We Choose Health Regional Health Improvement Collaborative (RHIC)
Concept Paper

Purpose of Regional Health Improvement Collaborative Concept Paper

With the creation of RHICs, Illinois aims to promote health systems transformation, and advance progress towards achieving the triple aim: better health for the population, better care for individuals, and lower per capita costs. This concept paper provides framework for local customization and innovation around the RHIC concept, and will be used as guidance to develop future funding opportunities as they may arise. (In order to meet the specific needs of each funding source, funding opportunities will likely contain varying parameters).

This concept paper provides an overview of the RHIC concept, and is not meant to be limiting or exhaustive in describing the potential role of RHICs. Development of community-based priorities and innovations are critical for the success of individual RHICs.

(Important information about definitions and explanation of terms used in this paper is included in Attachment 1.)

Overview of Regional Health Improvement Collaborative

Regional Health Improvement Collaborative: A local model that integrates "population management" and community health using the 10 Essential Public Health Services. Note: it is anticipated that regions will be defined "organically" and will not necessarily coincide with the currently defined regions of the Illinois Department of Public Health (IDPH).

In order to effectively achieve the triple aim, it is necessary to have core objectives that will allow for the advancement of public health; acute, primary, and specialty care; and human/ social services.

RHIC Core Objectives:

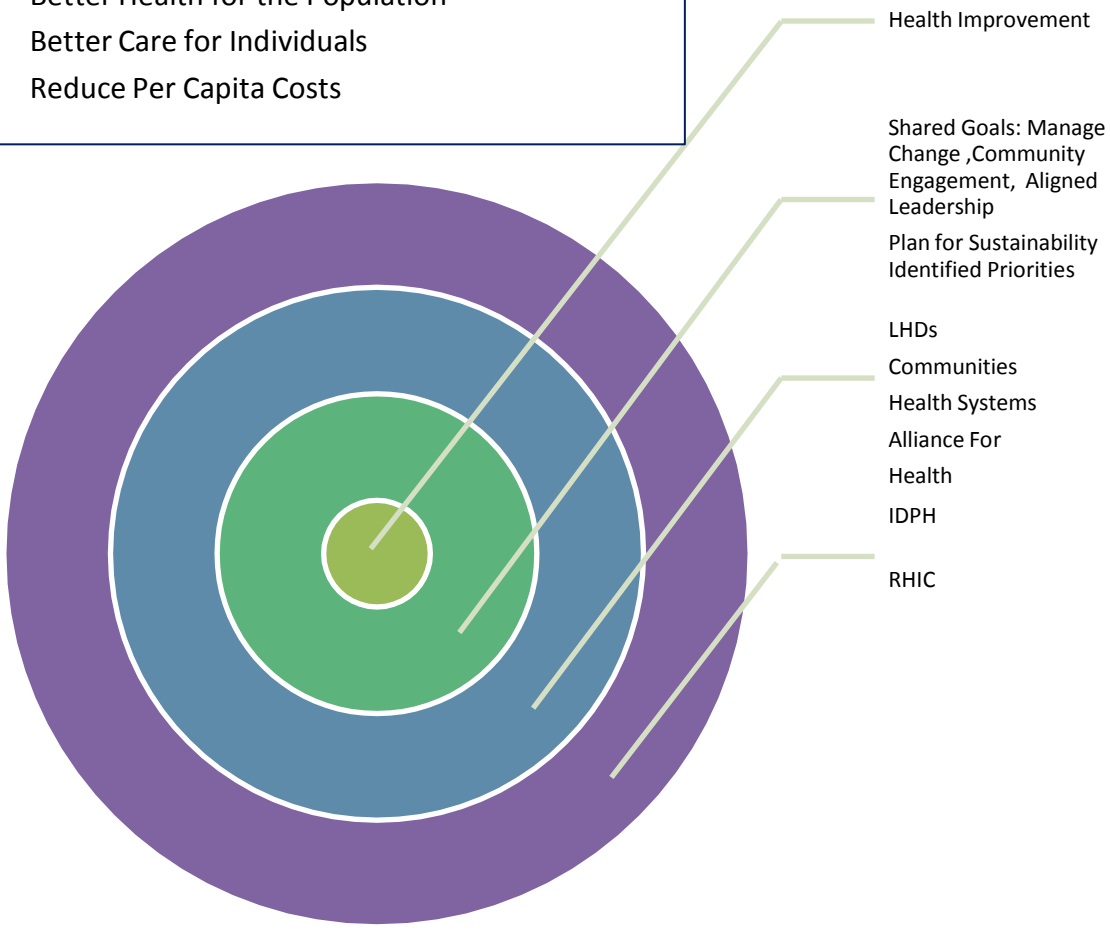
- Primary goals of improvement in the **health of populations** and achieving **health equity**, including improvement of **population management** and **community health**
    - Establishes c**ommunity engagement** through defining and addressing health needs
    - **Aligned leadership** that recognizes that accountability for health outcomes is shared and bridges disciplines, programs, and jurisdictions to reduce fragmentation and foster continuity
    - Identifies **priorities,** clarifies **roles**, and increases **accountability**.
    - Utilizes clinical and community **evidence and practice-based** approaches to improve health
    - Identify and garner **financial resources** for **coordinated interventions** aligned with regional priorities
    - Develops and supports appropriate **incentives**
    - **Manages changes** effectively
    - Provides **technical assistance** support to effectively implement interventions
    - **Plan for sustainability**, key to the establishment of shared infrastructure to ensure enduring value and impact
    - Establish **ROI** of community health interventions
    - The **sharing and collaborative use of high quality data** (pooled from diverse public and private sources) in order to support robust clinical, epidemiologic and economic analytic approaches

