Proposed Structure of the Collaborative Community Response Initiative

Discussion Draft[1] July 2022

The proposed structure of the Collaborative Community Response Initiative (CCR) can be thought of as four interconnected and mutually supporting layers: (1) local: community collaborative Commons; (2) regional: entities and staff that support multiple local Commons; (3) state level: overall coordination, Activity Teams developing best practices on different topics, and provision of supporting services; and (4) five specific functions that would be best resolved with diverse national input.

In a complex, necessarily interoperable, and cross sectoral ecosystem, there clearly are functions that are best performed at each of these levels. *The boundaries between the layers are likely to vary by function, by community, by region of the state, and by service sector*. Clearly and efficiently defining these functions is a challenge to be undertaken with leaders of each level over time. Establishing effective two-way communications between the layers and between the members of each layer (e.g., a learning collaborative of leaders of various Commons) is an essential part of the CCR proposal. The following summarizes these four layers.

1. **Local: Community Commons**.

We propose that local leaders come together and create multiple versions of Commons that take responsibility for the frontline clinical and social service needs of specific groups of people that they define and attract to join their Commons. Each community will need to find its own path starting from whatever collaborative structures they have today. Collaboration across organizational boundaries is hard. Collaboration across all the sectors required to support thriving is even harder. One core principle of CCR is to reorient the financial incentives to make it in each organization's interests to collaborate. But we do not expect fully formed, formal Commons on day one, but rather a process over time to reach this definition.

The target Members[2] of a Commons could be all the people in a local geography who wish to join, or the members of a particular ethnic or interest grouping.[3] ("Members" is capitalized to emphasize that a *Commons needs to be responsible for supporting specific people for the sustainable business model to work*.[4]) The essential aspects of a Commons are that:

[1] This is a work in progress that has benefited greatly from critiques and additions by the leaders and participants of the Collaborative Community Response Initiative. We would be grateful for any criticisms and suggestions you may have. Please direct those to: david.aylward@cuanschutz.edu

[2] We envision a Commons as an organization that people join, somewhat a cross between joining a sports club and signing up for an insurance policy.

[3] While each Commons will probably begin its operations focused on one or more narrow target groups (e.g., youth with behavioral health problems, seniors with multiple chronic conditions, parents with little children, employees of local companies), we suspect that a comprehensive approach (all people in that community who wish to join, whatever its definition) would serve best in the longer-term.

[4] A Commons is not a collective impact organization designed to find common ground on community level actions, although it might also perform that role.

(1) it is a formal organization (usually but not necessarily nonprofit) committed to helping its members thrive. It may be a new organization or a new/expanded mission of an existing one.

(2) its board of directors represents the members of the community to be served[5], along with leaders of the key Community Benefit Organizations (CBOs) and social/human service government agencies, and health providers (public, behavioral, and oral health, and primary care) who will deliver supporting services to the Members of a Commons.

(3) it adopts a person/family-centered approach and supporting budget to provide individualized and integrated wraparound packages of supports that implement success plans developed with the Member individual and/or family enabling them to thrive[6].

(4) it is designed using equity and person-centered principles such as human-centered[7] design to overcome outcome disparities in thriving, taking into consideration local conditions and community preferences.

(5) the provider participants agree to collaborate in managing the Commons, including supporting single, integrated "person/family-owned" success plans and collaboratively implementing them. This includes:

> (a) working in good faith to overcome the inevitable challenges that will arise so that the Commons can succeed
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> (b) having their staff serve on success plan/support teams for Members and minimizing redundancy for the Member regarding any agency-specific planning/reporting processes
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> (c) sharing information about Members (e.g., in the implementation of success plans), including confidential or otherwise protected information, assuming appropriate consent of the Member has been given
>
> (d) cooperating in the development of an effective model of success-based financing from the benefits of thriving produced by the Commons, including sharing financial and operational information and being open to novel financing schemes; and
>
> (e) committing to transparency about the process, including regular ongoing sharing of data with the Members and community; and

(6) Collaborate with the CCR Initiative, including with other Colorado Commons and the teams supporting them:

> (a) participate in CCR and its Activity Teams

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[5] Community ownership is essential. We suggest that three kinds of community leadership be considered for the Board of Directors: elected representatives of the membership, respected community leaders, and elected officials. This may involve modifying the leadership of existing organizations which often have representation from some of these sectors, if not all.

