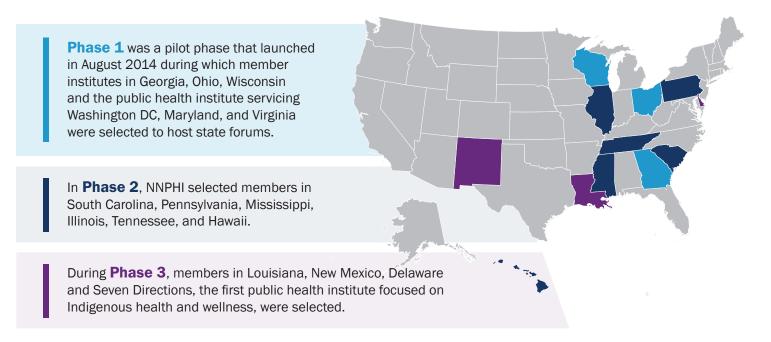
STATE FORUMS TO ADVANCE HEALTH SYSTEMS TRANSFORMATION

The passage of the Affordable Care Act (ACA) in March 2010 created an unprecedented opportunity to catalyze health system transformation with an emphasis on shifting toward prevention and value-based care. Two years into the rollout, efforts to improve health systems centered on supporting transformation through progress towards universal coverage, with an intense focus on the rollout of insurance exchanges. One of the most significant challenges in aligning public health and health care around prevention is based in semantics. These two disciplines do not currently speak the same language which creates a challenge for aligning priorities and speaking with a united voice on the community level and with state decision makers.

Recognizing the unique opportunity this national movement to improve access presented, the National Network of Public Health Institutes (NNPHI) and the Robert Wood Johnson Foundation (RWJF) designed the State Forums to Advance Strategies to Align Public Health and Health Care (*State Forums*) to create practical strategies on the state and local level that support the goal of aligning health care and public health towards prevention—a critical component of realizing the long-term cost savings of the ACA.

Launched in 2014, the *State Forums* program funded public health institutes (institutes) to facilitate a series of state or regional meetings that advanced practical strategies for bridging public health and health care. Each forum developed a shared definition of population health, designed mutual goals, strategies, and activities between public health and health care and created a path for meaningful collaboration in achieving reduced health care costs and improving population health outcomes.

The project included three separate phases. The final two phases were focused primarily on rural, Southern, non-Medicaid expanding states, as the populations in these states have very specific and unique needs and challenges.



¹Recent examples include: How can we pay for a healthy population. Jan 2013, Prevention Institute (co-sponsored by RWJF and other funders) http://www.preventioninstitute.org/component/jlibrary/article/id-332/127.html

⁻ Opportunity Knocks: Population Health in State Innovation Models - IOM, Aug 21, 2013

http://www.iom.edu/Global/Perspectives/2013/OpportunityKnocks.aspx

Population Health Implications of the Affordable Care Act - Workshop Summary, 2013 http://www.iom.edu/Reports/2013/Population-Health-Implications-of-the-Affordable-Care-Act.aspx

REPLICABLE STRATEGIES THAT EMERGED FROM STATE FORUMS

Several promising strategies, themes, and ideas emerged through the project that can be replicated in other states throughout the country. These forums laid the groundwork for more successful, multi-sector collaboration between public health and health care, and many of the awardees were able to build or further establish relationships with health systems, hospital associations, or managed care organizations (MCOs) in their state.

The importance of exploring what health means locally and within the unique cultural contexts of communities was elevated, and the recognition that many communities have experienced historical trauma and a lack of culturally appropriate interventions to address pressing health challenges was highlighted. Some of the specific recommendations that could be replicated in several geographic and sociocultural settings include:

- Engage Community Health Workers (CHWs) States can elevate the voice of CHWs, explore creative financing models and develop a CHW scope of work
- Create a community health fund to align state funding sources and priorities, particularly in areas experiencing health disparities
- Promote health systems transformation in indigenous communities
- Launch a pilot program between Medicaid MCOs and community-based organizations (CBOs) to support the delivery of the Diabetes Prevention Program
- Discuss the barriers and potential solutions for improving behavioral and public health
 systems integration
- Identify strategies to build the healthcare workforce of the future with skills in systems thinking, authentic community engagement and knowledge of evidence-based population health interventions
- Develop a Health Value Dashboard that is a composite measure of a state's performance on population health outcomes and healthcare spending

CASE STUDIES

Examples of *State Forum* projects that could be replicated in other geographic and sociocultural settings include:

Improving Health Outcomes through Community Health Workers in Washington, D.C., Maryland and Virginia

As trusted members of the localities in which they work, Community Health Workers (CHWs) serve as the liaisons between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. While CHWs have existed in the United States for decades, they have not been historically recognized as a core unit of U.S. health infrastructure the way they are in many countries abroad². The Institute for Public Health Innovation strengthened the community health worker (CHW) profession in Washington, D.C., Virginia and Maryland by working with healthcare institutions to recognize the CHW profession, creating jobs and expanding financing of CHW-delivered preventive health services.