Regional Public Health Improvement Collaboratives (RHICs) will be based on these core principles and will serve as nexus among the local health departments, health systems, health plans, a diverse array of other public and private entities, including human and social service agencies, IDPH, and the Alliance. The RHIC will engage in processes to: (1) align current planning efforts in the region; (2) identify target health priorities that address population and community health needs and ensure health equity; (3) select evidence-based clinical and community interventions to address health priorities, but also encourage innovative community interventions; (4) align community resources and assets; (5) coordinate implementations of interventions by partners; and (6) evaluate the interventions' effectiveness.

The RHIC

Leading to Improved Health In Illinois

- Better Health for the Population
- Better Care for Individuals
- Reduce Per Capita Costs



RHICs should foster both population management and community health by: a) encouraging innovative collaborations (including those among health care systems), partnerships and programs that will expand access to health care and social services that contribute to health, including services for Medicaid clients and uninsured individuals and groups; b) supporting the development of interconnected and comprehensive systems of care, prevention, and health promotion; c) increasing use of team-based care, such as use of community health workers; d) promoting data sharing across systems and use of this data to improve population management and community health; e) promoting health equity in primary care, population management and community health; f) identifying potential cost savings and return on investment (ROI) related to population management and community health ~~improvement activities; g) using policy, systems, and environment (PSE) strategies to address the social~~

determinants of health in order to improve population management/community health and promote health equity; leveraging health care delivery system and community assets to improve community health; and h) ensuring appropriate collaboration and alignment around Community Health Needs Assessment and IPLAN development and implementation.

Initial Regional Health Improvement Collaborative (RHIC) Activities

The RHIC must design and implement interventions that achieve health improvements and return on investment (ROI) within a short time frame (≤2 years after implementation). In addition to short-term initiatives, the Regional Health Collaborative must have a balanced portfolio, and design and coordinate medium and long-term objectives focused on achieving the triple aim, including improved community health outcomes. An RHIC could layer interventions to address near-term and long-term cost drivers to increase ROI. For example, an RHIC may address issues such as asthma management and falls prevention to reduce near-term expenditures, as well as address obesity, which will take longer to gain ROI. Another example of a regional health collaborative focus could be around developing a coordinated system effort to prevent premature birth, which can be a significant driver of both short and long-term costs. This will require close collaboration of community stakeholders (e.g., local health departments, other community organizations, and employers) with health care delivery systems, health care providers, and health care payers (including the Illinois Medicaid program) to achieve these shared goals.

