



MODULE 7

WORKSHEET

What Integrative Activities Could You Get Paid For?

OBJECTIVE: To identify the integrative activities you conduct, so you can figure out (using exercises in other modules) how to get paid for them.

TIME: 60-90 minutes (depending on size of group)

MATERIALS:

- Copies of this module (including briefs), this worksheet, and [Appendix 1](#) for everyone in the group
- Flip charts
- Markers

PARTICIPANTS: Two-to-five people most familiar with your integrative activities; could include a mix of an executive team, staff, finance committee, and board members of your multisector partnership or organization.

STEP 1

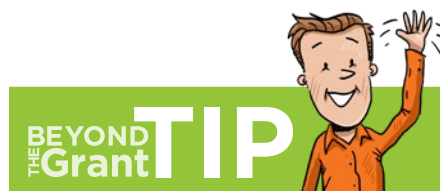
Provide each participant with a copy of the module (pages 1 and 2), this worksheet, the briefs below (pages 15 – 27), and [Appendix 1](#). Provide time for participants to independently review the definitions and examples associated with each integrative activity on pages 5 – 14. For each activity there is a set of reflection questions to help you determine if your partnership or organization conducts the activity. Participants should take time to answer the questions independently.

STEP 2

As a group, go through each of the eight integrative activities and briefly discuss your answers to check for alignment. Quickly analyze whether the group is in agreement about the activities your partnership conducts, or if there is some variance or disagreement. If the former, agree on short phrases or sentences for each integrative activity conducted (include the specific functions and deliverables the group identified). This will confirm you have alignment and help shape future work. (See the examples provided on pages 5 – 14; specifically the sentences under “Specific function(s).”)

If there are differing ideas about your partnership’s integrative activities, the following steps might help to generate some alignment:

1. Share ideas about any key services or deliverables your partnership provides and how they relate to the eight integrative activities. Give each participant three-to-five minutes to share their ideas; write and post each one on separate flip chart pages. If there are similar ideas, make a tally mark on each flip chart—and note any small distinctions—to reflect how many people brought similar ideas to the table. Once everyone has shared their ideas, gauge the degree of alignment that exists for each idea by reviewing the flip chart notes. Hopefully, you’ll notice that there are a few standout activities that everyone is in agreement on.
2. If necessary, briefly discuss the standouts. Take the temperature of the room. If you sense there is more discussion needed in order to reach consensus around which integrative activities your partnership conducts, take the time to have the discussion.
3. Agree on the integrative activities your partnership conducts. Then generate short phrases or sentences that describe the specific functions (what you do) and deliverables (what it produces) associated with each.



It’s possible to prepare for this meeting by asking group members to come prepared with Step 1 completed as well as draft sentences for the “yes” boxes they checked. Then the group can jump right in to Step 2 discussions to make the most of your time.



STEP 3

Determine the integrative activities for which your partnership will seek payment. Now, go back to [Module 5](#) and step through the Value Sequence to outline the value those integrative activities create. If you want help putting a price tag on the activities' value, [Module 6](#) can help.



What integrative activities do we conduct that we could get paid for?

1

INTEGRATIVE ACTIVITY
Convening Stakeholders for Cross-sector Collaboration and Information Sharing

Do you conduct any of the following specific functions?	
1. Engage stakeholders or multisector partnerships	5. Facilitate connections and one-to-ones among key leaders
2. Build public will	6. Provide communications support, including partnering with conveners to build public will (e.g., website, newsletters, outreach)
3. Enroll others in advocacy via convening/organizing	7. Manage meeting logistics
4. Determine agenda	8. Create detailed meeting design, including preparation and follow-up

Example (see brief on page 23 and 24)	
Name of multisector partnership or organization	Specific function(s)
Michigan Health Improvement Alliance (MiHIA)	Neutral convener to bring about stakeholders' information sharing and cross-sector collaboration
Why stakeholders value this function	Arrangements by which stakeholders pay multisector partnership or organization
Stakeholders want a voice in determining the agenda, which resources will be pursued (and how), and access to any resources leveraged.	Stakeholders pay via direct payment to MiHIA or make donations to its affiliate organization.

1 | Do you conduct this integrative activity for regional partners? ☐ YES ☐ NO

2 | What specific functions do you conduct?

3 | What specific deliverables do you provide when you conduct those functions?

4 | How do other organizations providing similar functions in your region collaborate or compete with you?

What integrative activities do we conduct that we could get paid for?

2

INTEGRATIVE ACTIVITY

Analyzing and Planning for Regional Health Improvement

Do you conduct any of the following specific functions?

1. Lead the setting of collective vision and goals; ensure resident involvement in the process
2. Devise shared strategy among stakeholders
3. Identify critical strategic questions, including differences in interests of stakeholders
4. Secure commitments to implement strategy
5. Advocate daily for goals and strategy (internal and external)
6. Facilitate strategy development process, including conducting of needs assessment
7. Serve as a neutral data synthesizer

Example A (see brief on page 15–18)

Name of multisector partnership or organization	Specific function(s)
Central Oregon Health Council (COHC)	The COHC staff acts as a neutral convener to facilitate the COHC board's work to reach consensus around a state-required Regional Health Improvement Plan (RHIP).
Why stakeholders value this function	Arrangements by which stakeholders pay multisector partnership or organization
(1) COHC board members want to co-create the plan for achieving their collective goal of better coordinating care for the Medicaid population in the region, to make sure their organizational interests are represented. They want to do this without having to become experts in coordination, and without having to step out of their own organizational roles when they come to the table. (2) Working with COHC, the local Medicaid Coordinated Care Organization (CCO) gets to show it is reinvesting savings, informed by the public. This might help the CCO hold on to their state contract with Medicaid—especially since the state seems to look favorably on this model.	The CCO pays, according to a Joint Management Agreement (JMA) formed with COHC. The JMA specifies that whatever payment the Medicaid CCO takes in from the state, per member per month, 0.325 percent (or 3/10 of 1 percent of its total revenue from the state) percent is paid to COHC to be used for operating costs (mostly, to ensure creation and implementation of the RHIP). The JMA also caps the Medicaid CCO's profit at 2 percent and provides that any additional profit must be paid to COHC for reinvestment into the RHIP (this additional profit is called "shared savings.") In order to be able to establish this agreement, the COHC board pursued a state law that would make them governing body of the CCO.

