Collaborative Community Response Initiative: A Story of a Commons (detailed)

Discussion Draft April 14, 2022

The fifth reunion.

In April 2027, the founders of the Greenbush Community Commons convened to celebrate receiving a report that documented the success of the community collaboration they had launched five years earlier. "Greenbush Steward of the Year" awards were awarded to several key leaders. The Commons Executive Director announced that if the savings sharing planned for the future were put in place, the Commons was projected to begin distributing substantial "thriving dividends" to both its providers and its Members within two years – in addition to fully funding its activities. Leaders of each major stakeholder group then rose in turn celebrate their joint success community stewardship, and specifically in moving members of the Commons "up the thriving scale," and to highlight the achievements in their areas of particular concern.

The community activist (who was an initial member of the Commons' Board) told stories of families lifted out of illness and poverty. She described the empowerment of underserved segments of the community by their participation in the planning and implementation of the Commons. She noted specific improvements in vital conditions in what had been the most at risk neighborhoods in the city.

The Superintendent of Schools highlighted both significantly increased readiness for pre-K and kindergarten, and the highly effective adolescent mental health response team that had reduced suicide rates amongst his students. The Board representative of the aging community [1]pointed to the major increases in social connectedness, while noting the significant decrease in avoidable emergency and acute medical care and their large associated costs. The federal representative from the Medicare program happily applauded.

The regional public health department director praised the value of the Commons' Companion, Block Captain, and Ambassador programs for increasing civic participation as well as assisting with specific areas of health such as prevention education, vaccination campaigns, registration for critical programs like WIC and SNAP, and disease surveillance. Combining community data with Member data on the components of thriving was proving to be a powerful tool. He looked forward to the extra income from future "thriving dividends."

The CEO of the FQHC described how the shift from per visit payments to a higher per member per month reimbursement, along with the provision by the Commons of wraparound, holistic care management and social services (with FQHC staff compensated for their time on individual person/family teams), has allowed her staff to focus on and push the boundaries of next-generation frontline clinical care to include remote digital services in people's homes, workplaces, and learning environments, and leveraging the use of specialists as coaches for primary care providers. These

[1] See https://www.reframingaging.org/Portals/GSA-RA/images/RAI%20Communication%20Best%20Practices%20Guide%20220328.pdf

enhancements allow her staff to focus on medical care, limiting FQHC care management to the coordination of clinical care in complex medical cases while community-based care coordinators (the Commons' Companions) attend to the patients' social needs. Profile information about Members from the Commons' Companions has enriched care, creating awareness and adjustment. Continuous engagement of the Companions on matters like adherence to prescriptions had substantially increased effectiveness of necessary medical care. The operations director of the community mental health center agreed, noting how the multi-sector team approach was producing better outcomes for their patients.

The Executive Director of the Family Resource Association spoke of the satisfaction of being able to address far more of the needs of families because the Commons system now compensated them and their social service provider partners for supporting Members. The representative from the Area Agency on Aging endorsed those comments for the same reason.

The CEO of the largest employer described the direct benefits to his company of a healthier, more present workforce and promised a major contribution to the Commons to reflect that benefit. He noted the increased civic pride from the impact of the involvement of so many community members. The representative of the Business Alliance for Health expressed his satisfaction with the results of its contract with the Commons in quality and cost savings and pledged to renew it, containing a wraparound service package, including primary care, oral and behavioral health needs

The state Medicaid representative thanked the Commons for successfully implementing a plan that both created better quality of life for Members, and materially reduced the overall cost per capita. She pledged to sign a savings sharing agreement with the Commons going forward, as did the Medicare representative from CMS.

The Sheriff said he was delighted by the program's results and the predictions that the court and jail system would be contributing substantially to the Commons in the future based on the reductions in the cost of incarceration of homeless people with behavioral health issues (replicating Denver's Sanderson Apartments success), and by the longer term reductions in projected crime by youth due to reduction of adverse childhood events. A representative of the Community College noted the success of its training program for Commons Companions, instituted in partnership with the Colorado School of Public Health.

Investor representatives announced they were convinced and ready to invest in the future at an appropriate level of risk. The Presidents of the Community Foundation and Chamber of Commerce jointly announced a program to fund the early childhood investment program, the one with the longest return on investment, outside the risk and return on investment time frame of the other investors and agencies.

How did it happen?

A small group of Greenbush community leaders convened in the spring of 2022 to address the health and well-being of their community. The Covid-19 pandemic had made it brutally obvious that they could no longer tolerate the vast disparities in opportunity and illness that were present in their community. They had been complaining about the enormous amounts of money spent when people got sick or in trouble with the law, noting that far less attention and funds were being invested in the community's people and families to help them thrive and prevent the expensive results of illness and social failure. A pastor spoke of the need for his people to thrive and described an article about "shared stewardship" he

had read. The critical thing, he said, was to commit to a shared goal of broad inclusion: everyone in the community should thrive. No exceptions.