[6] This collaboration could also be a logical leader in identifying and seeking community level investments from all sources to address drivers of thriving that will supplement (and/or enable) individual person/family packages. See thriving.us.

[7] The primary "humans" for design centering are the Members, the intended beneficiaries of the Commons.

(b) use common, interoperable information technology (IT) infrastructure as it develops

(c) collect and report common metrics; participate in inputs and outputs of the shared measurement and evaluation system as it develops

(d) participate in learning collaboratives to share experiences and best practices for realigning Members, communities, and agencies toward thriving, Member outcomes, optimizing resources, financing (braiding and blending vs new), etc.

Commons are designed to produce progress toward thriving amongst their Members by investing more, and more efficiently, in prevention of health and social dysfunction, frontline clinical care (behavioral, physical, oral), upstream social/human services, and the collaboration necessary to deliver them in an integrated, person–centered, efficient way. Over time we believe this will create benefits and savings to a variety of government and nongovernment entities. Agencies that provide services for social dysfunction should see reductions in their costs through the prevention of incarceration and other social ills. The Commons business model is based on capturing and sharing some of these savings with the Commons directly or indirectly, similar to what is done more narrowly with Accountable Care Organizations in the medical field today, or with other forms of success-based payment. In other words, initial and continuing investment in thriving should produce significant aggregate returns on investment from multiple sources (not to medical payors alone).[8]

Commons could be self-financed risk-taking entities negotiating success-based savings/benefits sharing agreements independently with multiple downstream beneficiary organization themselves. Or they could be financed by third-party investors who assume that risk. Or there could be some combination of these benefit sharing types. Investors and a Commons might agree to share some combination of upside and downside risk. A Commons might negotiate "Thriving Dividends" for both its Members and its service providing organizations. Investors in a Commons could include major purchasers of health today, such as major employers seeking to reduce their acute care and specialist costs.[9]

2. **Regional Entities.** There are already regional organizations with various human welfare service and coordination responsibilities in Colorado, and more coming. By the end of this year there will be six such efforts in Colorado: 7 Regional Accountable Entities (funded by Medicaid), 21 Regional Health Connectors, 20 Medicaid Case Management catchment areas, 30+ opioid settlement districts, three Health Information Exchanges (HIEs)[10], and a yet indeterminant number of new regional Behavioral Health Administration Service Organizations[11]. There are also new coordinating organizations focused on early childhood stemming from the recent reorganization of those state agencies. Some of these will have contracting authority with other organizations to provide various care management and clinical services.

[8] See CCR's "Financing Vitality not Sick Care," July 2021, for a more detailed discussion of this financing model.
[9] See, e.g., https://cbghealth.org/mission/. Iora Health is another interesting partial example, although its service and business model is limited to primary health care. In both cases, the comprehensive approach of a Commons (including social determinants) should produce greater health and non-health savings and benefits.
[10] CORHIO, QHN, and CCMCN. The latter two are merging.
[11] A contract was just awarded by BHA to HMA to propose the entire BHASO structure.

The seven regional RAEs are responsible for coordinating the physical, behavioral, and oral care of persons on Medicaid. The new Behavioral Health Administration will be contracting with organizations to provide care coordination services (hopefully in the same seven regions) for behavioral health patients (connecting them to behavioral health providers and other health and social services they need). It is not clear what the relationship between them and the RAEs will be[12]. HCPF is reorganizing the Case Management regions and entities to make access for services for complex patients more "one stop."