Example B (see brief on page 19–22)

Name of multisector partnership or organization	Specific function(s)
Greater Fall River Partners for a Healthier Community (GFR Partners)	Neutral convener of a coalition of 25 member organizations that collaboratively plan prevention strategies for benefit of the community overall.
Why stakeholders value this function	Arrangements by which stakeholders pay multisector partnership or organization
The Commonwealth of Massachusetts is interested in communities like Greater Fall River having a plan to maximize value from lean investments in prevention, through collaborative coalitions [in 27 Community Health Network Areas (CHNAs)] that identify and address specific community needs. Stakeholders work to achieve regional health improvement through multi-agency projects (stakeholders raise project funds together), and projects run by individual organizations (that raise their own project funds). Having a plan brings more grants into the community, helping stakeholders to—through all of their various efforts—realize the common goals the plan lays out and get increased investment in their own work.	The Commonwealth of Massachusetts pays, through a Determination of Need regulation that provides dedicated funding from hospital construction projects (5 percent of each project) to CHNAs for the purpose of bringing community expertise into regional strategy development around prevention.



What integrative activities do we conduct that we could get paid for?

2

INTEGRATIVE ACTIVITY
Analyzing and Planning for Regional Health Improvement

CONTINUED

- 1 | Do you conduct this integrative activity for regional partners? ☐ YES ☐ NO
- 2 | What specific functions do you conduct?
- 3 | What specific deliverables do you provide when you conduct those functions?
- 4 | How do other organizations providing similar functions in your region collaborate or compete with you?



3

INTEGRATIVE ACTIVITY

Designing Ongoing Infrastructure and Governance

Do you conduct any of the following specific functions?

- | | |
|---|--|
| 1. Design and ratify shared governance structure as well as composition and decision-making rules | 4. Provide facilitation for interim governance bodies to design governance changes over time |
| 2. Provide strategic oversight of infrastructure and governance | 5. Manage recruitment, elections, and transitions in membership of governance bodies |
| 3. Build relationships with other oversight groups | 6. Facilitate communications among oversight groups |

1 | Do you conduct this integrative activity for regional partners? ☐ YES ☐ NO

2 | What specific functions do you conduct?

3 | What specific deliverables do you provide when you conduct those functions?

4 | How do other organizations providing similar functions in your region collaborate or compete with you?



4

INTEGRATIVE ACTIVITY

Implementing Strategy; Managing Performance of Region-Wide Efforts

Do you conduct any of the following specific functions?

- | | |
|--|--|
| 1. Strategic oversight of actual implementation; ensure accountability and effectiveness | 3. Direct and/or manage projects, which might be about supporting work groups or alignment of activities |
| 2. Celebrate successes; share learnings | 4. Support stakeholders' abilities to work within the partnership (e.g., use the partnerships' systems for sharing data) |

Example (see brief on page 15-18)

Name of multisector partnership or organization	Specific function(s)
Central Oregon Health Council (COHC)	The COHC staff coordinates accomplishment of the RHIP, within the context of the shared purpose established by the COHC board.
Why stakeholders value this function	Arrangements by which stakeholders pay multisector partnership or organization
(1) COHC board members are interested in implementing the RHIP, and taking on specific aspects of the work, but no one stakeholder could take on the integrative activity itself and still represent its own interests. (2) Working with COHC, the local Medicaid Coordinated Care Organization (CCO) gets to show it is reinvesting savings, informed by the public. This might help the CCO hold on to their state contract with Medicaid—especially since the state seems to look favorably on this model.	The CCO pays, according to a Joint Management Agreement (JMA) formed with COHC. The JMA specifies that whatever payment the Medicaid CCO takes in from the state, per member per month, 0.325 percent (or 3/10 of 1 percent of its total revenue from the state) percent is paid to COHC to be used for operating costs (mostly, to ensure creation and implementation of the RHIP). The JMA also caps the Medicaid CCO's profit at 2 percent and provides that any additional profit must be paid to COHC for reinvestment into the RHIP (this additional profit is called "shared savings.") In order to be able to establish this agreement, the COHC board pursued a state law that would make them governing body of the CCO.

1 | Do you conduct this integrative activity for regional partners? ☐ YES ☐ NO

2 | What specific functions do you conduct?

3 | What specific deliverables do you provide when you conduct those functions?

4 | How do other organizations providing similar functions in your region collaborate or compete with you?

5

INTEGRATIVE ACTIVITY

Catalyzing Innovation and Redesign

Do you conduct any of the following specific functions?

- | | |
|-------------------------------------|--|
| 1. Set audacious goals | 5. Build human capacity to generate and test innovations |
| 2. Lead learning activities | 6. Conduct and synthesize research |
| 3. Create conditions for innovation | 7. Facilitate networking |
| 4. Provide seed capital | 8. Manage process of identifying innovations to pursue |

1 | Do you conduct this integrative activity for regional partners? ☐ YES ☐ NO

2 | What specific functions do you conduct?

3 | What specific deliverables do you provide when you conduct those functions?

4 | How do other organizations providing similar functions in your region collaborate or compete with you?



6

INTEGRATIVE ACTIVITY

Designing Financing Structure and Strategy

Do you conduct any of the following specific functions?

- | | |
|---|--|
| <ol style="list-style-type: none">1. Determine financing vision and strategic priorities2. Create governance structure for funding decisions and accountability management3. Determine financing structure for integrative activities4. Mobilize funding to implement priorities and initiatives5. Research possible structures and provide design support<ol style="list-style-type: none">a. Develop charitable giving strategyb. Write grants | <ol style="list-style-type: none">6. Administer grants, which might include acting as fiscal agent7. Host innovation fund<ol style="list-style-type: none">a. Receive and review applicationsb. Provide recommendations to governance bodyc. Act as fiscal agent for funds to be redistributed8. Provide staff support for governance of financing |
|---|--|

Example (see brief on page 15-18)

