North Carolina Institute of Medicine
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Task Force on Accountable Care Communities

TASK FORCE ON ACCOUNTABLE CARE COMMUNITIES

MEETING SUMMARY

April 6, 2018

10:00 am – 3:00 pm

North Carolina Institute of Medicine

630 Davis Drive

Morrisville, NC 27560

Attendees:

- *Co-Chairs:* Sec. Mandy Cohen
- *Steering Committee:* Jason Baisden, Chris Collins, Allison Owen, Melanie Phelps, Jeff Spade, Shelisa Howard-Martinez
- *Task Force Members*: Donna Albertone, Paula Swepson Avery, Blair Barton-Percival, Rep. MaryAnn Black, Tristan Bruner, Brett Byerly, Heidi Carter, Debbie Collins, Satana Deberry, Al Delia, Howard Eisenson, Rebecca Nagaishi (for Robert Feikema), Peter Freeman, Mark Gwynne, Robby Hall, Christine Pernell (for Nicole Johnson), Lisa Macon Harrison, Ann Meletzke, Nicolle Miller, Kevin Moore, Kristin O'Connor, Abbey Piner, Maggie Sauer, Linda Shaw, Pam Silberman, Anne Thomas, Sheree Vodicka, Ciara Zachary; *Via phone*: Kim Green, Shauna Guthrie, Eva Meekins, Mary Warren

Introductions:

Task Force member Pam Silberman opened the meeting and asked Task Force members to introduce themselves. Steering committee members, Task Force members, and guests introduced themselves, including their position and the organization they represent.

Panel: Coordinated Community Health Assessment/Community Health Needs Assessment and Working With Communities
Marian Arledge, Executive Director, WNC Health Network

Ms. Arledge explained that community health (needs) assessments are a systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community. She described WNC Healthy Impact's role in facilitating Community Health Assessments (CHA) as systematic, neutral, and including community members. With a regional approach there are challenges of having feedback from a large group and needing to be careful to maintain local autonomy.

The first step in coordinating the region's CHAs was time cycle alignment. A regional approach helps to make primary data collection data collection consistent by using standardized collection methods and allows for data comparison across communities. Participants are trained on using data collection methods to help reach groups that might be less accessible through a phone or internet survey, such as photo voice and focus groups. WNC Healthy Impact has used secondary data to create regional comparisons that are given to each county and uses scorecard software called Clear Impact to display data. They support action planning and provide electronic community health improvement plans with a data tracking and display tool. Results-based accountability is a key tool used by the group for measuring results.

William Broughton, Coordinator, office of Health Access, Brody School of Medicine at East Carolina University

Mr. Broughton described the problems with each county and each hospital doing their own CH(N)A, including duplication of efforts and lack of comparability of data from fragmented surveys. Similar to WNC Healthy Impact, standardizing the questions people are using and getting everyone on the same cycle has been the first step to their work. The initiative has a steering committee to guide this shift from local to regional and work began in January 2015 to organize stakeholders and define the process. Data collection for the first assessment cycle is beginning this month and will go until October 2018. An important aspect of the partnership is that the health departments and hospitals signed the same Memorandum of Understanding. Participants include 33 counties, and in most counties the health department and hospital are partnering. They will collect primary data using an online community health survey and compare the demographics of respondents to the secondary data demographics. A vendor (Conduent) was hired and they are also writing county-level reports using a standard template for each participating county, and then doing a regional report to identify opportunities for action at the regional level. Health departments and hospitals will be responsible for distributing the surveys in their communities, targeting groups with low response rates, attending focus group trainings, organize and facilitating focus groups. Ongoing efforts will include partnering with the Foundation for Health Leadership and Innovation, seeking out funding for the regional approach, finding an anchor organization that can keep the initiative going without having to worry about employee turnover, and building partnerships to foster collaborations and identify pervasive regional issues. They are also exploring collaboration with the WNC Health Network.

Zack King, Interim Public Health Strategist, Catawba County Public Health, LiveWell Catawba

Mr. King explained that LiveWell Catawba started as a sub-committee but is now an independent non-profit organization. They have supported a collaborative community assessment process since 2007 with the health system providing much capital to the process. He asserted that the collaborative assessment and the commonly defined goals should be what drives the work of partners and holds the partnerships together. At their core, LiveWell Catawba is seeking to broaden the definition of health and keep a strong commitment to equity, particularly in how they assess health in the community. There has been a shift in how health is understood, with both hospitals and public health focusing increasingly on social determinants of health. They are creating opportunities for mutually-reinforcing activities among

sectors and have seen how the health assessment has impacted things outside of what LiveWell touches, including other organizations using the health assessment in developing their strategic plans. The next health assessment processes include online GIS map that includes health data and social determinants of health, engagement around the interactive platform, institutionalizing wins – making it a policy for local government and other agencies to be informed by the CHA, strengthening data-sharing processes, and participatory inclusion of the community – going beyond the agencies, not doing things "for," "to," or "on behalf of" people but "with," and "about" them. This final point emphasized the need to bring community members to the table early on, rather than inviting them later, thus doing them a disservice in the process.