Illinois Department of Public Health (IDPH) Role

IDPH will provide the RHIC with technical assistance, assistance with linkages to other state agencies, data and analytic support, and epidemiological expertise. IDPH will also assist with performance monitoring and evaluation support (including analysis of ROI and cost avoidance). In collaboration with the Alliance for Health, IDPH will ensure the use of evidence-based and best practices, as well as monitor technical assistance needs among RHICs.

Regional Health Improvement Collaborative (RHIC) Governance

RHICs must be nimble organizations that include both community health and healthcare delivery expertise. A variety of governance structures may be utilized based on specific regional circumstances and priorities. The applicant from each region will determine the governance structure of each prospective RHIC. In addition, RHICs must have the capability to utilize a diverse set of funding vehicles to make community investments, and to contract with partners as needed for short, intermediate, and long-term interventions.

Regional Health Improvement Collaborative Partners and Stakeholders

All RHICs must include representatives from: (1) at least one, and preferably more than one, large healthcare provider organization or healthcare delivery system; (2) one or more local health departments; and (3) regionally relevant ACEs, MCOs, and private payers; (4) other community-based organizations, including human/ social service organizations. Establishment of a community advisory board that provides significant, ongoing input will also be required. It is also expected that some RHICs ~~will include representatives from more than one health care delivery system, and/or more than one local~~

health department. For example, when systems have overlapping service areas, health departments can more efficiently address needs together. Additionally, it is anticipated that social service entities, school systems, local governments, transportation planners, faith-based organizations, medical-legal partners and employers will also be involved in RHICs.

RHIC Membership Benefits

- Establishes a neutral venue for competitors to work together
- Provides a framework for aligning and coordinating efforts to maximize impact and resources
- Validates achievements, due to the visibility of the work being done
- Motivates continuously improving performance
- Assists all partners in increasing visibility through community engagement and communication efforts
- Reduces partners' duplicative efforts
- Completes requirements for community health needs assessment and implementation of IPLAN/ PHAB and CHA/CHIP plans
- Identifies and leverages existing community assets
- Strengthens partnerships between public, private, and nonprofit human services sectors
- Fosters linkages between economic development partners and health partners
- Improve capabilities to achieve the triple aim, including overall community health

Attachment 1

Definitions and Explanation of Terms

Because not all stakeholders are familiar with the terms used in this concept paper, some terms (e.g. population health) may have varying interpretations, the following definitions and explanation of terms is included in the concept paper.

Regional Health Improvement Collaborative: A local integrated model that is centered on "population health management" (subsequently called "population management" in this document—see below) and interventions that promote community health. Note: it is anticipated that "regions" will be defined "organically" and will not necessarily coincide with the currently defined Regions of the Illinois Department of Public Health (IDPH).

Population health refers to the health (including mental health) status and health outcomes of a group of individuals, including their distribution within the group. It is understood that such outcomes are the product of multiple determinants, including: medical care, genetics, behaviors, and historical, social, political, economic, and environmental context. Public health practitioners typically use "population health" and "public health" interchangeably, referring to the health, and distribution of health, in an entire population.

While health care providers and managed care plans, etc. typically use "population health" in the context of **population health management**, *i.e.* the management of and improvement of health of specified population (less than the whole population) – usually individuals whose care they are responsible for. To avoid confusion caused by different uses of "population health" related terminology, we will use the term "population management" in this document, when referring to the concept of "population health management."

The term "population management" means an approach to care aiming to improve the care and clinical outcomes of enrolled patients that uses information on a group or panel of patients "enrolled" within a primary care practice, group of practices, health plan, or healthcare delivery systems. Most individuals only spend a small fraction of time within a healthcare facility, and population management using community-based interventions can play a significant role in improving population management. Examples of community-based interventions include, but are not limited to, smoking cessation and reduction in exposures to second hand smoke, falls prevention in the elderly, secondary prevention of asthma exacerbations, and better care coordination for "super-utilizers."