Name of multisector partnership or organization	Specific function(s)
Central Oregon Health Council (COHC)	COHC staff monitors, measures, and evaluates the grants/investments COHC makes in organizations throughout the community, checking for the organizations' adherence to their proposals and informing wise investment strategy.
Why stakeholders value this function	Arrangements by which stakeholders pay multisector partnership or organization
(1) COHC board members (who are the stakeholders) do not have the bandwidth to carry out this work, and want to be in more of a broad, oversight position in reviewing whether COHC is making the wisest investments to realize the goals of the Regional Health Improvement Plan. (2) Working with COHC, the local Medicaid Coordinated Care Organization (CCO) gets to show it is reinvesting savings, informed by the public. This might help the CCO hold on to their state contract with Medicaid—especially since the state seems to look favorably on this model.	The CCO pays, according to a Joint Management Agreement (JMA) formed with COHC. The JMA specifies that whatever payment the Medicaid CCO takes in from the state, per member per month, 0.325 percent (or 3/10 of 1 percent of its total revenue from the state) percent is paid to COHC to be used for operating costs (mostly, to ensure creation and implementation of the RHIP). The JMA also caps the Medicaid CCO's profit at 2 percent and provides that any additional profit must be paid to COHC for reinvestment into the RHIP (this additional profit is called "shared savings.") In order to be able to establish this agreement, the COHC board pursued a state law that would make them governing body of the CCO.

1 | Do you conduct this integrative activity for regional partners? ☐ YES ☐ NO

2 | What specific functions do you conduct?

3 | What specific deliverables do you provide when you conduct those functions?

4 | How do other organizations providing similar functions in your region collaborate or compete with you?

7

INTEGRATIVE ACTIVITY Advocating for Public Policy

Do you conduct any of the following specific functions?

- | | |
|---|---|
| 1. Set policy priorities | 3. Communicate impact of policies |
| 2. Build relationships with thought leaders and policy makers | 4. Implement through influence campaigns and more |

1 | Do you conduct this integrative activity for regional partners? ☐ YES ☐ NO

2 | What specific functions do you conduct?

3 | What specific deliverables do you provide when you conduct those functions?

4 | How do other organizations providing similar functions in your region collaborate or compete with you?

8

INTEGRATIVE ACTIVITY

Monitoring, Measuring, and Evaluating Region-wide Efforts

Do you conduct any of the following specific functions?

- | | |
|---|---|
| 1. Provide strategic guidance and oversight of overall information system | 4. Design and facilitate learning and improvement process |
| 2. Review results and modify action plans | 5. Monitor progress toward shared goals |
| 3. Envision and develop process for sharing results with residents | 6. Design and facilitate forums for accountability to residents |

Example A (see brief on page 25–27)

Name of multisector partnership or organization	Specific function(s)
Trenton Health Team (THT)	THT works with its partner members to design and run regional performance monitoring efforts, using a regional health information exchange (HIE).
Why stakeholders value this function	Arrangements by which stakeholders pay multisector partnership or organization
Now, with one system of aggregated data, THT and others can “watch” how patients move through the community in a way that is timelier and more cost efficient than ever before. THT also provides consulting to partners who want to use the HIE. This allows partners to incorporate the technology into the work they do every day.	THT receives unrestricted revenue from annual HIE membership fees paid by health practitioners who so they have real time access integrated and holistic patient records that support treatment decisions and strategies.

Example B (see brief on page 15–18)

Name of multisector partnership or organization	Specific function(s)
Central Oregon Health Council (COHC)	COHC staff monitors, measures, and evaluates the grants/investments COHC makes in organizations throughout the community, checking for the organizations' adherence to their proposals and informing wise investment strategy.
Why stakeholders value this function	Arrangements by which stakeholders pay multisector partnership or organization
(1) COHC board members (who are the stakeholders) do not have the bandwidth to carry out this work, and want to be in more of a broad, oversight position in reviewing whether COHC is making the wisest investments to realize the goals of the Regional Health Improvement Plan. (2) Working with COHC, the local Medicaid Coordinated Care Organization (CCO) gets to show it is reinvesting savings, informed by the public. This might help the CCO hold on to their state contract with Medicaid—especially since the state seems to look favorably on this model.	The CCO pays, according to a Joint Management Agreement (JMA) formed with COHC. The JMA specifies that whatever payment the Medicaid CCO takes in from the state, per member per month, 0.325 percent (or 3/10 of 1 percent of its total revenue from the state) percent is paid to COHC to be used for operating costs (mostly, to ensure creation and implementation of the RHIP). The JMA also caps the Medicaid CCO's profit at 2 percent and provides that any additional profit must be paid to COHC for reinvestment into the RHIP (this additional profit is called “shared savings.”) In order to be able to establish this agreement, the COHC board pursued a state law that would make them governing body of the CCO.



8

INTEGRATIVE ACTIVITY

CONTINUED

Monitoring, Measuring, and Evaluating Region-wide Efforts

- 1 | Do you conduct this integrative activity for regional partners? ☐ YES ☐ NO
- 2 | What specific functions do you conduct?
- 3 | What specific deliverables do you provide when you conduct those functions?
- 4 | How do other organizations providing similar functions in your region collaborate or compete with you?



BRIEFS

Some Multisector Partnerships Already Get Paid for Their Integrative Activities

Central Oregon Health Council (COHC)²

WEBSITE: COHealthCouncil.org

Integrative Activities COHC Gets Paid For:

- **Analyzing and planning for regional health improvement.** COHC staff acts as a neutral convener to facilitate COHC board's work to reach consensus around a state-required Regional Health Improvement Plan (RHIP).
- **Implementing strategy and managing performance of region-wide effort.** COHC staff coordinates implementation of the RHIP, within the context of the shared purpose established by COHC board.
- **Designing financing structure and strategy.** COHC staff supports COHC board review and approval of proposals from organizations throughout the community that seek grants to help address RHIP goals. COHC allocates grants from funds that are generated through a joint management agreement (JMA) with PacificSource, a Medicaid coordinated care organization (CCO). The CCO's profit is capped at two percent; the JMA provides any profit over two percent to COHC for reinvestment into the RHIP—creating a shared savings arrangement. Recently, the staff has been working with the board to co-create a process that allows staff to take on more of the review and approval process.
- **Monitoring, measuring, and evaluating region-wide efforts.** COHC staff monitors, measures, and evaluates the grants/investments COHC makes to organizations throughout the community. COHC learns from its successes and mistakes, and uses results to inform its future investment strategies.