Through multiple meetings the group expanded and worked through various ideas for thriving. One young person excitedly said: “We are making a plan for everyone, not just the rich.” They decided to implement a Greenbush version of the Collaborative Community Response model following detailed discussions with leaders of the state level CCR Community Activity and Model Teams. The CCR leaders described the seven areas they would need to address to get going, starting with recruiting leaders from the key parts of all three sectors needed to create a thriving program: community, social services, and health. Each leader reached into their constituency to recruit additional participants in the planning, particularly probable beneficiaries. They applied for a wide variety of grants and were successful in gaining funds sufficient to fund a 5-year pilot.

1. Governance. They formed the Greenbush Commons and applied for 501©(3) charity tax status. The Regional Health Connector played a significant role in bringing the leadership group together, connecting them with state level resources, and recruiting to fill gaps in needed services. The board of directors represented key constituencies in three major areas: community, social services, and health. The initial directors were the pastor of the largest African American church in town, the executive Director of the Hispanic Chamber of Commerce, the Superintendent of Schools, the Sheriff, a County Commissioner, the public health director from the multi-county region around Greenbush; the CEOs of the local Federally Qualified Health Center and community mental health center; the Chairman of the Greenbush Family Resource Center, the Dean of the Community College, and the human resources VP of the largest employer in town. Three seats were reserved on the Board of Directors for elected representatives of the future Members of the Commons.

They signed a vision statement and commitment to focus their attention on helping the least among their community to thrive. Knowing they would face challenges, they agreed to work in good faith to modify their agreement as needed in the service of this shared objective. These commitments were recorded in the articles of incorporation and bylaws.

2. The Model. A representative team worked through all the details of the CCR Model making alterations to make it work best in Greenbush. At its core was the “shared human and technical infrastructure”: combination, expansion, and refinement of the success planning/care management program of the regional health alliance, and the community health worker program that had been established by the public health department during the pandemic. The Commons would be the backbone of collaboration to link the participating providers of clinical and social services. Ongoing calls were held with the CCR state level Model Activity Team about best practices, and with a Learning Collaborative of other communities undertaking similar programs. Ongoing financial and expert support was provided by the Regional Accountable Entity and Behavioral Health Service Organization. These coordinated their efforts to support the Greenbush Commons in creating a single system in their community, focused on the Members, not the particular needs of any participating agency.

The community health workers were rapidly trained as “Companions” in a program at the community college, developed and coordinated by the Colorado School of Public Health. The training was continuous. They were tasked with helping families develop their own success plans to thrive and then assisting them in accomplishing those plans, with input and direct supports from the participating

agencies as called for by individual person/family plans.[2] A new state law provided that the costs of this Companion were shared between the various local, state, and federal programs that were integrated under the CCR Model. That sharing extended to the cutting-edge IT system developed by the Office of eHealth Innovation and its partners which shared relevant information amongst all the system stakeholders starting with the members the Commons served and including the Companions and support teams for each family success plan[3].

The Greenbush Commons decided to focus on mothers and small children as its first target group to work out the kinks in the family-centered model. As this was being finalized, additional teams began planning the application of the model to two other groups: teenagers with behavioral health challenges and older adults living at home with multiple chronic conditions, especially those with one or more behavioral health issues. In both cases they started with the detailed protocol suggested by the Model Activity Team.

The information technology underlying the system and the system for continuous measuring and evaluating results were provided by the State at no charge to the community.

In the case of all three target groups, likely members of the Commons with relevant lived experience were paid to participate in the specific programmatic design to ensure that it was appropriate to the Greenbush community. Broad inclusion was the goal and result.

3. Community level investment. The Directors of the Commons established a special committee to explore community level investments in vital conditions[4] that would be synergistic with the person and family-centered individual success plans. In addition to the typical needs for housing, transportation, and food, the committee identified the need for extending the current daycare program through the weekend to address a need expressed by numerous potential Members in the need surveys gathered during the creation of the Commons, and repeated annually, in conjunction with regular public health and hospital community needs analyses.

4. Engagement with the community. As participation in the Commons was voluntary, an educational and outreach program to the community was carefully planned and undertaken. They borrowed from the successful membership marketing campaigns of other Colorado Commons. From day one, a program to make sure Members were well served and satisfied, and their voices heard, was launched.[5]

New Members were assigned Companions who worked with them to develop a relationship of trust and a success plan, building on the family's assets, including extended family, friends, neighbors, and community, as well as the appropriate provider organizations[6]. One of the high priorities in this regard

[2] Hiring empathetic people with a lived experience from the relevant community was agreed to be the goal for these companions. The Colorado School of Public Health modified its community health worker and patient navigator training programs to accommodate this person- and family-centered model and developed a program for continuing in-service training. Shorter training sessions had been created for Block Captains and Ambassadors.
[3] A common state Consent Registry allowed Members to control which people and organizations had access to their information, insuring compliance with federal and state privacy laws.
[4] For discussion and definitions of "vital conditions," see www.thriving.us.
[5] Retaining attributable members is essential to the success of the financial model. The Commons will lose the financial benefit of its investments if members leave the Commons, particularly for reasons within its control.
[6] The intensity of support, the amount of time devoted by a Companion to a Member/family, varied by needs and over time.

was to ensure registration in all programs for which the person or family was eligible[7] and to address social contact/social capital needs, not just material ones. In each target group, an initial priority was placed on making sure Members were registered for existing entitlement programs that were already funded such as Medicaid, SNAP, and WIC, and/or connected with already funded arts, training, social, or similar activities within the community that would be of benefit and interest to them.

