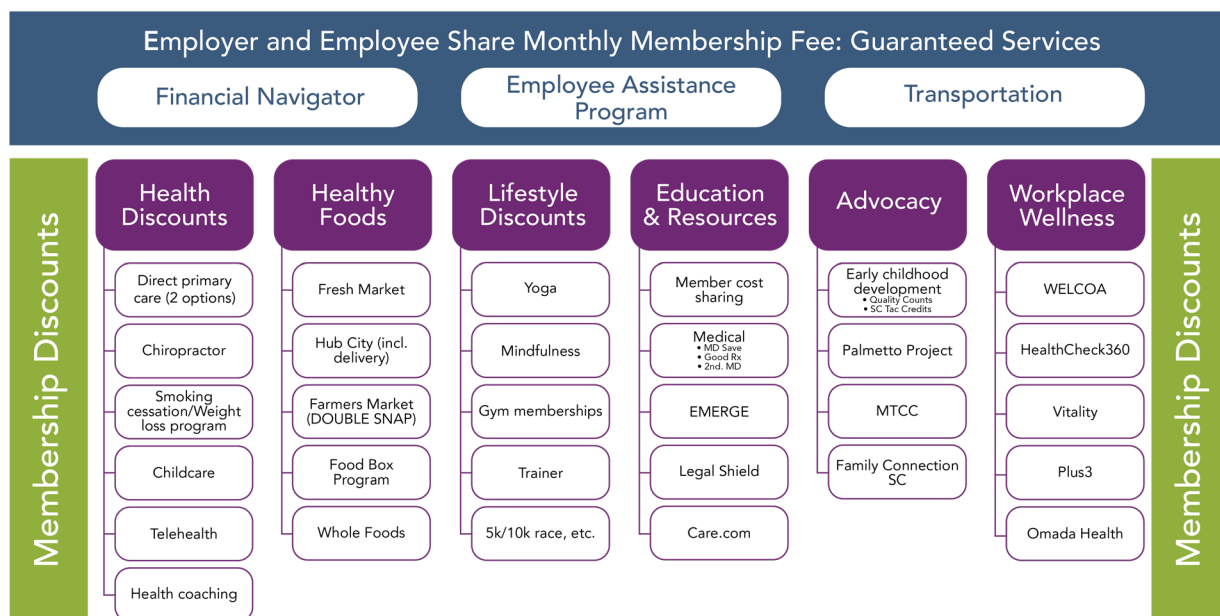
The Bridging for Health work has changed Spartanburg's Way to Wellville in three significant ways:

- The team has acquired knowledge about innovative financing, how to craft financing models, and how important innovation is to sustainability,
- The effort is now associated with cutting-edge work — GHPC and others experts in the field lend credibility to the work in Spartanburg, and
- The team is now challenged to do “big, deep” work that can be sustained and that matters.

The association with Bridging for Health has also given Spartanburg's Way to Wellville more credibility with its partners, which in turn has resulted in more investment in this and other Wellville projects. Wellville's view of financing is more informed. The team understands that other models can be adopted or adapted and that there are more possibilities for Spartanburg than it initially imagined. The team's view of partnerships has also expanded; it has a new appreciation for TA, viewing it as even more important than direct funding.

As Figure 13.2 shows, at this point — and after a number of programming pivots — the Wellville Exchange is planning several specific interventions. Further, the Core Team is also considering innovative approaches for emerging interventions aside from the Wellville Exchange. Other next steps include to continue in the current phase of program and funding design for the Wellville Exchange and to nail it down so that employers can invest and the pilot can commence in July 2019.

Figure 13.2. The Wellville Exchange's Planned Interventions



Acknowledgments

The Spartanburg Wellville Exchange would not have happened without the national Way to Wellville team, especially Rick Brush and Jeff Doemland, who provided the connections, inspiration, and ongoing assistance from conception to launch. Special thanks go to the members of the small-business collaborative who gave two years of their valuable time to this project and who made clear the needs of small employers and their employees in Spartanburg. The Spartanburg Area Chamber of Commerce, especially Betsy Sikma, Samir Masic, and Allen Smith, had the insight to adopt the exchange as their own as a one-of-a-kind model for economic development, fleshing out the business plan and the funding model. The Mary Black Foundation, in their deep commitment to advancing health for all, provided backbone support and supplemental funding. Finally, the Spartanburg Way to Wellville Team invested in this project to improve health and well-being for working residents of Spartanburg who have limited access to care and services. Kathy Dunleavy, Molly Talbot-Metz, Chris Story, Jennifer MacPhail, and Renee Romberger spent untold hours making sure this dream for Spartanburg became a reality.

COMMUNITY PREVENTION AND WELLNESS FUND: YAMHILL COUNTY, OREGON

Samantha Kinney

Yamhill County is a large rural county located one hour southwest of the Portland, Ore., metropolitan area; with a population of approximately 105,000, it is the 10th-largest out of the 36 counties in Oregon. Yamhill County's vast geography and rural, dispersed population makes access to services a long and arduous process, especially for residents who lack private transportation. Half of Yamhill County adults have one or more chronic diseases, including angina, arthritis, asthma, cancer, COPD, depression, diabetes, heart attack, or stroke. Like many other U.S. communities, Yamhill County is affected by the opioid epidemic, which is causing increased substance abuse, trauma, and homelessness in the county.

The Yamhill Community Care Organization (YCCO) coordinates care for enrollees in the Oregon Health Plan (OHP), or Medicaid, in Yamhill County and parts of surrounding counties. YCCO is a 501(c) grassroots nonprofit committed to building a unified, healthy community that celebrates physical, mental, emotional, spiritual, and social well-being. YCCO is the only coordinated care organization (CCO) in the state to be awarded an Early Learning Hub by the Oregon Department of Education's Early Learning Division. YCCO oversees Yamhill County's Early Learning Hub, coordinating early childhood services and family supports with local agencies. The Early Learning Hub works closely with all seven local school districts, as well as with childcare providers, health providers, and families, to ensure that:

- Families are healthy, stable, and attached,
- Children enter kindergarten ready to succeed, and
- Services are aligned and coordinated.

In October 2015, YCCO joined the Bridging for Health initiative with the goal of investing in upstream prevention and wellness activities based on the recommendations of a preventive scientist consultant and information from both the local public health department and community stakeholders.

As a result of the Bridging for Health partnership, YCCO was able to invest in an evidence-based intervention for local elementary schools: the PAX Good Behavior Game. The game is a behavioral support program designed to include students in creating a positive, nurturing classroom culture through activities such as the PAX Vision Board, which foster equity, and by empowering students to

provide input on the classroom culture while identifying expectations of themselves and their peers. The Good Behavior Game has been shown to improve academic performance and self-regulation, and reduce behavior problems in children. Further, long-term studies have shown that children exposed to the program had higher graduation rates and fewer behavioral health needs and chronic diseases.^{17, 18, 19}

Prior to its Bridging for Health involvement, in fall 2016, YCCO had funded a Good Behavior Game pilot in a batch of classrooms in three school districts. Based on the program's early success, YCCO needed an innovative funding model to ensure the program's sustainability in Yamhill County. With TA provided by Bridging for Health, YCCO developed the Community Prevention and Wellness Fund, a financial innovation to expand the Good Behavior Game and support future upstream population health investments focusing on social determinants of health.