State of Oregon Establishes COHC to Plan for Regional Health Improvement, but There's No Funding for Implementation

When a local man with severe and persistent mental illness was found dead on the street in 2011, community members knew they had to do better for the region's Medicaid population. This devastating event immediately created a shared value among major health organizations in the community to work together, but they needed a coordinating organization. Bruce Goldberg, who was the state director of Medicaid at the time, heard the community's desire to approach health care differently in Central Oregon, and asked if some influential leaders would be willing to be part of a multisector partnership to better address the health needs of Medicaid patients. They said yes. "Central Oregon is kind of an odd duck," said Donna Mills, director of COHC. "If we believe in something, we will work relentlessly to get it done."

That same year, as a result of Goldberg's efforts, the State of Oregon passed Senate Bill 204 to create the Central Oregon Health Council (COHC) as the community group that would be required to develop and manage a Regional Health Improvement Plan (RHIP), informed by a regional health assessment. COHC became a 501(c)3 and passed bylaws, a step encouraged in the authorizing legislation. The bylaws stipulate that no more than 14 members (from specific sectors influencing health) will have voting power in determining the RHIP's scope of the activities and services.

² Donna Mills, interview by Kim Farris-Berg, February 13, 2017.



Today, these members comprise the board of directors of COHC. Each member of the board must have the authority to make the ultimate decisions on behalf of their organizations and have influence in the community—delegates and proxies are not permitted. Members include the senior vice president of PacificSource (the local CCO that works with the state to provide health services for those enrolled in the Oregon Health Plan), the CEO of the local hospital, the president and founder of the dental care organization (DCO), the superintendent of High Desert Education Services District and Long Term Service Supports, the county commissioners (from each of the three counties served), a leader of behavioral health delivery, the leader from the federally qualified health center, and citizen representatives.

As the members began to plan their first RHIP, it quickly became clear that hiring staff for COHC would be of great value to its board members (and ultimately the community) for one main reason: the staff's ability to serve as a neutral convener. "Negotiating an RHIP with all COHC members, each coming to the table with different perspectives and priorities, is difficult. But our work would be impossible if they did not feel safe and respected in bringing their own perspectives to the table," said Mills. With COHC staff at the center of the work, all the members can help realize the common purpose of better coordinating care for the region's Medicaid population without each board member having to become an expert in coordinating the region's health care, and without having to step out of their own organizational role when they come to the table.

Mills explained, "COHC staff's work is of value to our board members because *they* get to keep being the experts in what they do; they don't have to come here and be the 'jack of all trades and master of none' when it comes to cross-community coordination. I don't wear all of their hats, I just wear COHC's. My role is to be neutral, so each member of the community can do its best work to help co-create our RHIP. In this way, we end up with an RHIP that is rooted in all of their expertise. I have their trust, which puts me in a place to expose and blend the opportunities each of them offers. And we are very transparent. Sometimes members of the finance committee question a line item in our budget. To that I reply, 'Let's talk about it. We need to make sure it's right, and that everyone who wants to learn understands what's going on.'"

With COHC staff at the center of the work, all the members can help realize the common purpose of better coordinating care for the region's Medicaid population without having to become experts in coordination, and without having to step out of their own organizational role when they come to the table.

In its early years, COHC worked hard at establishing a high-performing, collaborative culture, which led to the co-creation of a highly valued RHIP. But implementing the RHIP proved next to impossible without any significant funding—a factor not provided for in legislation (other than the ability to enter into contracts and receive grants). So the board began raising the question: how would it fund the work of the RHIP and the work COHC staff does to coordinate accomplishment of the RHIP?

COHC Determines the Medicaid CCO Will Pay for COHC's Coordination, and Potentially the Work of the RHIP

After what Mills described as a long period of "disagreements and gnashing of teeth" about where sustainable financing ought to come from, COHC board decided to pursue state legislation that would formally make COHC the governing body of PacificSource, the Medicaid CCO. COHC board's intent was to secure formal authority for COHC to enter into a JMA with PacificSource. A JMA would allow them to ensure that the CCO would pay to cover the costs of COHC's operating budget and potentially pay for the work required to carry out the RHIP. A new Senate Bill 648 was passed for this purpose in 2015.

With legislation in hand, the board could work with a team of lawyers to establish the terms of agreement between COHC and PacificSource. The terms were agreed on as follows: whatever payment PacificSource takes in from the state, per member per month, 0.325 percent (or 3/10 of 1 percent of its total revenue from the state) is paid to COHC to be used for operating costs. There is also a secondary stream of funding embedded into the agreement, called "shared savings," which caps PacificSource's profit at two percent and provides that any additional profit must be paid to COHC for reinvestment into the RHIP. (No one ever expected this to be used, but Medicaid expansion created an influx of unexpected funding.)



When asked why PacificSource is willing to pay, Mills speculated, “If there is additional profit and it goes to COHC, even if we hold it for a bit, the public sees it as money reinvested in the community. If PacificSource hangs on to any additional profit, they are seen as withholding it from the community, even if they plan to hand it over when needed. In this arrangement, PacificSource gets to create a different image. They can show they are working with COHC to ensure reinvestment of savings, and that the public informs the reinvestment strategy. This could potentially help them hold on to their state contract with Medicaid—especially since no other CCO is doing this and the state looks favorably on this model.”

In 2014, 2015, and 2016, due to uncertainties about Medicaid expansion, Oregon overestimated the pent-up demand for health care services Medicaid recipients might use. PacificSource paid COHC \$17 million in shared savings. COHC immediately called for community members to submit proposals that aligned with the RHIP, and formed a special committee to review and approve them. As of 2018, \$9 million has been reinvested in the community.

Until recently, COHC board has had a significant role in reviewing and approving any proposals over \$150,000, but this has made the approval process unintentionally cumbersome. COHC staff is now working with the board to co-create a process that will allow the staff to take on more of that role in a way that continues to consider the board’s shared purpose (mission, vision, values, and goals established in the RHIP). COHC recently hired a data analyst to assist in ensuring adequate measurement and oversight of their investments.

A positive side benefit of receiving the \$17 million has been that the broader community is increasingly attracted to getting involved with COHC, which has allowed two important things: (1) internally, the staff has been able to open important conversations with the board about widening its circle of members; and (2) externally, COHC has been able to demonstrate just how well the concept of organizations like COHC can work on behalf of the community.