Questions/Discussion:

Question: What primary data sources are you using?
Response: Marian: When Healthy Impact started, they used a vendor to do a shared survey and do a representative sample. They are now in the third cycle of this survey. They start with what secondary data already exists. Clinical partners share state data, and 211 data, so they look at that first before deciding what primary data needs to be collected. Zach: With our county GIS dept. we've had a lot of project support for specific initiatives, so we could encourage our county GIS to broaden the perspective and not only use it to prioritize resources. Marian: In rural areas maps can sometimes be less meaningful, as there is a less density to drill down into. Zack: We need to be having conversations about how to move to a regional approach because there is a lot difficulty in defining regions.

Question: Noticed that many less healthy counties are not included in the Health ENC collaborative, why not?
Response: Zack - There are challenges around defining a region for smaller areas. Will – Some of the counties did not want to give up their autonomy.

Arledge presentation here.

Broughton presentation here.

King presentation here.

Stakeholder and Community Partner Engagement: Best Practices in Developing Partnerships
Calvin Allen, Director, Rural Forward NC, Foundation for Health Leadership and Innovation

Mr. Allen explained that Rural Forward NC provides capacity building services and seek key changes, including: more diverse partners at the table, increased collaboration and communication, working toward a common goal. As network of partners grows, hopefully gaps start to disappear. Rural Forward has found that social media has been a useful tool for communication among partners. They are working in skill translation – models that may work in one setting (e.g. Rural vs. urban) but not in another so how can we adapt the model to be effective in other areas. He shared lessons learned

around coalition building, including that: sharing data is a big deal, developing trust is foundational to innovation, and having a core group to serve as leadership is helpful. They have found that partners working in the same county sometimes do not know they are working in the same community. Collaboration traps include: needing an incentive for organizations to be involved, voices need to be evenly distributed, need to have access to necessary resources, partners should have equitable roles, and needing buy-in from people who can make the decisions. Partnerships are on a spectrum from simple information exchange to consolidated mission and/or structure. He listed six useful tools for partnership and collaboration: 1) MOU or statement of desired outcomes, 2) An asset map – includes not only data but relationships, etc., 3) Temporary structure and roles (a convener, a chair, a facilitator), 4) One pager to describe the group (including a mission & vision), 5) Strategic plan with benchmarks and timelines, 6) Permanent structure so that there is accountability among partners. Partners can get into process fatigue and you may lose some of the action-oriented people during the process. This is normal, and they will usually come back once the action is going. Mr. Allen provided a handout on Aspects of White Supremacy Culture and its impacts on collaborative work amongst diverse groups. He highlighted two points: Relying too much on data and Reliance on objectivity – open conflict is okay if it is productive, it can build trust.

Questions/Discussion:

Question: How do you facilitate those conversations for people for whom data might not be useful?
Response: You need to find ways to get past the people who always speak, creative ways to get voices in the room.

Question: seems like a lot of collaboration starts because one party sees a problem and either sees overlap or needs resources from others. Is a backbone organization necessary to effective collaboration?
Answer: Most of the room agreed that a backbone organization is important.

Allen presentation here.

Shared Governance
Christine McNamee, Executive Director, Cape Fear HealthNet

Ms. McNamee provided an overview of Cape Fear HealthNet's (CFHN) goals and explained that collaboration often arises because of availability of funding. CFHN came out of Cape Fear Healthy Carolinians. Their collaborative model includes a board. Cape Fear Area United Way wanted to have a large grant to fund the safety net, so CFHN developed a collaborative grant and developed a matrix. In developing the matrix, they had to consider all the variations between the partners in terms of resources, services, patients etc. They had to put a dollar figure for the various service units in order to equitably divvy up the resources. Each organization had different priorities and had to come up with collaborative approaches for referrals, enrollment, and grant writing. In FY 2018 they are moving away from counting outputs to look at outcomes, looking at clinical values. Their formalized collaboration includes: MOUs between funded partners, grant agreements specific to each grant, business

agreements, rules and requirements – agreed upon rules to maintain being a funded partner. Ms. McNamee shared some issues with shared governance, including: funding provides a carrot but also creates competition for funds; market share – there have been times when the clinics have been over capacity, but now that clinics are looking for patients, there is some competition if a client chooses a different clinic for their needs; fairness; and conflicts of interest – CFHN has a board that CFHN funds. Some of the benefits of shared governance include: stability – have been able to stabilize safety net clinics in turbulent times for health care; sharing the wealth; more efficient programming; and better patient care

Questions/Discussion:

Question: You were cautious in collecting outcome data, how are people feeling about using that as a benchmark for resource distribution?
Response: This is something that clinics are worrying about.