Yamhill County: Context, Challenges, Opportunities

YCCO serves residents of Yamhill County and portions of the surrounding area. One-third of residents live in the southeast region, which includes the county seat, McMinnville, which has a population of 33,892. The remaining two-thirds reside in 10 rural communities, with a significant population cluster in the commercial center of Newberg (population 22,780), an agricultural and viticultural center with a robust manufacturing sector.

Key Challenges

YCCO currently has 25,302 members — around one-fourth of the population. YCCO members are approximately 16 percent Latin and 77 percent white, which roughly mirrors the county demographics. YCCO's Early Learning Hub coordinates programs and services for the 4,979 children who are experiencing poverty or are underserved in Yamhill County, which has a 25 percent poverty rate for children under 18.

Much of the county is economically impoverished, with an unemployment rate of 6.6 percent (compared with 4.7 percent statewide). Further, in 2013, the McMinnville-based Evergreen International Aviation, the primary source for commercial helicopter operations in agricultural and forestry applications, was sold and liquidated. This resulted in additional economic and job losses.

Among the county's higher-poverty areas are the Sheridan and Willamina school districts. Both face considerable challenges:

- Both districts receive 100 percent free and reduced-price lunch for their elementary students,
- Less than 70 percent of Sheridan's high school students graduated on time in 2018, and
- In 2018, the percentage of third-grade children in Willamina elementary schools who met or exceeded required reading scores was less than 15 percent — a 4 percent decrease from 2017.

Opportunities

In 2011, the Oregon Legislature passed HB 3650, creating the CCO model, which has the three-pronged goal of improving health, improving health care, and lowering cost by transforming health

care delivery. In February 2012, the Oregon Senate passed SB 1580, the state's 'health system transformation' legislation, which approved the Oregon Health Authority's proposal for the CCO model of health care delivery within the state. The bill used the Medicaid 1115 waiver to formulate CCOs, allowing increased local control of and flexibility with Medicaid funds in Oregon. The CCO model is intended to help support new approaches to health care delivery services and payment.

CCOs can receive incentive payments from a state bonus pool — Pay for Performance — to improve specific outcomes identified by the state. These outcomes are called incentive measures — that is, CCOs can receive financial incentives for improvements in performance; the funds are flexible and can be used at the discretion of individual CCOs.

The Organization

YCCO was one of the first CCOs developed after SB 1580 bill passed; it was also one of the first such organizations to be a grassroots nonprofit created specifically to become a CCO. As a collective-impact agency, YCCO is owned and governed by the local community. The board of directors and community members include representatives from health care clinics, education, early childhood centers, and health care consumers, all of whom inform YCCO's decisions and operations.

Decision-making power lies with YCCO's multisector board of directors, which includes representatives from OHP health care providers, social services agencies, and early childhood services. The board has four subcommittees: the Early Learning Council, the Community Advisory Council (half of whom are OHP members/families), the Quality and Clinical Advisory Panel, and the Community Prevention and Wellness (CPW) Committee.

YCCO promotes well-being through a multifaceted strategy:

- The YCCO Wellness Center offers continuing medical education for providers and

Yamhill County at a Glance

Region: Located within Oregon's Willamette Valley near the Cascade Range, the county is well-known for its wine industry, Evergreen Aviation Museum, and steel mill. The Confederation Tribes of the Grand Ronde Community includes 26 tribes and bands, which reside in the county's West Valley area.

Population: 105,035

Collaborative: Yamhill Community Care Organization (lead agency), Yamhill County Health and Human Services, Lutheran Community Services, Ford Foundation, Juliette's House, and Smilekeepers.

Overall goal: Through a collaborative effort, the program seeks to target and sustain investments in evidence-based programs that improve the health and wellness of Yamhill County by leveraging community partnerships through a Wellness Fund.

Innovation solution: The Community Prevention and Wellness Fund, which uses the wellness trust model to incentivize community organizations to reinvest into community and prevention activities.

Target "upstream" strategy: The PAX Good Behavior Game an evidenced-based classroom management program providing self-regulation techniques while fostering nurturing classrooms with peer-to-peer support. Long-term benefits include mental health, reduced substance use and chronic conditions, and improved third-grade reading scores, social-emotional skills, and social determinants of health.

coordinates a Community Health Worker Hub that conducts outreach to high-need members, reduces emergency department use, and coordinates with the school districts to work with children and families.

- The Early Learning Hub conducts outreach activities and events for families, trauma-informed care events and trainings, and preventive wellness campaigns. It also coordinates the Family CORE, which is a referral system for families with children 0-8 who need access to home visits and other resources.
- YCCO coordinates Yamhill County's Service Integration Teams, working with various community partners to provide coordinated resources and information for local families in need.
- YCCO's CPW committee coordinates and funds evidence-based interventions, such as the Good Behavior Game and Positive Family Supports, two school interventions designed to improve academic and social outcomes for children.

Bridging for Health

GHPC engaged YCCO in mid-2015 based on YCCO's growing reputation as a collective-impact nonprofit health leader with a multisector board of directors. GHPC sent a team to meet with the YCCO board, where they discussed stewardship and innovative, sustainable financing models. The board of directors served as the first coalition to improve health upstream.

With GHPC support, YCCO could explore and expand opportunity for further community engagement and broader population health impact. YCCO's goal was to grow beyond being a Medicaid health plan and into being a community health organization, impacting health through social determinants of health and equity. The group recognized that any strategy to meet its three-pronged goal of better health, better care, and lower costs must be directed upstream and at the county level.

YCCO had developed and approved a three-year Prevention and Wellness Plan that included prevention activities. Stakeholders understood that bolstering the health of the Yamhill County area as a whole would benefit its Medicaid population. The goal was to be able to sustainably fund population health and prevention programs, while recognizing that the initial primary funding source would be Medicaid funds. It decided upon three key strategies:

1. Develop a better understanding of the need and the most appropriate method to meet it,
2. Identify additional community stakeholders to engage in this work, and
3. Review potential innovative financing models and, through an iterative, community-based process, choose the most appropriate funding approach for the community.

The Innovation

Through the Bridging for Health initiative, Yamhill County selected the Community Prevention and Wellness Fund as its target financial innovation. The fund is a focused, centralized pot of money designated for investments into upstream, population-level interventions with an evidence base to address social determinants of health.

The fund will be sustained by funding commitments from YCCO, YCCO business partners, Yamhill County, and local businesses and banks, while also building relationships with funding partners outside Yamhill County, such as large banks and philanthropic organizations. Further, the community itself will be empowered to decide on investment strategies and to solve complex health disparities in the county's most vulnerable population.

Technical Assistance and Support

Through its five-step Innovation-to-Action Cycle, GHPC TA offered crucial support as YCCO developed its innovative funding mechanism (see Table 14.1).