Mills said, “It makes sense that more people want to join us! We’ve got money, and they would like some of it. We say, ‘If you start participating, you will have a voice! And our current board and staff will understand more about what you do, so you’ll have a better chance of your proposal being understood and approved.’ We also know that, when they see what’s happening at the table, they’ll understand better where the money is going and why, and they’ll come to appreciate why our standards for approval are so high.”

What’s Next?

There are 16 other CCOs operating in communities across Oregon, but only two regions have the business model that COHC does with PacificSource (the other is a similar community group in another region). And in most communities, even planning the RHIP is the job of public health professionals. The COHC-PacificSource arrangement was considered somewhat of an experiment, so the legislation is scheduled to sunset in 2022. COHC is advocating for an extension, and Mills reports that the state of Oregon is interested in encouraging similar models in the next iteration of its CCO legislation. Some policy makers are already informally talking about creating “CCO 2.0.”

But if that is not to be, it’s important to understand that Senate Bill 204 would still exist—so COHC would continue to exist, and would need to find other means of sustainable financing. In fact, COHC is well aware that it should also be prepared for lesser amount of shared savings under the current arrangement, which would happen if the Oregon Health Authority were to impact the CCO’s profit margin by reducing the Medicaid reimbursement rates. As a precaution, COHC planned a five-year budget as if no additional shared savings would be available to it in future years. And COHC has invested some of the shared savings already earned, for the long-term interest of the community.

COHC believes that its regional presence—its understanding of the local players and how to make things happen in the region—could attract funding, especially as the state and other groups seek COHC’s expertise in making programs work. Some possibilities for funding include:

- All of the board members could make a financial contribution relative to the value they receive from COHC.
- COHC could be a fiscal agent (i.e., performing financial duties on another organization’s behalf) for organizations that need such a service within the region.

- COHC could secure arrangements similar to the one it has with PacificSource with other payers (perhaps as part of their community benefit spending), given that the population health work COHC does has benefits beyond the Medicaid population.
- COHC could pursue large grants.

What Are the Challenges?

- *COHC staff must be widely trusted in order to maintain effectiveness as a neutral convener.* Being perceived as friendly, open, and trustworthy to all stakeholders is the key to effectiveness, and requires the staff to have very specific interpersonal skills.
- *If the shared savings weren't going to COHC, PacificSource would probably keep it.* COHC must consistently demonstrate its value to PacificSource and other stakeholders.
- *There are a lot of unknowns.* Will the Senate Bill 648 arrangement extend past its current planned sunset in 2022? How much will shared savings vary from year to year? Will smaller CCOs, like PacificSource, even be able to stay in business as rates are cut and if Medicaid populations are reduced? It's hard to make predictions about what's ahead in this environment, and working to open other lines of business "just in case" while preserving current funding sources is a lot of work.

Resources:

Oregon Senate Bill 648, 2015³ : Established COHC as the governing body for the CCO (so it could enter into formal agreements to receive funding from the CCO).

Oregon Senate Bill 204, 2011, Sections 13-18⁴ : Established COHC as a community group that would be required to develop the Regional Health Improvement Plan (RHIP).

³ <https://olis.leg.state.or.us/liz/2015R1/Downloads/MeasureDocument/SB648/Introduced>

⁴ <https://olis.leg.state.or.us/liz/2011R1/Downloads/MeasureDocument/SB204>



Greater Fall River Partners for a Healthier Community (GFR Partners)

WEBSITE: GFRpartners.com

Integrative Activities GFR Partners Gets Paid For:

- **Analyzing and planning for regional health improvement.** Neutral convener of a coalition of 25 member organizations that collaboratively plan prevention strategies for benefit of the community.
- **Designing financing structure and strategy.** Helps small groups of stakeholders work together to secure large grants for projects that will improve prevention in the region.

Commonwealth of Massachusetts Amends the Determination of Need Regulation to Provide Dedicated Funding for 27 Community Health Network Areas

In the early 1990s, Dave Mulligan, a visionary commissioner of the Massachusetts Department of Public Health (DPH), advanced a message that health is not created by hospitals, where people go when they already have diseases, but is instead a function of community health prevention efforts. He asserted that hospitals have a responsibility to help support prevention work in the communities, and that the community itself ought to have the lead role in determining how the prevention money is best spent for its specific population and context. This can be particularly important in Massachusetts where there's a perception that state-level decisions are sometimes the result of Boston-centric thinking (other parts of the state have very different needs).


Acting on this vision, Mulligan helped enact amendments to the Determination of Need (DoN) statute that divided the state into 27 Community Health Network Areas (CHNAs), each with the purpose of bringing community expertise into regional strategy development around prevention. To fund each CHNA, hospitals within each of the 27 geographic boundaries must dedicate five percent of any hospital construction project costs (which must be approved by DPH) to prevention work in their respective boundary. The hospitals make payments to their local CHNA over five years. Currently, all the Massachusetts CHNAs together are receiving about \$107 million from construction projects.

In Boston, there are 17 hospitals whose projects fund one CHNA and that CHNA, therefore, has millions of dollars to work with. The Greater Fall River area, by contrast, has two hospitals, and both have provided funding to the area's CHNA, the Greater Fall River Partners (GFR Partners), as part of their hospital construction budgets. The last project resulted in \$215,000 of unrestricted funding per year for five years. There have been other projects with other amounts, and the projects sometimes overlap so there are multiple income streams at once. The stakeholders involved with GFR Partners feel a sense of responsibility to use those funds to cover the costs of something the 15-25 community partners on the steering committee value—GFR Partners' role as a neutral convener leading the partners through collaborative analysis and planning for what's needed to achieve regional health improvement.

The Commonwealth and Its Communities Are Getting Plenty of Value from State Investment

The purpose of the Commonwealth's investment is to bring community expertise into regional strategy development around prevention. This is happening in the Greater Fall River area in at least three ways:

⁵ David Weed and Wendy Garf-Lipp, interview by Kim Farris-Berg, October 26, 2016.



First, GFR Partners has established a coalition of 25 member organizations that take ownership of collaboratively-developed prevention efforts, for benefit of the community overall. Every member organization has representation on the GFR Partners' steering committee, which has cultivated high levels of collaboration in setting and accomplishing a shared set of goals and objectives. Partners recognize that collaboration brings more grants (and potentially other funding) to the community and this leads each organization to bring many funding opportunities to the full table so partners can work together to decide who is best positioned to be the lead agency.