Question: With social determinants of health being the primary focus of this Task Force, how is your collaboration looking at those?
Response: We have a screening and we do have a list of referrals we can provide. It's an issue of limited capacity in being able to really address social determinants.

McNamee presentation here.

Panel: Experiences Engaging Community Partners
Roxanne Elliott, Project Director, First Health of the Carolinas

Ms. Elliott discussed the implementation of The Daily Mile in Montgomery and Richmond counties, which were the first in the US to implement the program. The healthcare system paid for trails at schools and asked for the schools to open the trails to the community. Transparency in partnerships has been key. There are a lot of partners at the table because of a shared vision of improving health of the community. They found that they didn't need official documents to formalize partnerships; that was unwanted by the community. Ms. Elliott reiterated the point that Mr. Allen made about partners coming in and out of the process at any time because of interest and capacity. Her recommendations for successful partnerships include: everyone comes to the table around a shared vision; building trust is vital; celebrate accomplishments – even small ones; Collective Impact Model can be informal.

Brett Byerly, Executive Director, Greensboro Housing Coalition
Josie Williams, Project Coordinator, Greensboro Housing Coalition

Ms. Williams and Mr. Byerly discussed their work with the Collaborative Cottage Grove project. Greensboro Housing Coalition is the lead agency for the collaborative and receives the funding for distribution to partners. The collaborative began with about four partners in 2015 and has now grown to about 15 partner organizations that participate in bi-weekly partner meetings. The collaborative is a

community-centered health partnership to address social determinants of health and increase community capacity to improve health in the Cottage Grove community of approximately 4,000 people. The community has a resilient population, which was historically an affluent African American community that is now disproportionately affected by chronic disease and poverty. Ms. Williams said that building relationships is key – not only across sectors but within the community and working with people not for them. There are a lot of environmental concerns in the community, including housing and infrastructure. The collaborative's number one priority is creating community ties. Getting out into the community and showing up builds trust. Health equity and social justice are significant factors in their work. One of the collaborative's partners is UNC-Greensboro, where they are mapping social determinants of health and related health concerns. The collaborative is rethinking how to get community feedback – when going out to collect data, residents have guided the process. They have done over a thousand surveys with residents to identify community hopes. As part of this work, residents get a small stipend, meal, childcare, or other helpful incentive for participating. Every month they have more than 30 residents for meetings. The primary challenge of collaboration that they identified: backbone organization capacity is key to obtain grant funding, but that does create a power dynamic with how resources are distributed.

Questions/Discussion:
Question: How to build partnerships in the faith community?
Response: When you go into a community, churches don't really work together as you might expect. Moving monthly meetings so that they are held in different areas can be helpful. Greensboro Housing Coalition does distribute funds to churches which brings up its own challenges because the community hasn't interfaced with projects like this before. We have created teams that deal with different pieces of the project. They are resident-led but there is a co-leader from a partner organization to provide support. The teams work together to develop a proposal if they want to use some of the funds.

Question: Sometimes in these situations there are perceived or real "villains." How do you bring those organizations to the partnership if they feel they will be vilified?
Response: Make the case that it is in their interest as well.

Question: What about gentrification in the area?
Response: It is not an immediate concern, but there are areas on the edge of the community that are being gentrified currently.

Elliott presentation here.

Byerly/Williams presentation here.

Discussion: Taking on Determinants of Health in our Communities – Bringing Partners Together
Facilitators: Maggie Bailey, Brieanne Lyda-McDonald, Allison Owen, Adam Zolotor

Four small groups discussed which officials, organizations, and stakeholders should be brought to the table to address a social need in the community, such as stable housing, transportation, food insecurity,

and interpersonal violence. The groups also discussed the incentives and barriers to bringing stakeholders to the table, and how to address those barriers.

Next Steps
Brieanne Lyda-McDonald, Project Director, NCIOM

Ms. Lyda-McDonald gave a brief presentation on the upcoming meeting dates and topics we will cover.

Lyda-McDonald presentation here.