Table 14.1. Yamhill County's Innovation Cycle

STEPS	ACTIVITIES	TA SUPPORT PROVIDED	OUTCOMES
Empathy and Mindset	<ul style="list-style-type: none"> GHPC site visits, including module presentations on financing and stewardship during YCCO board meetings Work pace was affected by both leadership change at the YCCO and other organizational priorities 	<ul style="list-style-type: none"> Facilitated meetings to establish stewardship mindset and knowledge of financial innovations Recommended subject matter experts on pay-for-success innovations Guided financing conversation with YCCO leadership and board 	<ul style="list-style-type: none"> Developed understanding of innovation cycle; began prioritizing the Bridging for Health initiative Assigned staff to Bridging for Health and moved responsibility from board to CPW Committee
Define and Agree	<ul style="list-style-type: none"> CPW Committee refocused efforts to define the strategy prototype first, instead of selecting the financial innovation first then fitting a strategy 	<ul style="list-style-type: none"> Offered input on Pay for Success model, focusing on building community buy-in Guided the facilitation with community partners Shifted from "giving us information and expecting us to act on it to giving us technical assistance about how to act on it" 	<ul style="list-style-type: none"> Shifted the mindset to focus on population health as complementary to core business; agreed to address social determinants of health

STEPS	ACTIVITIES	TA SUPPORT PROVIDED	OUTCOMES
Ideate	<ul style="list-style-type: none"> YCCO board struggled to grasp the financial innovation concept and how to be a part of the initiative. Leadership expressed concern about staff's bandwidth to move the financial innovation forward 	<ul style="list-style-type: none"> Guided the team to think on the macro level; provided tools for presentations to the YCCO board; emphasized a focus on financial concepts versus the prototype Offered the CPW Committee direction on moving the vision forward 	<ul style="list-style-type: none"> Shifted focus beyond pay for success and toward a financial innovation with community involvement and ownership Allocated funds for a project coordinator to ensure the project progressed; the evaluator role switched from being someone outside the community to being a community partner with existing relationships with the project
Prototype	<ul style="list-style-type: none"> CPW Committee vetted various financial models and chose the wellness trust model Decided to build on existing initiatives, with PAX Good Behavior Game selected as prototype 	<ul style="list-style-type: none"> Guided the team on messaging mechanisms to communicate with community partners and funders Designed a timeline and steered the CPW Committee on selecting stress test candidates Facilitated learning from other sites through networking and peer learning; guided decision-making on moving the wellness fund forward 	<ul style="list-style-type: none"> Developed a TA grant, recruiting school districts to participate in the prototype Five of seven school districts began the Good Behavior Game program, with the two other schools committing to implementation during the 2018-19 school year

STEPS	ACTIVITIES	TA SUPPORT PROVIDED	OUTCOMES
Test and Implement	<ul style="list-style-type: none"> Although the community supports the Wellness Fund, the CPW Committee stress testing found that not everyone agrees on how to use the funds Leadership negotiated contracts with wellness fund investors 	<ul style="list-style-type: none"> Broke down action items to complete for the remaining grant period Maintained a focus on the bigger vision and helped guide the team through roadblocks Provided critical tools such as messaging, communication, and business plans; these helped ensure tangible deliverables for the project coordinator Helped in developing a governing body and bylaws, and in guiding the governing body in collaborative cohesion on selecting investment programs 	<ul style="list-style-type: none"> Increased CPW membership to support the initiative within the community as well as build relationships with potential funders Secured sustainable funding by investors Greater understanding of (and perhaps interest in) other innovative financing options for population health

Empathy and Mindset

Shifting mindsets to embrace stewardship, health equity, and systems thinking, as well as cultivating relationships and identifying community need.

Over the three years prior to Bridging for Health, YCCO was a health care payer for the Medicaid population, and population health was outside the organization's domain. When the CPW Committee was developed and the partnership with GHPC emerged, YCCO began to shift its mindset to focus on population-level interventions — especially upstream strategies targeting early childhood development.

The GHPC team traveled to Yamhill County during summer 2016 to discuss stewardship with the YCCO board. It gave the board self-assessments on stewardship in relation to pursuing innovation in policy, health care delivery, and financing mechanisms to improve population health. Many board members expressed a strong commitment to focusing on population health through a financial innovation. Conversations began on how to accomplish the innovation and strategies for prototype. The board realized, however, that it was far from consensus. When assessing funding and how to administer the financing innovation, the board had challenges reaching unanimous agreement on next steps on the project.

During the first stage of innovation, YCCO leadership change required time frame adjustments to move forward with the second stage of the cycle. GHPC team members maintained contact, checking in during the transition and encouraging YCCO to move forward with the project.

Define and Agree

Building a shared vision of the Innovation-to-Action Cycle plan through an innovation agreement between partners.

In March 2017, GHPC members joined the YCCO board to help coordinate a strategic planning process to align the Bridging for Health initiative with the YCCO mission and values. The planning process included further stewardship conversations and investigation of the Pay for Success model as a possible financing mechanism for the innovation cycle. Pay for Success is a multi-stakeholder collaboration that shifts the risk of implementing evidence-based social service interventions from a traditional funder to a private investor.

In Pay for Success models, stakeholders work together to identify a community need, determine the target population, and define the intended health outcomes. The investor — which can be a commercial, community development, or philanthropic organization — then provides up-front capital to service providers to launch an evidence-based program. If the intervention shows improvement among the predetermined desired outcomes, the traditional funder repays the investor with a prenegotiated premium for funding the intervention.

The GHPC team walked the board through the Pay for Success phases to facilitate an exploration of how this option might work in the Yamhill County community. Using the tools created by the case study samples, YCCO decided to select three initiatives to present to community partners with a goal of further exploring possible use of the Pay for Success model as the primary financial vehicle for one of them.

In summer 2017, work on the financial innovation began to shift from the YCCO board to the CPW Committee. Under the YCCO administration, the CPW Committee became the effort's "think tank" and workgroup to implement the ideas generated through the Bridging for Health process, with a focus on prevention and innovation. The CPW Committee included multiple YCCO board members as well as YCCO staff to help move the initiative along, and the committee was chaired by the local public health administrator.

The CPW Committee was responsible for launching phase 1 of the Pay for Success model by assessing the community's needs for the proposed interventions. To help guide the selection process, committee representatives suggested either focusing on state priorities or reviewing other communities' financial initiatives. The CPW Committee decided to coordinate a community discussion with YCCO board champions and community leaders to conceptualize and develop an intervention to field as the prototype.

Ideate

Generating ideas that fit the sweet spot of a high-leverage strategy — the intersection of a community's needs, funding opportunities, and evidence-based strategies.

Supported by GHPC, YCCO hosted a Pay for Success community forum in July 2017 and hired consultants to guide the conversation on selecting strategies and determining the needed financial support and infrastructure. The meeting consisted of YCCO, the Yamhill County Department of Health and Human Services (YCHHS), Lutheran Community Services, the Early Learning Council, school district leaders, and representatives from local nonprofits and businesses to vet proposed projects funded by the Pay for Success financial mechanism.

Three potential Pay for Success projects were presented at the meeting:

- Foster care reform. Coordinate with YCHHS to reduce the county's rate of children in foster care and to improve care for foster children by coordinating screening and wraparound support while building system capacity.
- Complex care management. Use health care data to identify the members with the most complicated needs, focusing on those who use emergency department services. The initiative would offer wraparound support to reduce cost and improve quality of life.
- County housing initiative. Improve opportunities for affordable housing in the county and use case management to provide additional behavioral health support and social service needs.