"None of our community problems can be solved by any one agency," said GFR Partners Secretary Wendy Garf-Lipp. "We have to apply a holistic approach." For example, multiple organizations are involved in youth prevention work—sometimes working collaboratively with a multi-agency grant and sometimes raising their own project funds for organization-specific goals that align with the GFR Partners' larger goals. This collaborative strategy led to a 37 percent reduction in youth violence over its first two years.

"As a nation we've done so much R&D. What we don't have is a way to implement what we we've learned at the community level, unless funding is built into the system like it is here in Massachusetts."

- Dr. David Weed

Dr. David Weed, a former GFR Partners executive director, said, "Dedicated state funding results in a feeling of shared, local ownership. GFR Partners has been here for 25 years now, with a sustainable funding source. People know us, they are part of us, they vote on these collaborative goals! Because the state makes it a priority to make this substantial investment at the community level, we all feel it is our responsibility to make the funding really work for our community. This is so important because at this time there are a thousand demonstrations of what works—as a nation we've done so much R&D. What many communities don't have is a way to implement at the community level, unless funding is built into the system like it is here in Massachusetts."

Second, GFR Partners has figured out ways to improve the community from the inside out, in partnership with stakeholders. There is no official building or office for the GFR Partners, a 501(c)3 in which everyone works remotely. All of GFR Partners' employees, two full-time and three part-time staff, are funded through the DoN funding, and are housed throughout the community. The GFR Partners' steering committee has found that working to establish a strong presence in the right places allows stakeholders to work from the inside out to more swiftly realize community goals. For example, a GFR employee who was placed in the education department was instrumental in leveraging her relationships inside her organization to uncover the need for a department head for physical education in order to achieve community goals. As a result, GFR Partners funded a new "head of physical education" position, which has been critical to increasing the commitment to physical education inside Greater Fall River schools.

GFR Partners points out that this is a far better investment of state money than the more typical top-down mandates, which are not only costly to administer, but which often get limited support at the community-level. "There are hundreds of millions of dollars going through this community in all aspects, and we are coordinating a lot of that with just \$215,000 a year. Why can't this exist in every community in America?" asked Weed. Garf-Lipp added, "Our mantra is the community will tell us what it really needs. This work has far more impact than what results when communities are only responsible for carrying out top-down mandates from state and federal officials who don't know what's happening at the local level."

Third, GFR Partners knows its local stakeholders (and their regional plan) well enough to help them respond quickly to opportunities to secure additional funding for projects that will increase prevention in the region. GFR Partners helps members of their partnership realize community priorities by:

- monitoring and identifying the right opportunities;
- perpetually helping stakeholders form strong relationships and common goals with each other, which make quick commitment to large, collaborative projects easier;
- bringing the right collaborators to a project by being aware of stakeholders' strengths and capacities;
- working together with collaborators to determine which organization is best equipped to be the lead agency to pursue a given opportunity; and
- working with the lead agency to bring all the pieces together to author and secure large grants on behalf of the group.



What Are the Challenges?

- *Basing DoN funding on geography has yielded imbalanced results across CHNAs.* Hospital construction happens more in urban areas than in rural ones, so a handful of the original 27 CHNAs are now defunct (they never had a sustainable source of revenue), and seven or eight are really struggling due to limited funding. That said, GFR Partners estimates that there are 10-12 CHNAs that are incredibly high functioning and several more that are high functioning.

Discussion is underway about ways to potentially modify this process to be more geographically inclusive, and help more CHNAs get to this level of function. One idea on the table is to put all the money from various hospitals into a single pot, and redistribute by population numbers. Another idea is to place CHNA's geographic boundaries around populations of 150,000.

- *High-functioning CHNAs need to prepare themselves for the possibility that no new construction will occur, and their funding streams will run dry.* This is true for all CHNAs, but is currently a real possibility in Greater Fall River. With its two hospitals in litigation over which will provide a particular service, and construction projects on hold, GFR Partners' funding stream could dry up in 2020. The CHNA is not taking any chances and is broadening its financial plan in case an alternate strategy is needed.
- *CHNAs need to fully understand the DoN regulation so they are prepared when challenged about what, exactly, it authorizes.* One hospital some time ago, for example, told GFR Partners that the DoN regulation specifies the CHNA must spend most of the funds on direct mental health services. But GFR Partners was well-versed in the regulation and pushed back, emphasizing that its purpose is not to provide direct service, and explaining that the community did not identify mental health as a top priority. Had GFR Partners not been so well-versed, it wouldn't have been so easily able to hold its ground.

Resources:

[Determination of Need Factor 9, Community Health Initiatives, Policies and Procedures](http://www.mass.gov/eohhs/docs/dph/quality/don/don-community-health-initiatives.pdf)⁶

Overview of the DoN regulation (105 CMR 100.000), established by Commonwealth of Massachusetts to promote the availability and accessibility of cost-effective, quality health care services to citizens and assist in controlling health care costs

[Determination of Need Regulation \(105 CMR 100.000\)](http://www.mass.gov/eohhs/docs/dph/regs/105cmr100.pdf)⁷

Regulation language

⁶ <http://www.mass.gov/eohhs/docs/dph/quality/don/don-community-health-initiatives.pdf>

⁷ <http://www.mass.gov/eohhs/docs/dph/regs/105cmr100.pdf>



“

If these opportunities were pursued by whoever felt like applying, our community would hardly ever see these major grants, I often go to our members and say, ‘Here’s a great opportunity. Let’s see what we can partner up on and pull together.’ GFR Partners has built up enough trust that now our stakeholders bring the opportunities to us to help them find the right team. Our stakeholders have learned that closed-doors are destructive to the community process.

- Dr. David Weed, former GFR Partners Executive Director



Michigan Health Improvement Alliance, Inc. (MiHIA)⁸

WEBSITE: MiHIA.org

Integrative Activities MiHIA Gets Paid For:

- **Convening stakeholders for cross-sector collaboration and information sharing.** Neutral convener to bring about information sharing and cross-sector collaboration among multisector partnership stakeholders.