The 21 Regional Health Connectors (RHCs) were put in place in the last few years to focus on developing collaboration between primary care, behavioral health, and other community resources to improve health. They are housed within organizations with different missions in the health and well-being ecosystem and are only partially funded by the state. Understandably, therefore, their focus varies widely. The more numerous and dispersed nature of RHCs allows them to be instigators and leaders of the creation of local collaborations, particularly if they are given clear direction and support for that work. The opioid settlement districts are brand-new and have not yet begun to function.

Each of these are important nodes on the statewide interoperable information network for which we strongly advocate. They must be seamlessly connected. The HIEs can play a particularly useful role here knitting together otherwise independent organizations for information sharing.

We advocate that state leadership bring these groups together to coordinate their work, particularly in supporting local collaborations such as the Commons. Each should be instructed to adjust to being whole person/family centered (and extend that requirement to the organizations they fund). We advocate for coordinating and integrating the functions of these organizations in a coherent community-centric manner collaboratively and that they be given the shared goal of helping the target population to thrive so that they are all pulling the oars in the same direction, including providing resources to them so they can be effective. We further agree with the recently concluded Office of Behavioral Health (OBH) care management policy committee recommendation that the emphasis on care coordination (what we call "success planning") needs to be at the local level, supported by regional and state entities.[13] We hope this direction is extended to formal collaborations to develop and support Commons in communities.

3. **State Level Activities.** We propose four types of state level activities: (1) coordination of state level activities through a public-private steering committee appointed by the Governor; (2) detailed communications between the three layers and establishing learning collaboratives between and among the participants in each layer (coordinated with similar activities in other states and nationally); (3) six cross sectoral Activity Teams whose responsibility is to gather organize and communicate best practices, and provide related services, in their assigned area; (4) specific services based on a common, shared infrastructure which are most efficiently and effectively provided from the state level, including interoperable information sharing and a common measurement and evaluation system.

[12] When care management staff work directly for RAEs, they can only directly serve Medicaid members. However, like FQHCs and some other care management organizations which are funded by RAEs, BHA has a responsibility for the entire population, not just Medicaid recipients.

[13] See recent report to BHA/OBH published by Colorado Health Institute.

Steering Committee: We suggest that the Governor establish a representative public/private Steering Committee representing key state agency leaders, local government, community leaders, social and human services, and health to guide the Initiative, supported by Activity Teams in key topical areas. This could be led from Colorado's existing Office of Saving People Money on Health Care. A primary objective of the Steering Committee should be to enhance collaboration and integration, and to reduce fragmentation. It should identify and eliminate existing barriers to encouraging collaboration between the sectors. It should connect existing and new programs from diverse fields that make up whole person care and thriving. And it should establish to the extent possible a common human and technical infrastructure for the delivery of coherent, integrated clinical and social services to Coloradans, particularly safety net populations. This should include programs of more narrowly targeted integration such as the new Department of Early Childhood and the Behavioral Health Administration. The new law establishing the Behavioral Health Administration provides a few new staff positions to support exactly these functions of integrating clinical and social services. The Office of eHealth Innovation has done a remarkable job advancing just this kind of collaboration, but it is limited to health. We suggest expanding its responsibilities to all agencies and organizations affecting thriving, supported by the IT Activity Team mentioned below.

Communications. The Steering Committee should establish a detailed communications program, including active learning collaboratives, to enhance two-way communications between and among the layers and participants described here.