Each selected project went through a consideration process that included short-term ROI, financial engagement from outside agencies, community needs, and feasibility based on the project timeline.

The consultant guided the conversation to help determine who would be the project's long-term financial beneficiary — and thus who would pay for the initiative. However, the community struggled to determine which agency would financially support the project, as well as successfully meet proposed outcomes within the project timeline. Further, YCCO was already managing multiple internal and community projects, and grappling with limited staffing and budget for new, complex initiatives. After discussing each of the three proposed new projects and the limitations of the Pay for Success model without a clear funder, the group decided to scale down the first stage of the Bridging for Health project and not invest in a new project.

Following the community forum, project traction began to shift from evaluating and possibly supporting the Pay for Success model back to supporting the CPW Committee's existing successful work.

In fall 2017, the CPW Committee had a brainstorming session with the GHPC team to help recommit to the financial innovation. The committee decided to refocus on the community's needs by comparing regional community health improvement plans (CHIPs) from multiple sources to look for commonalities. The CPW Committee also decided to allocate personnel to the project to ensure success as well as expand community involvement in the financial innovation.

YCCO assigned a project coordinator to organize the project and create work plans, while also ensuring that Yamhill County would meet GHPC project deliverables. YCCO decided to evaluate the project locally by contracting with YCHHS; both the project coordinator and the evaluator collaborated on other initiatives and were familiar with the Bridging for Health project, which helped with onboarding them to the project.

Prototype

Pitching a draft of the chosen idea to gain feedback from stakeholders.

With the new staff allocated to the project, the CPW Committee re-examined the financial innovation in preparation for the February 2018 reverse site visit in Atlanta. Using a cross-examining comparative assessment, the CPW reviewed eight financing models:

- Capture and reinvest,
- Blending and braiding,
- Community development financial institutions,
- Hospital community benefit,
- Low-income housing tax credits,

- New markets tax credit,
- Pay for Success, and
- A wellness trust.

CPW immediately ruled out Pay for Success, tax credit initiatives, and hospital community benefit due to the lack of feasibility within the community at that time. The blending and braiding model was often discussed in stakeholder organizations and the community, while a wellness trust model was the least familiar innovation — but also the most attractive for community activation and engagement.

The committee then organized the county's health priorities into seven initiatives: substance abuse prevention, the Good Behavior Game, housing, obesity prevention, access to care, foster care reform, and Positive Family Support. Next, for each initiative, it assessed current funding, required resources, feasibility within the timeline, health impact, and alignment with GHPC's proposed funding model. The Good Behavior Game ranked the highest of all initiatives, due to its positive traction within the community, upstream focus targeting population-based health, high impact, and tangible implementation plan with supportive funding.

The committee decided to explore two possible financing vehicles — blending and braiding, and a wellness trust or fund — to support and sustain the Good Behavior Game. By choosing the Good Behavior Game as the prototype, the group could build a work and funding plan that it was confident it could achieve and that would offer a platform on which to build larger and more innovative funding pathways. Choosing the game as the prototype also aligned health priorities in the regional community health assessments, CCO and Early Learning metrics, and CPW's three-year plan.

Four of the CPW Committee members traveled to Atlanta for the GHPC reverse site visit. The team presented on the prototype to the other selected sites with the anticipation of building a wellness trust as the financial vehicle. During the conference, GHPC staff guided the team through a pre-stress test process to determine how to infuse the innovation within the community by creating three critical assumptions for success. The team determined that if the innovation succeeded, the funding would be a viable vehicle for other evidence-based investments. Further, the community would support the initiative and any infrastructure needed to build relationships with investors. After the reverse-site visit, the CPW Committee solidified the financial innovation vision with realistic deliverables to leverage existing relationships within the community to move the project forward.

Test and Implement

Using the philosophy of "investing a little to learn a lot," sites test a small-scale version of the innovation to prove or disprove key assumptions.

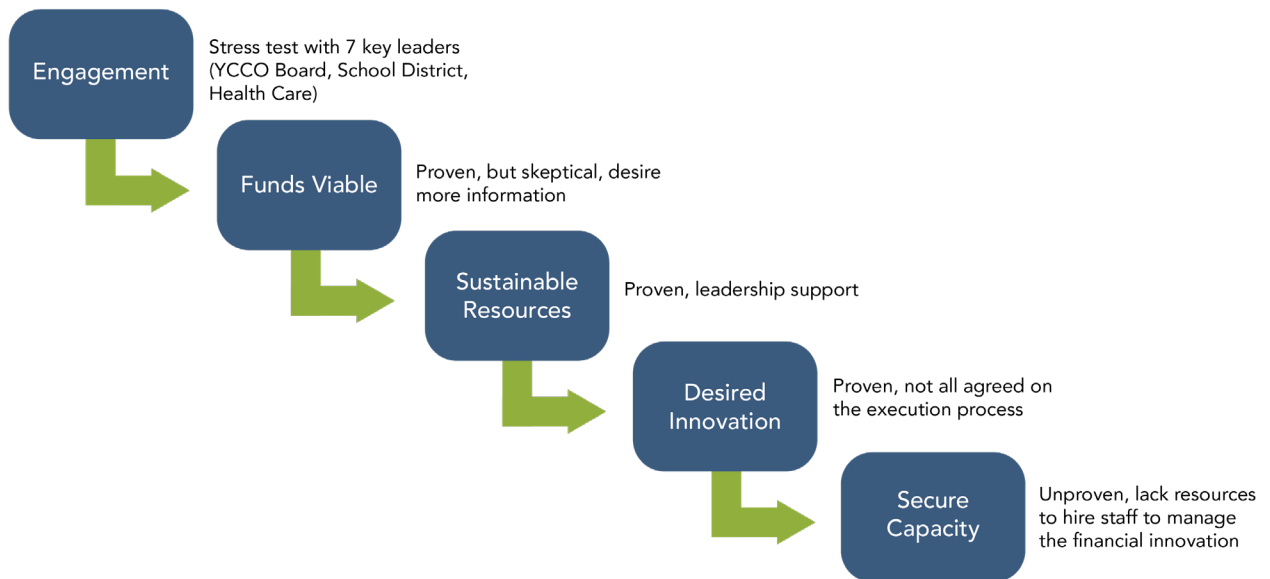
From March-May 2018, the YCCO CEO conducted individual stress tests with board members on their support of the Community Prevention and Wellness Fund (see Figure 14.1). The "pitch" to gauge interest (including in investing) was tailored to fit both individual community organizations and the mission, vision and value of YCCO. During the stress-testing phase, YCCO leadership discovered that board members supported the development of the financial mechanism, but disagreed on two issues:

- How to use the funds to improve health within the community, and
- How to structure the Community Prevention and Wellness Fund.

One board member expressed concern on the pace of adopting the financing innovation; that member also thought the CPW Committee needed to be more strategic in its marketing to the community to avoid threatening local nonprofit organizations or jeopardizing contributor investments to them through donations or contracts.

After collecting and analyzing community member feedback, YCCO decided to modify the marketing materials to ease local nonprofit organizations' concerns and to protect existing funding to local organizations. The project coordinator also modified the language about the Community Prevention and Wellness Fund, reiterating how YCCO was developed in the beginning — that is, by starting small and working toward a collective mission to service the community.