MiHIA Is Valued By Stakeholders As a Neutral Convener That Helps Stakeholders Establish Shared Goals

The Michigan Health Improvement Alliance, Inc., or MiHIA (pronounced ma-high-ah), is a formal 501(c)3, multisector partnership working to achieve health excellence for the 14-county region it serves. This initiative is based on a core belief that solutions to health and health care problems can be found and designed at a regional level, accelerating regional competitive advantage and sustainability. MiHIA's work varies, but it all falls under what it calls the "Quadruple Aim," which targets health and systems broadly at the regional level. The Quadruple Aim focuses on four facets of health delivery—population health; patient experience; cost of care; and work-life balance for health care providers, clinicians, and staff. At the individual level, this translates to good or better health, high-quality care, and good value.

As the convener for multiple parties, MiHIA helps its stakeholders establish shared goals and objectives, set collective targets, and align business plans. Stakeholders value the opportunity to influence how the Quadruple Aim will be pursued in their community. If their own priorities are reflected in the decisions and outcomes, they often get more out of their own investment in health and health care. MiHIA's board of directors is comprised of representatives from every sector involved with MiHIA—including hospital systems, independent providers, universities, mental health organizations, consumers, health plans, economic development, nonprofits, and employers.

MiHIA Makes a Value Case to Each Stakeholder Organization to Secure Their Investment

MiHIA demonstrates to each stakeholder organization how it has helped that organization be more successful in achieving the organization's own mission and leveraging funding (for help making a case for your own work, see [Module 5](#)). Most importantly, each case presented by MiHIA details specific benefits that merit the stakeholder's ongoing participation and investment. The level of detail needed in the case depends on the stakeholder. Some examples:

A hospital's value case described how MiHIA supported a community organization in obtaining a grant that established county community health workers as part of a sustainable health system. As part of that grant, the hospital system got to utilize those workers, who already had full salary funding. MiHIA showed the hospital that it had access to \$3 million worth of value, thanks to this one grant alone.

MiHIA also built the capacity for a multi-county Diabetes Prevention Program, including bringing three master lifestyle coach trainers to the region, which enabled self-insured employers to offer the program as a covered benefit. This essentially secured hospitals a new, revenue-producing line of service. In addition, MiHIA maintains a database that holds information that helps hospitals complete their community health needs assessments.

A university's value case is different. MiHIA shows how its work supports the institutions in building the health professional pipeline as well as in securing research grants. The grants support work at the medical school and help attract faculty and students.

⁸ Beth Roszatycki and Catherine Baase, interview by Stacy Becker, October 4, 2016.



Stakeholders from various sectors are willing and able to pay MiHIA in the following two ways:

1. **Corporate contributions** (total dues of \$225,000–\$300,000 annually to fund operations for integrative activities). MiHIA approaches each stakeholder represented on the board of directors with its specific value case and asks for a multi-year payment commitment. Typically, MiHIA proposes an amount the stakeholder should pay. Upon agreement, MiHIA asks the stakeholder to sign a commitment letter and sends invoices annually.

There are two formats in which corporate contributions are requested by MiHIA. One format is a contribution based on the number of covered lives in their benefit plan per year. Employers spend \$7,000–\$8,000 a year per covered life already, so MiHIA requests a contribution of \$3 per covered life (a small amount, mainly for the employers to show commitment to the community's goals). MiHIA also makes the case that this would improve the value of every dollar the employers spends on benefits.

The second format is a flat contribution request to each organization, asking each to pay a predetermined amount depending on its size (for example \$10,000 if you have x number of employees, \$5,000 if y number, and so on).

2. **Via an affiliate organization, which was established by MiHIA** (currently earns \$20,000 annually; goal is to work to \$25,000 to fund operations for integrative activities). Some of MiHIA's largest stakeholders (e.g., pharmaceutical companies, pharmacies, insurers) have money designated for increasing their corporate presence in the community but are unable to make direct contributions. Some of those stakeholders suggested that they could contribute funds for MiHIA to use for general operations if it were a membership organization. However, becoming a membership organization would have potentially disrupted its corporate contributions, so MiHIA looked for alternatives. Catherine Baase, chairperson of the MiHIA board of directors and former chief health officer at The Dow Chemical Company (a major anchor organization and employer in the region), had observed that other professional organizations have affiliates with the sole mission of accepting funds to support the mission and functioning of the professional organization. In 2016, MiHIA decided to establish such an affiliate organization, which would allow these contributors to be publicly named affiliates (listed on the website) who are recognized as highly committed participants, which gives the added benefit of name recognition.

What Are the Challenges?

- *There is only so much capacity and making individualized value cases for each stakeholder takes work.* MiHIA is grappling with the question of how much time it should put toward soliciting funding (managing communications, preparing customized value cases for each stakeholder, etc.) as compared to doing the work that is actually of value to the organizations and convinces them to contribute. “We are always examining the best use of our time and resources,” said Baase.
- *MiHIA staff and members could get too insulated in their own community.* They strive to consistently look across the nation at other multisector partnerships, organizations, and industries to learn new and different ways of going about their financing work.

Trenton Health Team (THT)⁹

WEBSITE: TrentonHealthTeam.org

Integrative Activities THT Gets Paid For:

- **Monitoring, measuring, and evaluating region-wide efforts.** THT works with its partner-members to design and monitor regional health care performance, using a regional health information exchange (HIE).
- **Implementing strategy and managing performance of region-wide efforts.** THT consistently works to ensure that HIE data can be used to help partner-members design initiatives that focus on areas of highest need and evaluate progress. The HIE also uses data on high utilizers of services to support THT's Care Management Team, which helps patients manage chronic conditions and access services in an effort to decrease emergency room visits.

DEFINITION

A Health Information Exchange (HIE) system allows health care providers and patients to securely share a patient's medical information electronically—standardizing data and improving the speed, quality, safety, and cost of patient care.

Trenton Health Team Creates Value for Its Partner-members Through Five Initiatives That Address Lack of Collaboration Among Care Providers

Trenton Health Team (THT) first came together in 2006 as the [result](#)¹⁰ of a report commissioned by Mayor Douglas Palmer to assess the impact of the proposed closure of Mercer Hospital. In February 2006, the Mayor of Trenton commissioned a study to research and develop a plan for improving the health status of Trenton's residents and increasing access to health care services. The study found that residents of Trenton, New Jersey did not have consistent access to primary care; accessed numerous, disconnected providers; and utilized emergency departments to meet their health needs—despite being served by three hospitals, a federally qualified health center, and a city health clinic.