The proactive measurement and management of the panel of patients in a medical practice or larger care organization (e.g. and Accountable Care Organization) is one component of the transformation of primary care that is being undertaken across the United States. Population management initiatives have the potential to significantly impact community health, e.g. by activities that address common conditions (such as cardiovascular disease) and are scaled to reach large numbers of individuals; conversely, community health interventions have the capability to significantly impact the health outcomes of populations managed by a health care entity. The American Hospital Association (AHA) has taken a leadership role in underscoring the importance of promoting community based prevention and

improving the societal factors that support good health. (Note: AHA has also recognized that interventions focused on promoting community-based prevention and improved societal factors may be difficult to evaluate based on short-term result).

"Public Health" consists primarily of organized community efforts aimed at the prevention of disease and the promotion of health. "Communities" can be as small as a local neighborhood, or as big as an entire country, and are not defined by membership in a particular health care entity.

The U.S. Department of Health and Human Services has identified 10 essential public health services (see below) that are intended to provide a working definition of public health.

Public health recognizes the key role of social determinants in health outcomes, and the focus of public health includes **policy, systems, and environments (PSE)** change, aimed at improving community health and promoting health equity. In addition, it should be noted that based on deficiencies in access to care, for individuals, especially among uninsured populations, an **essential public health service** provided by local health departments has traditionally been linkage of people to needed personal health services and assuring the provision of health care when otherwise unavailable. As such, public health entities may be engaged in activities that include primary care and population management.

Governmental public health agencies have historically been devoted to ensuring that the mission of public health is addressed and are often referred to as the "backbone" of the public health system. Governmental public health agencies are considered directly responsible for many public health activities but partnerships between public health agencies at multiple levels of government and with other organizations (both public and private) should be enhanced to achieve the wide-ranging mission of public health. As such, governmental public health agencies work closely with a diverse array of organization that affect population health, such as human service and social service organizations, academic institutions, healthcare entities, insurers, public health institutes, advocacy groups, charities, faith-based organizations, private foundations, media outlets, and businesses.

The term **"community health"** can be used to describe organized community efforts aimed at the prevention of disease, the promotion of health, and assuring health conditions for entire populations or communities. These efforts are interdisciplinary and address the multiple determinants of health: biological; behavioral; environmental; cultural; social, family and community networks; living and working conditions; etc. Public health is often considered synonymous with the activities of governmental public health agencies. Despite the critical importance of governmental public health, accountability for bringing about conditions under which people can be healthy is shared, due to the multiple factors described above. Use of the term "community health," will avoid misinterpretation of the term "public health" as synonymous with only governmental public health.

Social determinants of health are the complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors. Social determinants of health are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world.

Health Equity is achieved when all people have the opportunity to 'attain their full health potential' and no one is 'disadvantaged from achieving this potential because of their social position or other socially determined circumstances.'

Attachment 2

Resources

1. Community Pathways for Improved Health Outcomes
   http://www.cdc.gov/pcd/issues/2010/nov/images/10_0079_01.gif

2. Community-Defined Outcomes Model
   http://www.innovations.ahrq.gov/uploadedFiles/Profile2933/community-defined%20outcomes%20large.jpg

3. Pathway to Healthy Rural Communities Model
   http://www.rhap.org.za/wp-content/uploads/2014/03/pathway_to_healthy_rural_commities.jpg

4. Process To Innovate Model
   http://www.himss.org/files/images/Innovation%20Pathways%20Infographic.png

5. A Conceptual Framework For Action on the Social Determinants of Health
   http://www.who.int/social_determinants/corner/SDHDP2.pdf?ua=1

6. Social Determinants of Health Definition
   http://www.cdc.gov/socialdeterminants/Definitions.html

7. Patient-Centered Medical Home Management Model
   http://rnrindc.files.wordpress.com/2010/06/pcmh.jpg

8. Consumer Guide to Healthcare
   http://www.healthcarereportcard.illinois.gov/

9. The 10 Essential Public Health Services
   http://www.cdc.gov/nphpsp/essentialservices.html

10. Mobilizing Action Towards Community Health
    http://www.cdc.gov/pcd/collections/pdf/PCD_MATCH_2010_web.pdf

11. A Strategic Approach to Community Health Improvement
    http://www.naccho.org/topics/infrastructure/mapp/upload/mapp_field_guide2.pdf