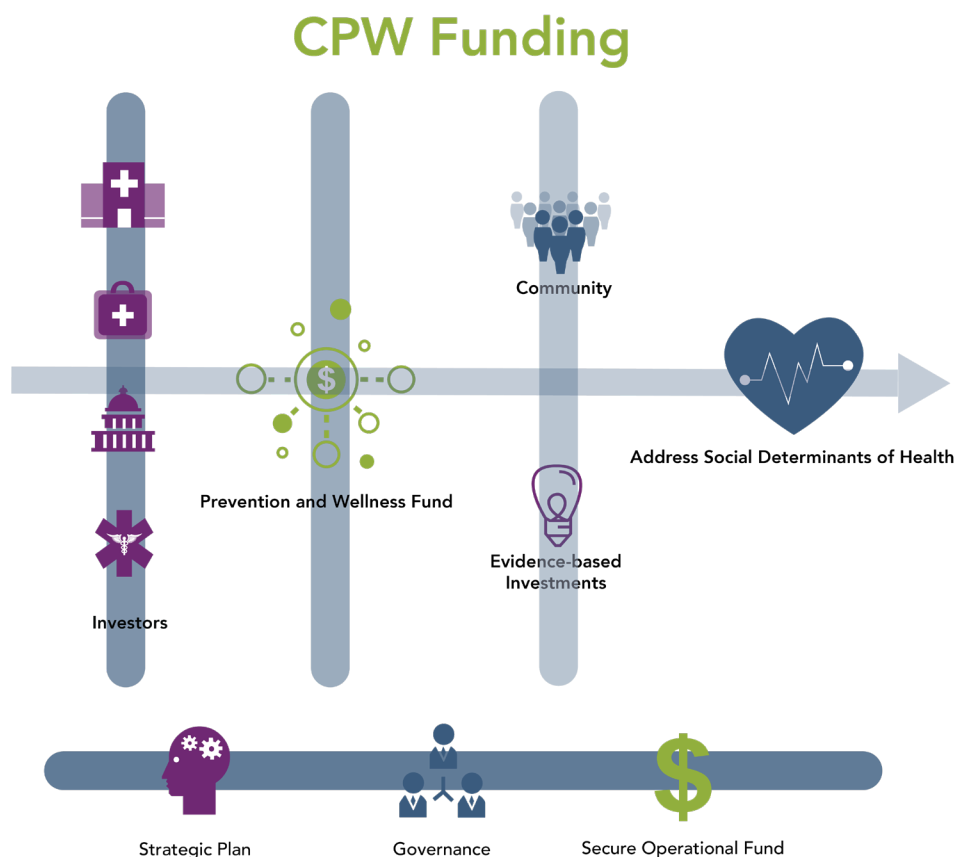
Figure 14.1. Financing Innovation Stress-Testing Results



As part of this stage, YCCO communicated with a range of community partners to gauge interest in using a wellness trust model as Yamhill County's Community Prevention and Wellness Fund. The team held regular planning meetings, both internally and with GHPC. YCCO also presented at the reverse site visit in Atlanta, receiving feedback from other sites and adjusting its plans accordingly.

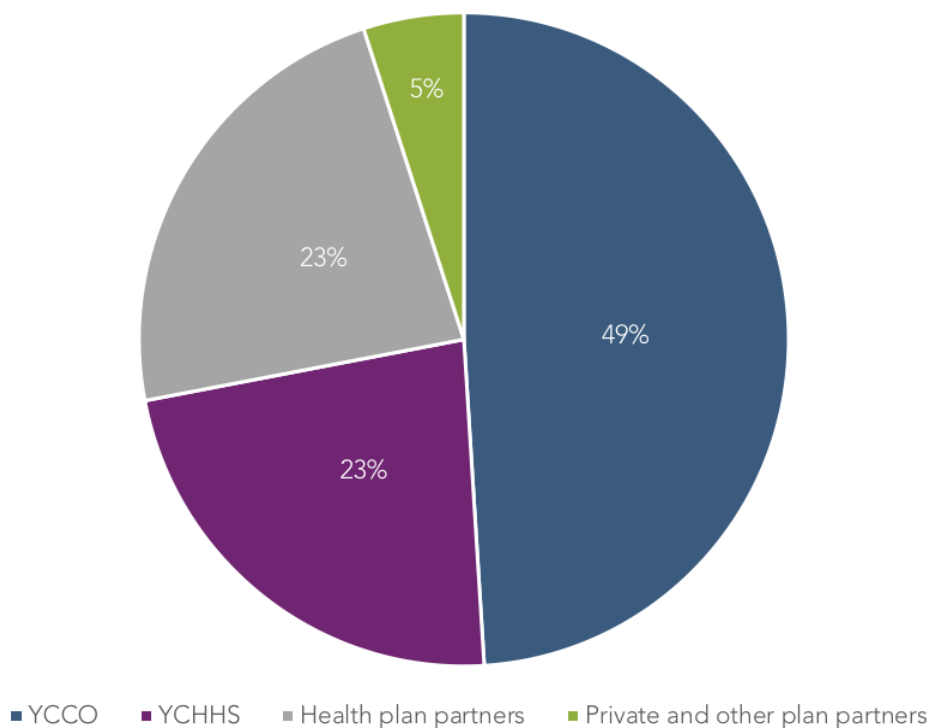
During the pilot phase, the team identified existing resources and new opportunities for the Prevention and Wellness Fund and determined the first iteration of its governing board. The team's work included refining the work plan and identifying how GHPC TA could best serve the CPW's needs. The CPW also redefined the charter for governing the fund and making objective funding decisions to support evidence-based or evidence-promising programs. Finally, the CPW developed materials to share with stakeholders and key partners. These innovation packets, templates, and resources have proven invaluable in moving this process forward. Meanwhile, the Good Behavior Game gained community buy-in and expanded into two additional school districts for the 2018-19 school year.

Figure 14.2. The Prevention and Wellness Funding Model



In December 2018, the CPW Committee secured funding for the wellness fund after contract negotiations were finalized (see Figure 14.2). The YCCO board agreed to allocate annually to the CPW Fund after successful presentation and conversations on the importance of investing into prevention programs. YCCO also secured a 1 percent contract allocation for Health Plan Partners dental providers, while YCHHS agreed to invest a portion of Pay for Performance dollars and allocated prevention dollars received from the state. Further, YCCO also received two grants from private foundations to support the Good Behavior Game program; it then funneled those grants into the wellness fund. Over the course of implementing the Bridging for Health initiative, the CPW Committee secured a total of \$1.7 million to support and sustain prevention intervention within Yamhill County (see Figure 14.3).

Figure 14.3. Funding Allocation Based on Investors



Seventy-five percent of the funding is sustainable and will total roughly \$1.3 million annually. The CPW Committee hopes to reach out to additional funders during year 2 of implementing the wellness fund. CPW also will be working on extending membership to the committee, building relationships with potential funders such as local hospitals and businesses, and selecting additional evidence-based programs to support (see Table 14.2).