² Singh, P. et. al. *Closing the Gap: Applying Global Lessons Toward Sustainable Community Health Models in the U.S.* December 2016, Office of the UN Secretary-General's Special Envoy for Health. Retrieved at: http://www.healthenvoy.org/wp-content/uploads/2014/05/Closing-the-Gap-Apply-ing-Global-Lessons-Toward-Sustainable-Community-Health-Models-in-the-U.S..pdf

State Forum-developed strategies included:

- Building the strength of CHW-led professional associations in DC, MD and VA as evidenced by creating a governance structure for the associations, increasing the number of members in the association as well as their engagement in association activities, and creating the Center for the Community Health Workforce, which includes a clearinghouse of regional and national CHW best practices.
- Increasing employment of CHWs throughout the region by health systems and managed care organizations. Since 2011, IPHI has worked with over 40 organizations to integrate CHWs into these types of organizations across the regions.
- Training over 500 current and emerging professionals in CHW core competencies.
- Demonstrating evidence on the impact and return on investment for IPHI's CHW initiatives through evaluation and use of common measures across projects. In pilot programs in the region, CHW support reduced hospital readmissions for heart failure patients, improved diabetes management and reduced viral loads for persons living with HIV.

Aligning Resources and Statewide Priorities for Better Health in Ohio

The Health Policy Institute of Ohio (HPIO) developed a Health Value Dashboard that ranks states and the District of Columbia on a combination of population health and healthcare spending metrics. The *Dashboard* is unique in its emphasis on "health value" rather than on population health outcomes alone.

No other national rankings factor in the impact of healthcare spending. HPIO published the first *Dashboard* in 2014 for their *State Forums* project, and they have updated the dashboard for the last five years. Several elected officials, policymakers and other stakeholders in Ohio have shared the value of this project to their work and the communities they serve.

"[The] Dashboard continues to be the go-to document that is shaping policy within many state level meetings."

"HPIO's dashboard is recognized on a bi-partisan basis as setting benchmarks for Ohio's performance on quality indicators."

In the four years since introduction of the first *Dashboard*, policymakers and other stakeholders have consistently used the data to set priorities, catalyze conversations and evaluate the effectiveness of existing policy strategies. Data from the *Dashboard* was cited at least seven times in testimony to the Ohio General Assembly. One legislative leader commented, "The *Dashboard* has really become a go-to report. Now it's part of the fabric of what we do."

In addition, a set of metrics in the *Dashboard* served as the foundation for Ohio's 2016 and 2019 state health assessments.

Improving Diabetes Management Outside the Clinic Walls in Illinois

With the goal of building broad access to community-based chronic disease prevention and management services in Medicaid, the Illinois Public Health Institute (IPHI) created a roadmap that recommended a pilot program to provide the Diabetes Prevention Program (DPP) and Diabetes Self-Management Program (DSMP) to Medicaid clients through Medicaid managed care organizations.

The Illinois State Forum helped to convince the deputy director of the state Medicaid agency to lead the pilot program development for managed care organizations (MCOs) in the state. Several MCOs recognized the value in partnering with community-based providers to provide these disease prevention and management programs after participating in the *State Forum*.

Community-based providers with adequate expertise and infrastructure pilot-tested referral, billing, and client retention systems to implement evidence-based diabetes prevention and management programs. As a result, **IPHI has become a go-to resource on systems change related to the national DPP and DSMP implementation and scaling.** IPHI's CEO chaired the payment/billing workgroup of the state's Diabetes Strategic Action Plan planning team. The *State Forum* process created a new scope and niche for IPHI to engage as a convener and systems-change leader.

As an evolution of this work, IPHI hosted *The Midwest Forum on Hospitals, Health Systems and Population Health: Partnerships to Build a Culture of Health* in November of 2017. The forum was co-sponsored by two other *State Forums* grantees, the University of Wisconsin Population Health Institute and the Health Policy Institute of Ohio. Participants shared innovative models that are working in their states and challenged attendees to support the transformation of the existing system of care in the United States into a system that strategically plans for and supports the health of its population.

Additionally, IPHI and the Chicago Department of Public Health (CDPH) joined forces with nearly two dozen community partners to launch a new initiative in Chicago to reduce racial and socioeconomic disparities in diabetes outcomes. The Centers for Disease Control and Prevention (CDC) is awarding approximately \$6 million over five years to IPHI to support the Chicago Collaboration to Advance Reach, Equity, and Systems (Chicago CARES) to Prevent Diabetes. The *State Forums* process laid the groundwork for this multi-sector effort to expand access to evidence-based diabetes prevention programs and telehealth diabetic retinopathy screening in Chicago community areas that have a disproportionate diabetes burden and lack sufficient preventive services.

THE FUTURE OF HEALTH SYSTEMS TRANSFORMATION

While the future of the Affordable Care Act is uncertain, the participants of the State Forums project acknowledged that transformation was still "the right thing to do and ...will benefit healthcare stakeholders and the communities they serve in the long run". The work of many of the State Forums has continued even though funding has ended. Partners on the local, state and national level have leveraged new funding to continue the implementation of strategies identified by these project.

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To learn more about the *State Forums* project or seek support for your state's health systems transformation efforts, contact NNPHI at **engagement@nnphi.org**.