Activity Teams. These should be composed of leaders of and experts from the relevant state agencies, sitting with the affected stakeholder groups, community leaders of cross sectoral collaborations, non-government experts and academics, and local government leaders. These should include leaders of underserved or marginalized populations, and of public, behavioral and oral health, primary care, and social and human services providers, including schools, engaged in collaborations of the kind encouraged by this Initiative. We propose that six statewide Activity Teams be established to gather best practices from around the country and provide detailed models of complex, person-centered integrated system design for community collaborations to use, allowing community leaders to focus on adjustments to meet local needs. The six Activity Teams suggested are: Community, Model, Metrics and Measurement, Information Technology, Finance, and Workforce. The high-level issues each is designed to answer are attached as Appendix A. In addition to thought leadership, the Metrics and Measurement and the Information Technology Activity Teams should support ongoing related live services supporting community collaborations. Community members with lived experience as well as experts need to be recruited for, and compensated for, their contributions to these Activity Teams.

State Level Services: Information Sharing, and Measurement and Evaluation. These two Activity Teams should support the provision of direct services to local collaborations and other stakeholders in the statewide ecosystem. That is far more efficient than each community trying to figure out those complex matters on their own. The Office of eHealth Innovation should lead the Information Sharing work in building a common interoperable infrastructure, including common components[14], to be shared

[14] By "common components" we mean shared utilities such as a common registry of approved providers and a common registry of permissions for interagency information sharing. See section 4.

by all safety net services across state, not just medical ones.[15] We believe the Governor should put the burden on individual agencies to justify unique IT expenditures rather than contributing to the development and sharing in the costs of a shared interoperable system. The Measurement and Evaluation system should be designed by a representative leadership of local, state, and federal government, state academic institutions, CBOs, and persons with lived experience whom the system is being designed to serve. It should be flexible so communities can address their special needs within an efficient, interoperable overall system.

4. **National Supporting Activities.** For the last few decades, leading researchers, foundations, and government agencies have recognized the importance of looking beyond medicine to achieve well-being. They have focused their attention on a wide range of issues related to community health: primary care, integrating behavioral health, investing in social determinants, person-centered delivery design, and empathetic, culturally sensitive workforce. There is a general consensus that we vastly overinvest in sick care and social failure (e.g., corrections), and underinvest upstream and in prevention.

A vast body of work points to most of the desirable pieces of a comprehensive replacement system designed to produce flourishing. However, these desirable pieces have not been incorporated into full, comprehensive replacement systems and field tested. Moreover, within the complex transformed system required to produce flourishing, a handful of key systems level questions remain unanswered, and those remaining questions stand in the way of fundamental systemic reform. They constrain the possibilities, forcing us to primarily pick at the edges of transformation. We suggest there are five such questions. We propose that diverse national teams of persons with lived experience and professional expertise address them:

Metrics: unless you change what you pay for, you will get the same thing. We posit that flourishing/thriving should be the goal. So how do you measure flourishing, thriving? Each sector that contributes to thriving has its own metrics; what is the measurement of the holistic combined result?

Finance: what is the additional investment needed in collaboration, and then in people and families (and services to them) to achieve those metrics? With success, what are the savings/benefits of progress towards thriving, when will they appear, in what organizations' budgets, and in what amounts? Can enough of those benefits be captured to make a success-based system sustainable?

Model: a comprehensive person/family – centered delivery system that develops an asset-based holistic success plan, integrating and implementing over time (through an empathetic "companion/navigator") the individualized package of supports that a person/family needs to thrive is emerging as a positive solution. It would replace today's fragmentation in which each provider is the center of their own model. These have not been tested at scale.

[15] Given the nature of modern IT development and service delivery (the rolling nature of which is antithetical to traditional government procurement rules), we suggest that both these be funded through non-profit partnerships between state government, IT providers, academia, and other relevant parties.

Measurement: what is the subsystem by which each key stakeholder can continuously evaluate this highly complex, highly adaptive system? In addition, we need to build complex simulation models that over time can become increasingly valuable planning tools.

Common infrastructure: the lifeblood of this system is information shared across sectors in real time, and the beating heart of that underlying information infrastructure is a “permission utility” where beneficiaries of the system can record in a single place who is on their supporting team and what information they choose to share with them. This should be built once and a version deployed in each state.