Table 14.2. Yamhill's Prevention and Wellness Fund

	CURRENT STATUS	NEXT STEPS
Funding sources	<ul style="list-style-type: none"> • YCHHS: Behavioral Health Pay for Performance and Prevention Funds, Prevention Funds from OHA • YCCO: Percentage of Pay for Performance Funds, Percentage of contracts with Health Plan Partners premiums • Private Funders: Philanthropist foundations and non-profit organizations through grants 	Recruiting other funders, including local hospitals, private foundations, state government, schools, and businesses over the next year
Purpose of funds	\$1.7 million total within the CPW Fund, with 75 percent received annually through sustainable funding sources to address social determinants of health	Funding for additional programs will be based in the following areas: <ul style="list-style-type: none"> • Community applies for funding to support an evidenced-based program • Programs identified in the local CHIPs (YCHHS, Providence, and YCCO)
Fund administration	Overseen by YCCO, with governing by local organizations within the community	Expanding governance to ensure local community representation to oversee funding allocation and program evaluation and reporting

Lessons Learned

In the past year, YCCO made great strides in better defining its programmatic and financial goals and in building materials to present its plans to potential partners. Over the GHPC grant period, those involved learned a great deal about defining a project's scope and capacity and about developing community buy-in and support. They also learned many lessons that may be of help to other partnerships exploring funding innovations:

Expect obstacles and adjust accordingly. Personnel and financial resources, staff and leadership turnover, and community buy-in were all barriers to progress. However, both YCCO and the Yamhill County community are well versed in the collective-impact model, and over the course of the site and reverse site visits, the team identified how existing resources, projects, and processes fit into the grant model and could be used to create a smaller-scale pilot.

Look before you leap. One of the team's biggest learnings was that, during the early stages of an innovation, jumping straight into a risky, multimillion-dollar Pay for Success experiment was not

necessary. Once YCCO began examining and capitalizing on existing resources and realistically scoping the project to the timeline and resources, progress was accelerated.

Build trust and strong partnerships. The successful creation of the Community Prevention and Wellness Fund was largely due to the extensive trust and partnership established among committee members and within the larger stakeholder group — and especially between key entities such as schools, YCCO, and the local public health department. The fund's sustainability will depend on partner participation, including publicly funded partners, as well as health plan and health care providers who are affiliated with YCCO. The project's visionary leadership and high-quality staff were also essential to the success of the initial project phases.

Set tangible milestones and short-term goals to make the work less overwhelming. GHPC's TA — including its consultation services and accountability tools — helped move the financial innovation forward. GHPC provided short-term goals, success measures, and tangible milestones in a project that often seemed overwhelmingly large.

Choose your project leaders and staff wisely. Having dedicated staff was a main driver of this project's success. Choosing a project manager from within YCCO who had the skills and expertise to move the innovation forward, as well as a highly skilled, local public health expert to conduct project evaluation, made a huge difference in mobilizing the group and building shared goals between the grantor and the team. The evaluator also guided project deliverables by creating marketing materials and developing messaging pitch for potential community partners and investors.

Expect disagreements — and move forward anyway. However ideal, full consensus is often elusive. Even after the funding mechanism (the wellness trust model) was chosen, the group and stakeholders often continued to disagree on how to create, house, and coordinate the trust. The group ultimately moved forward by scaling back and agreeing that even if decisions were not unanimous, they were part of a pilot process, subject to change, and required commitment from the whole group. Once the CPW Committee was given agency and decision-making tools, it was able to move forward successfully and create the current model for a Prevention and Wellness Fund.

Looking Ahead

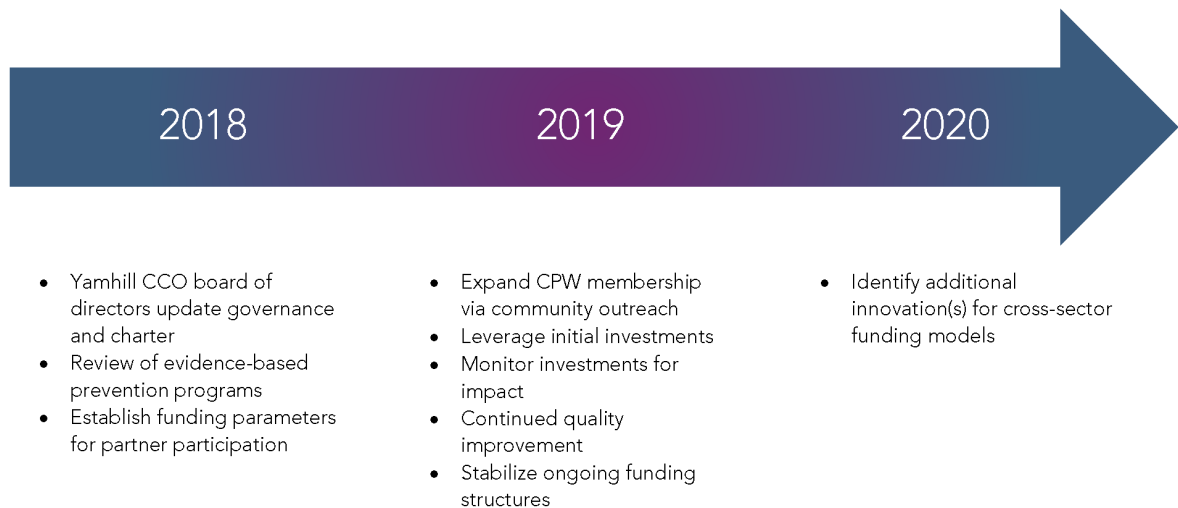
This project has been instrumental in solidifying a community and agency commitment to the value of investing in social determinants of health. As a health-focused nonprofit, YCCO was built on a foundation of community wellness; this project provided valuable guidance in formalizing that commitment and building an understanding of how investments in upstream health can impact a community. The project also offered several other significant benefits:

- It created a platform to educate medical providers and business leaders about the ways in which supporting school district programs and discussing housing needs can improve health and lower health care cost,
- It helped the organization take a vague, aspirational goal — to improve community health — and create a focused, streamlined plan to create sustainable funding that can support specific prevention programs in targeted age groups and communities, and
- It took an experimental funding plan to the next level, helping the group recognize where to most effectively leverage funds and invest them for the most impact.

The organization's mission of working together as a community to improve the quality of life and health of YCCO members by coordinating effective care remains the same. The methods of achieving that mission have shifted, however; it is now both more intentional and more population-health based. A key understanding gained through this project is that investment in the community as a whole will, by proxy, powerfully and positively impact Medicaid recipients.

This project is contributing to both YCCO and YCHHS establishing themselves as leaders in the community. Although the project itself has not been widely promoted, word of the Good Behavior Game has spread in the county, and its success is making YCCO and YCHHS leaders in innovation through their actions and investments. YCCO is also focusing on continued partnership with the business community and other potential future supporters of the Prevention and Wellness Fund. Figure 14.4 shows an overview of YCCO's plans moving forward.

Figure 14.4. Innovation Timeline and Plans for the Future



Before Bridging for Health, YCCO relied on its own funds (Medicaid dollars) and grant funding to support its programs and projects. Solely using Medicaid dollars for programs is not sustainable or predictable, as medical reserves fluctuate; YCCO thus realized that it needed to find more innovative funding sources. This search has initially led to leveraging and braiding community funds, but YCCO also plans to lean more heavily on funded agencies for in-kind support of their own programs, and work with them to build sustainability plans. Finally, YCCO is exploring how it can create stronger partnerships with the agencies it holds contracts with. The organization is moving toward no longer purchasing a service, but rather purchasing a partnership in which its contracts require certain investments back into the community. In this way, partnerships will transcend the business and financial relationship and start to build a community relationship.