As a result, the health status of Trenton residents was lower than their Mercer County neighbors and the rest of New Jersey. The study also recognized that the utilization of hospital emergency rooms by city residents was 54 percent higher than the national norm, leading to costly, inefficient, duplicative, episodic, and unsatisfactory health care. The study's final report recommended that the city's care providers collaborate to solve these health care problems.

As described on THT's website, "fierce competitors" came together to respond to this call for action. As those providers began to find common ground, a partnership grew. THT was formally constituted as a 501(c)(3) in February of 2010 to conduct a number of integrative activities for the partners. The partnership included more than 60 different community organizations, representing a variety of municipal, county, and state agencies; social service groups; the faith community; and higher education. Together these community organizations serve as members of THT's board of directors, its subcommittees, or community advisory board. THT's mission is two-fold: to make Trenton the healthiest city in the state, and to transform and reform the health care system. Today, THT is working to make this vision a reality by conducting integrative activities for five strategic initiatives:

- Expansion of access to primary care
- Community-wide clinical care coordination
- Engagement of residents
- Operation of the Trenton health information exchange (HIE)
- Serving as a Medicaid Accountable Care Organization (ACO)

⁹ Greg Paulson, interview by Kim Farris-Berg and Lindsey Alexander, April 7, 2017. Follow-up interview by Katherine Wright, March 29, 2018.

¹⁰ <https://trentonhealthteam.org/wp-content/uploads/Making-Trentons-Healthcare-Plans-A-Reality-August-7-2006.pdf>



In Addition to Grants, THT and Its Five Initiatives Generate Two Revenue Streams: Annual HIE Membership Fees and Service Contracts

THT receives grants, which reimburse some of the indirect costs of conducting integrative activities for its initiatives (including salaries). General operation costs are covered using unrestricted funds from two additional revenue sources:

1. **Annual HIE membership fees from health practitioners who pay to access integrated and holistic patient records in real-time to support treatment decisions and strategies.** Since Trenton is a relatively small community with safety-net providers and hospitals, and since THT partner-members want to limit financial barriers to using the HIE, the annual HIE membership fee pricing model is more appropriate for the community than the more expensive traditional usage-based pricing model. Membership fees are set by the HIE Steering Committee, which is comprised of representatives of each member institution. The fees are based on institution type, ranging from approximately \$15k for smaller clinics to more than \$100k for hospitals. The HIE launched in January of 2014 using a health-based information technology vendor, CareEvolution, and quickly grew as providers learned the value of the HIE's data. Now more than 600 clinical users have access to millions of clinical and Medicaid claims records for more than 250,000 patients. The data partners include fourteen participating institutions that contribute to the HIE by sending or receiving data.
2. **Member organizations and other organizational partners contract THT for services.** For example, partners (both health plans and hospitals) contract with THT for the services of its Care Management Team, a highly effective and scalable service, which helps patients access a range of services. The Care Management Team provides basic health education, connects patients to social services, takes them to the pharmacy, and/or accompanies them to appointments. Health practitioners also contract with THT to access more complex, specific HIE services that do not come with the basic package as part of the annual membership fee. The Care Management Team currently creates just enough revenue to cover its costs, which are relatively high, due to the intensity of the work.

Overall, the Care Management Team service contracts and the HIE membership fees generate revenue which THT uses to cover Care Management Team costs, general infrastructure costs, and the rare initiative costs that happen to exceed their allotted budget, which are essential to the mission.

Data Generated By THT's HIE Is a Revenue Source That Also Helps Ensure Better Patient Treatment Across the Region

In Trenton, the HIE plays a vital role in advancing efforts to improve population health, allowing THT to generate integrated reports designed to identify issues and trends around particular health needs or disease conditions. THT's HIE does this for clinical organizations, public health agencies, and more. THT regularly solicits feedback from users to ensure that the HIE is serving their needs and remains an effective tool for regional health improvement. THT's goal is not only to provide the right data to organizations but also expertise to help partners interpret the data correctly (for instance, a partner might know what they want to learn, but not know how to use the data to find the answer).

Currently, THT is partnering with a small payer (covering about 3,000 lives) that is using the HIE data. Greg Paulson, executive director of THT, reports, "The payer cannot believe everything they can now see because they're used to only seeing claims data. They previously did not know about an ER visit for 90 days, but now they can see who of their members were in the ER yesterday. This is revolutionary to them." Without such information in the past, this payer was unable to track their member population and their health in real time. Now, with one system of aggregated data, THT and others can "watch" how patients move through the community in a way that is timelier and more cost-efficient than ever before.

As Paulson says, "Partners get both a data source and something of a consulting piece" when using the HIE, and partners are looking for answers to difficult, pressing questions so "they can reflect the technology back to their day jobs."

THT's Care Management Team would also be less efficient and effective without this information. When relying on the ER for care, patients receive treatment from different clinicians, which can result in fragmented and



sometimes repetitive or contradictory treatment. The Care Management Team, on the other hand, offers complete care, known as wrap-around services, which include help accessing social and psychological services as well as primary health care. They need to access new and different data in new and different ways.

THT is at the forefront of using cross-institutional and combined claims and clinical data to direct and monitor population level health improvement activities. “Using the capabilities of the HIE to pinpoint community needs,” Paulson says, “users are able to move beyond just getting records on one patient.” While the Care Management Team doesn’t generate a revenue margin, it is a critical part of meeting the individual need in the community. As Paulson says, “Creating data systems is great, but if you don’t get out to the people and help them get their needs met...it is all for naught. The Care Management Team functions as an important part of our intervention to connect individuals in the community and provide the services they need.” Their work is made all the more effective because it is built around the HIE’s ability to report on the needs in the community.

What Are the Challenges?

- *Promotion of the HIE and Care Management Team’s ongoing value is necessary—and expensive.* Most of the revenue generated from the HIE goes into ongoing efforts to recruit new users and remind current users of its value. This promotional work has a cost that must be factored in when considering how much funding the HIE might generate.
- *Infrastructure costs, and associated staff costs, are expensive given the cost of health IT systems in general.* THT, and other organizations running HIEs in New Jersey, are wrestling with how to design their ongoing business models to cover high infrastructure and staffing costs. Federal and state grants paid for the early work, but aggregating and effectively analyzing disparate data sources in order to improve health outcomes is expensive.