12. NPHPS Factsheet
    http://www.cdc.gov/nphpsp/documents/nphpsp-factsheet.pdf

13. Policy, Systems and Environmental Change Factsheet
    http://www.cookcountypublichealth.org/files/CPPW/PSE%20Change.pdf

14. Illinois Projects for Local Assessments of Needs (IPLAN)
    http://app.idph.state.il.us/

15. The American Hospital Association
    http://www.aha.org/

16. Illinois Practical Playbook of Success Stories https://practicalplaybook.org/success-stories/results?field_location_value=IL&field_county_nid=All&field_topic_nid=All&field_population_size_value=All&=Apply

17. A Practitioner's Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease (Health Equity Guide)
    http://www.cdc.gov/NCCDPHP/dch/pdf/health-equity-guide/Practitioners-Guide-full-version.pdf

18. Million Hearts Partner Engagement Toolkit:
    http://millionhearts.hhs.gov/resources/toolkits.html

19. A Guide to Facilitating Health Systems Change:
    http://www.cdc.gov/dhdsp/programs/nhdsp_program/docs/guide_facilitating_hs_change.pdf

20. National Prevention Strategy: America's Plan for Better Health and Wellness:
    http://www.surgeongeneral.gov/initiatives/prevention/strategy/report.pdf

21. Successful Business Strategies to Prevent Heart Disease and Stroke:
    http://www.cdc.gov/dhdsp/pubs/docs/toolkit.pdf

22. The Prioritization and Strategic Implementation of Clinical Preventive Service Benefits:
    http://www.businessgrouphealth.org/preventive/resources/part4.pdf

23. Creating a Culture of Wellness through Worksite Policy Change:
    http://publichealthlawcenter.org/webinars/archived

24. CDC Worksite Health ScoreCard:
    http://www.cdc.gov/dhdsp/pubs/docs/HSC_Manual.pdf

25. National Center for Medical-Legal Partnerships
    www.medical-legalpartnership.org

Attachment 3

Regional Health Improvement Collaborative (RHIC) Concept

Frequently Asked Questions (FAQ)

Q. How will the RHIC be funded?

A. The goal is to infuse funding/build capacity of the entire public health and personal healthcare delivery systems on regional basis for collaboration, information exchange, planning, and coordinating interventions to improve population health. However, there is no guaranteed funding to any specific entity. There will be a competitive funding process in place to fund RHIC. The funding processes will be determined by the funding source.

Q. What is the focus of the Regional Health Improvement Collaborative?

A. Improve population health for defined geographical regions via deliberate, systematic, facilitation of joint assessment (amplify existing planning efforts, such as IPLAN and MAPP process), prioritizing, planning, with active "coupling" of clinical & community best practices, tracking progress.

Q. Will RHICs be limited by existing planning processes?

A. No, the RHICs will build on IPLAN or MAPP process to leverage existing resources, but RHIC are expected to expand beyond those processes.

Q. Is the Regional Health Improvement Collaborative a "brick and mortar facility?"

A. Not necessarily, RHIC may be part of an existing "brick and mortar facility," but will function as a "Virtual" Collaborative with rotating meeting sites among coalition partners; e.g., IDPH Regional Health Office or LHD may serve as site; web-based data analysis/tools.

Q. What is the proposed staffing of the RHIC?

A. Health plan or health provider staff and resources will be leveraged along with those from IDPH and Local Health Department staff; fund additional subject matter experts (e.g., epidemiologist, health economist) as needed to support "Collaborative" and surrounding LHDs (Outside Collaborative) where possible; maintain direct access to IDPH as needed.

Q. What is not proposed for staffing of the RHIC?

A. To employ entire team to supplant current employees at IDPH or LHD; impose an intermediate layer of bureaucracy between LHDs and IDPH offices.

Q. How are the Regions selected?

A. A funding opportunity with guidance that allows LHDs to join with other health entities and stakeholders (e.g., FBO, CBO, hospitals) to propose region and governance; leverage "naturally occurring" Collaboratives. There are no pre-determined regions selected by IDPH, it is not expected that "one size fits all."

Q. When will the implementation of the RHIC occur?

A. The implementation is in a rolling process based on available funding, need, and readiness. Statewide, Simultaneous implementation of full-fledged Regional Collaboratives is not proposed.