The CPW Committee has identified a few key strategies for continuing success. First, the group will build stronger relationships with the business community and invite representatives of it to the decision-making table. The vision: to create a reputation for the Community Prevention and Wellness Fund steering committee as a capable, valuable committee to be a member of, as well as to ensure that people view fund donations as a practical investment.

Second, to achieve the first goal, the committee must refine its messaging around both the ROI for prevention programs and upstream investment's impact on each sector. YCCO will be a leader in educating the community on how to address social determinants of health, such as improving school success, and how doing so will ultimately impact the business community's bottom line.

Third, programs such as the Good Behavior Game will continue to grow and be implemented in each school district in the county. The results of this program's implementation will start to compound and become visible in the community as teachers experience less burnout, children are more successful socially and academically, and parents begin incorporating the trauma-informed, pro-social elements of the game into their homes.

Finally, YCCO will develop recommendations for multiple evidence-based interventions that the community can support. The vision is for a five-year plan, informed by experts, the community, community health assessments, and research. The plan will address each age group and community, and combat specific issues based on community needs. It will align with the CHIP and YCCO's other local strategies and will serve the whole community as a method to improve population health.

Acknowledgments

The following people were instrumental in the success of this initiative: Anthony Biglan, preventative scientist for Oregon Research Institute; Silas Halloran-Steiner, director of Yamhill County Health and Human Services; Emily Johnson, project and grant coordinator for Yamhill Community Care Organization; Samantha Kinney, community health and wellness coordinator for Yamhill County Public Health; Lindsey Manfrin, deputy director of Yamhill County Health and Human Services; Seamus McCarthy, C.E.O. and president of Yamhill Community Care Organization; Jennifer Richter, early learning program administrator for Yamhill Community Care Organization; Jordan Robinson, area director of Lutheran Community Services; and Mark Russell, C.E.O. and president of Juliette's House.

PART III. NEXT PHASE

NEXT PHASE

Chris Parker

At the outset of this book, architect and design theorist Christopher Alexander is referenced. His theories of human-centered design serve as a backdrop to the question of how to give people the tools with which they might build and develop their own designs. His theories and question find application here, and following Bridging for Health, at least three responses focused on continuous learning beyond this initiative are relevant.

Accelerating Coinvestments and Learning About Stewardship Dynamism

After four years of significant investment of time, TA, local leadership, and resources, most Bridging for Health sites landed on pooled community funds as their innovative approach to financing population health. Some sites are well on their way — having already put the infrastructure in place to receive funds and agreed on the strategic focus of funding for the next few years. Others are just beginning to stand up these funding models.

Whatever their stage, the next four to five months will be critical to fund development. How will they attract additional coinvestments to expand the pool (new sources or more money from the same sources)? How will they consider and review the types of programs they fund (new, modified, or expanded uses)? And what kinds of changes to their stewardship functioning and structure will be necessary to support these pooled funds as they grow and mature?

In moving to this next phase, GHPC, in its role as the national coordinating center for Bridging for Health and with additional sponsorship from the foundation, is providing some of the sites with additional resources and support in an attempt to answer these questions, learn together, and inform the field. This is a critical, immediate next step to shore up and underpin the efforts of the sites, especially given that the realization about the uses of these funds was occurring in the final phases of the Bridging for Health support.

In a relatively quick and simple competitive bid process, sites applied for additional resources to accelerate their pooled funds to the next level. The process used specific criteria to identify the sites that would likely be able to accelerate their efforts: strength and merit of their proposed acceleration effort, readiness of the collaborative to act, and likelihood of success, given their local context. At the end of the selection process, four sites were awarded more resources to focus on adding new sources and/or expanding and modifying the use of the funds themselves (General Acceleration Awards). All of these sites were also required to participate in a stewardship learning partnership aimed at

broadening the knowledge base to support and grow our understanding of the dynamic and likely evolutionary nature of stewardship accountability and structure. One additional site was selected to participate in the learning partnership only. All of the selected sites will participate in this learning partnership for a period of four to five months.

General Acceleration

The general acceleration awards will allow sites the opportunity to continue improving and honing their funds and operations. Some of the key activities to be conducted over the period include:

- Identifying additional, sustainable, and unique sources of funding that will include developing partnerships, specifically with local business, foundations, and banks, and securing long-term commitment to contributing to a pooled fund,
- Engaging appropriate TA services to support local efforts at establishing and sustaining these efforts, such as —
 - Legal consulting and other services needed to address possible barriers to the current organizational structure and to support the groups as they seek to develop the appropriate accountability structure for the fund
 - Staffing, business development, and marketing to support models for increasing sources of revenue, creation of promotional messaging for the funds and building a solid communication strategy, and planning for outward-facing launches of the funds
- Formalizing and finalizing contracts with existing and new partners in order to build support for community prevention and wellness into the financial partnership,
- Fully developing and testing agreed-on lists of recommended evidence-based prevention programs and strategies in which to invest, and
- Revising funding decision-making rubrics, reviewing charters to reflect membership, and working to increase collaborative visibility in the community.

Site leaders, supported by local evaluators, will bear responsibility for tracking acceleration and progress in each community. GHPC will provide sites with a recording and reporting template that will help them collect data and information to track their progress over time. Evaluators, through a more limited scope of work than was previously the case with Bridging for Health, will also support sense-making and documentation of changes and progress made at the end of period. A final report that details process and maps achievement of targets and deliverables to their efforts will end this phase of the work.

Stewardship Learning Partnership

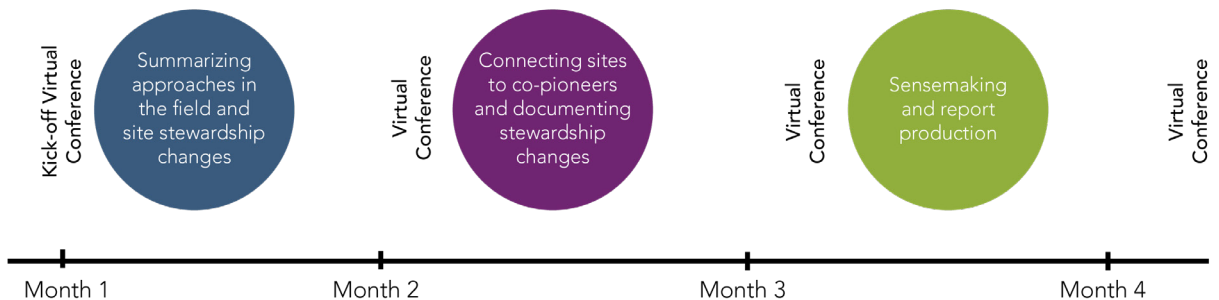
Stewardship, defined as the acceptance or assignment of responsibility to shepherd and safeguard the valuables of others, is an important component of pooled community funds. As these funds mature, stewardship capacity becomes a critical component for these collaborative organizations to consider. We hypothesize that the stewardship capacity and accountability structure are likely to change or adjust as collaboratives begin gathering and distributing these resources and evaluating their impact.