5. Finance. The finance team developed an understanding of the (a) current funds supporting the target population which could be braided, (b) estimated the costs of the Commons (including management, the Companion program, training for participating organizations, and the costs of collaboration for each of the participating groups), and (c) the estimated additional investments in clinical and social services needed by the target population to thrive. It used the model from the CCR Finance Activity Team to estimate the specific organizational beneficiaries, amounts, and timing of upside benefits and savings that would flow from the successful implementation of the model with the initial target groups. Together, these become the return on investment of community thriving.

The participating groups agreed to an accounting system to track and braid their expenditures for collaboration and in support of individual members, thus creating an overall budget.

Part of the grants was used to establish a "Wellness Fund" to attract and manage the funds needed to help Members thrive (the total of (b) and (c) above), until the benefits and savings of thriving became apparent after a few years – which they did.

A group of private investors and foundations interested in this pay-for-success model was invited to the first of a series of quarterly briefings on the program. The briefings described the Model and the projected savings and benefits that would accrue to the array of local, state, federal agencies, and private organizations, along with the estimated size of the savings, and when they would occur.

Discussions were opened with each of those organizations as to their willingness to share in the savings created by the Commons. In some instances, such as benefits to children in learning, the discussion was with the community itself as to how much it would invest to achieve that valuable outcome. Other proven methods of aggregating public investment contributions were explored.[8]

As the program gathered steam and began to produce results, Medicare agreed to treat the Commons as an Accountable Care Organization and to share with it a percentage of downstream (acute and specialist care) costs saved that were attributable to Commons members compared to what had been actuarially predicted for them. Similar negotiations began with the state Medicaid program. The county law enforcement system agreed to share half of the savings of the otherwise predicted expenses of attributable members, following the lead of the Denver Court System in the pay-for-success agreement that created the Sanderson Apartments and its wraparound services for homeless people with behavioral health issues. The Colorado Business Health Alliance contracted with the Commons to provide primary care and related social services to the employees of any of its participating

[7] Fully half of the women in Colorado who are eligible for the WIC program are not registered in it. Similarly, a high percentage of people eligible for SNAP are not signed up. A wide variety of programs exist to support seniors, including in addressing loneliness, but many seniors do not know about them. Area Agencies on Aging do.
[8] These can range from savings to hospitals for helping meet Hospital Transformation Program requirements, to the innovative approach fostered by Len Nichols and colleagues to share investments in social determinants. See CCR paper on financing options.

organizations who wished to become Members, sharing in both cost savings and (later) measured productivity benefits.

6. Measurement and evaluation (M&E). After extensive consultation with stakeholders and the managers of the state level M&E system, the Commons leadership designed accountability dashboards for Members, Companions, Commons management, and participating providers. They decided which metrics would be public. This data drove continuous improvement.

7. Information sharing and technology. It is only possible to manage a complex, multistakeholder system of this kind with advanced, interoperable information technology that supports people and families, connecting them to peers and friends, as well as the assigned Companion from the Commons. It needs to support the Companion in accessing, integrating, and following through with each Member's team to implement multisector, multiparty success plans. It needs to provide a flow of information to all the stakeholders in the system for continuous improvement and evaluation, as well as reporting.

The Greenbush Commons had an enormous advantage because it didn't need to figure out any of this on its own. That was and is being done by major effort led by the Office of eHealth Innovation and others to create a common information technology infrastructure shared by all providers of safety net clinical and social services. This included a complex adaptive systems model developed by the Colorado School of Public Health which simulates outcomes of various forms of the Model based on an expanding base of experience, supporting the negotiations with investors.

And so off they went implementing the new system.

As the techniques of person – centered integrated management and service delivery were learned and refined, the Commons system was extended to far more members in the community.

As it became clear that increased investment in integrated delivery of frontline clinical care and social services produces significant benefits and savings downstream, investor dollars will replace the grant-funded Wellness Fund and/or payor organizations will extend their time horizons for required returns. And the Commons model is increasingly adopted in additional communities.

This story is a work in progress. It is intended to describe a possible, but certainly not the only, pathway to meet the goals of CCR. Suggestions and criticisms are enthusiastically encouraged. Please direct any comments to David Aylward at david.aylward@cuanschutz.edu.