The purpose of the stewardship learning partnership is to:

- Provide sites with opportunities to learn from each other and to adopt or adapt approaches,
- Learn how to best support advanced stewardship, and
- Document learnings for dissemination to other communities interested in building or strengthening pooled community wellness funds.

GHPC will facilitate the establishment and functioning of the partnership and lead in the design of activities to identify and document learnings. GHPC will also connect sites to other groups and/or TA providers (sometimes referred to as catalysts) who are engaged in supporting and learning about stewarding pooled resources. These designed interface opportunities will facilitate sites in problem-solving with support from each other and TA providers.

Figure 15.1 Proposed Activities and Timeline



Site leaders and evaluators are also expected to participate, together with GHPC staff, in a series of sense-making sessions to agree on the learnings over the period and contribute to a report that will likely be an addendum to this book.

Understanding and Advancing the Practice of Pooled Community Funds

The concept of pooled funding is not by itself an innovative idea. The model was, and remains, the basis for prevention and wellness trust funds, which have been part of the toolkit of approaches available to, and used primarily by, a few states, most notably Massachusetts over the last decade or more. In a 2015 publication, the Prevention Institute defined a wellness trust or fund as a “pool of funds that is raised as part of a health improvement and cost-containment strategy to fund community prevention interventions.” The Ohio Policy Institute describes the purpose of these funds as being set up to “establish a sustainable funding source to support a strategic and coordinated set of evidence-based prevention activities that will improve population health outcomes, promote health equity and reduce healthcare costs.”

While the long-term effect of the pooled funds being set up and administered by Bridging for Health sites might be reduced health care costs, this is not an explicit focus or required outcome of their

efforts. Because this effort is occurring at the level of local and regional collaboratives, and not at the state level, the innovation is not so much in the pooling of the funds, but rather the sources of funds that might be identified and engaged to be included in the fund over the short- and long-term range of the effort. The opportunity also exists for new and different accountability structures to be established to administrate these funds. Sites have engaged private-sector (e.g., banks) and public-sector (e.g., taxes) dollars to either begin their funds or have plans to include those sources over time. Additionally, most of the sites have described a process of growth that includes using resources to finance and not just fund population health-improvement strategies. To that end, some plan to use a low-interest loan strategy with returns so that additional sustainability is added to what technically over time would look a lot like a revolving loan fund.

Bridging for Health sites are not the only ones across the country attempting to influence and use new and modified funding models for upstream health. A similar body of work (potentially with evidence) has been underway in California — the California Accountable Communities for Health Initiative, aimed at supporting multisector collaboratives across the state to develop integrated community health strategies using community health funds as their primary funding mechanism.

This post-Bridging for Health initiative period should allow for the assembling and packaging of the information and learnings across these practice groups as the basis for providing other communities with the tools and information upon which to develop locally appropriate yet similar models and structures in their communities. In an RWJF-commissioned study in 2017, the Non-Profit Finance Fund determined that “while only a handful of communities have launched community health funds (CHF),” others are exploring this concept. They concluded that progress of CHFs will require increased opportunity for dialogue among communities of practice to discover and share lessons learned; proven practices and ideas for innovation; and support for planning and development in interested communities and regions including TA on key “how-to” elements in developing, administering, and sustaining these funds.

More than a year later, the “launch” of the CHFs by a handful of communities has grown into active experimentation by an undetermined number of communities. The time is perhaps ripe for stakeholders to know more about those communities and put together a playbook and manual based on experiential learning of these collaboratives.

Monitoring the Development of Other Financing Innovations

From early in our initiative, we recognized that the sites were fascinated with knowing and understanding more about the wealth of ideas and mechanisms that could potentially support sustainable financing and funding of population health improvement. Accordingly, and very quickly in our engagement, we generated and distributed the Financing Population Health booklet, which outlined some of the more significant approaches. Other catalysts in the field have also been engaged in documenting these mechanisms and attempting to help stakeholders make decisions about the appropriateness of the mechanism to their local context. Over the past year, Rethink Health developed a typology of mechanisms and a workbook titled *Beyond the Grant — A Sustainable Financing Workbook*.

Of particular interest has been the broadening appeal of the use of bonds, loans, and impact investing approaches borrowed from the business world. How far will they penetrate as sole mechanisms for innovative financing when the commodity is community health improvement? More communities are beginning to consider and use referenda and ballot initiatives to secure the funds

for upstream health initiatives. What can we learn together about how to accelerate the success of those efforts?

As more communities are emboldened to attempt the use of one or more of these mechanisms, they will serve as ongoing natural experiments. They are a potential treasure trove of information about which of these mechanisms, beyond pooled funds, might be a good or promising fit for more local or regionalized solutions. To that end, in the immediate post-Bridging for Health phase, care should be taken to keep monitoring how communities across the country are using these mechanisms, learning from their evaluation, and sharing that information with other critical stakeholders who are seeking ways to implement and support the implementation of these innovations.

Much has been learned from the Bridging for Health sites — the importance of a process to move innovation to action and the necessity of addressing the foundational questions of sources, uses, and structure when designing a pooled community fund. But there is much more that can be done to disseminate the learnings and, ultimately, catalyze a movement where communities large and small across the nation are using financing innovations to sustainably fund efforts to improve health and health equity.

GLOSSARY

Assumptions: A list of the key things that are believed to be true for this to be worthwhile. This list is then prioritized to unearth potential “deal killers.”

Domain: The intersection of need and strategy. Exploring and choosing the best strategy to address the need.

Financing tool: Identified portfolio of available funding mechanisms, informed by innovations in financing population health initiatives and prioritized by feasibility and potential for improving health and equity.

Idea: The intersection of the need, strategy, and financing, which together create a high-leverage opportunity for improving community health. We will prototype, obtain feedback from health and community leaders, stress-test, iterate, pilot-test, learn and iterate, and further test as we move toward idea implementation.

Intervention: Proven evidence-based programs that deliver the strategy to a specific population in a tangible, tactical, and measurable way.

Need: Shared understanding of the key health issues facing a community, including by subpopulation and priority areas, to address with available funding to improve community health.

Pilot test: This test has more scale to prove the concept following rigorous stress-testing, ample feedback from stakeholders, and several rounds of iteration or modification. Key assumptions have been proven or disproven. A good pilot test should be mapped out, as well as have a set of benchmarking data to measure effectiveness, a budget, and seed funding.

Prototype: A rough and rapid way to mock-up, model, visualize, simulate, or story board the chosen idea. A good prototype is visual, includes a succinct description of the idea, is easily understandable by others, and clearly addresses a need in the market. Feedback from stakeholders or potential users is a key component.

Strategy: Collection of vetted, evidence-informed, upstream interventions that improve population health. Prioritized by those with greatest evidence of effectiveness and impact on health and equity.

Stress test: A way to quickly learn a lot about the idea — with as little investment in time and money as possible. “Invest a little to learn a lot.” Scope the stress test carefully. Determine flaws with the idea quickly, pivot, change the chosen approach, modify the strategy, iterate the idea, and test again. Feedback and analysis is a key component of the stress test, as it serves as a barometer to ratify or disprove some of the key assumptions and uncover additional work and conversations that are needed.

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