# COMMUNITY HEALTH TRANSFORMATION TOOLKIT

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# INTRODUCTION

## BACKGROUND

To deal with healthcare transformation health systems, communities and a myriad of organizations are bonding like never before to engage, find health quality innovation and reduce related costs by reaching their population health goals. Dynamic versions of community collaboration are emerging in Iowa and nationwide. These vital partnerships execute change, advocate for meaningful services and demonstrate value.

Historically organizations and communities have developed a variety of collaborative initiatives. More recently the nation has been drawn into the important cycle of healthcare transformation. According to the Healthcare Transformation journal,[1] this includes: delivery, disruption, innovation and transformation of healthcare delivery as well as funding mechanisms. It identifies specific populations knowing healthcare must focus on creating value for the health of populations.

**"Look forward and focus on the best interest of your community. This is what helped us get through any collaborative hurdles we encountered along the way."**

[1] Peter W. Roberts, Elizabeth MacLaren, and Michael H. Samuelson (2018). Introducing design thinking to enhance population health management. *Healthcare Transformation, 3(1)*,17-26.

## AN IOWA DEMONSTRATION

During the four-year **Centers of Medicare & Medicaid Innovation Center State Innovation Model** (SIM) grant, the Iowa SIM Community & Clinical Care (C3) pilot project was initiated. Seven communities comprised of multi-sector groups of committed stakeholders implemented innovative strategies and processes to meet the clinical and social needs of a target population. The C3s accomplished two primary functions:

- Addressing social determinants of health (SDOH) through care coordination
- Implementing population-based, community-applied interventions related to the Iowa Statewide Strategies

These initiatives were intended to enhance care coordination and transitions for both providers and patients. They identified population risks and addressed barriers to health such as social determinants by connecting patients (and providers) to community resources and developing and/or implementing strategies to address diabetes.

The C3 demonstration strategies and activities resulted in innovative, award-winning projects with meaningful program outcomes that were shared with other communities.

In SIM Award Year 4, successes from the C3 initiatives expanded to additional Iowa communities that were committed to similar health transformation efforts.

# ORGANIZATION OF TOOLKIT

This concise toolkit is intended to offer guidance, give resources and present related Iowa scenarios. It is organized around three sections: 1) What is Community Engagement? 2) Accountable Communities for Health 3) Appendices. The toolkit also includes Components for Sections 1 and 2. The Components have descriptor links to electronic resources and websites. Note URLs tend to move or "break" over time.

For the purpose of this toolkit, **collaboration** is defined as activities in which partners work together through various vehicles (e.g., contracts, formal memoranda of understanding, charters, etc.) to maximize resources and efficiencies, with a common goal of ensuring access and provision of services. **Coordination** is the deliberate organization of and communication about care activities between two or more participants involved in a patient's care to facilitate the appropriate quality healthcare and delivery of social services.

# SECTION ONE: WHAT IS COMMUNITY ENGAGEMENT?

For the purpose of health transformation, community engagement is aimed at collaboration among interested organizations that can enhance service delivery and improve coordination efforts by building economies of scale and leveraging the strengths of individual organizations. Collaborations can focus on priority community health needs and develop a "community-minded" rather than a clinical/medical driven approach to population healthcare. Focusing on SDOH solutions is a uniting goal for community engagement initiatives.

## ELEMENTS

Community engagement lessons and information from current healthcare collaboratives can be summarized in five elements.


*Figure 1. Elements*

1. Analyze the environment – develop an in-depth understanding of potential partners organizations. Understand your environmental drivers at the local, state and national level.
2. Engage potential partners – identify partners most impacted by the collaborative goal. Determine their organizational strengths, abilities and limits.
3. Develop a collective strategy – ensure partners know upfront that inclusiveness and an open-minded approach are key. Identify "proven" management concepts and systems. Consider a facilitator for developmental phases.
4. Know requirements and seek technical assistance – ensure partners understand regulatory and programmatic compliance issues. Determine when legal and consultant advice is needed (e.g., data transfer, funding).
5. Evaluate processes and outcome - determine evaluation processes. Utilize Plan, Do, Study, Act (PDSA) cycle or similar process to audit and improve projects.

U.S. Department of Health and Human Services, Health Resources and Services Administration, *A Guide for Rural Health Care Collaboration*. Rockville, Maryland: U.S. Department of Health and Human Services, 2019.

# LESSONS LEARNED

IA SIM C3 projects and Health Resources and Services Administration (HRSA) Rural Leaders identified key engagement strategies:

- Organizations with no prior history of collaboration might start with a small-scale project to establish a working relationship for larger projects.
- Leaders are important in establishing and maintaining collaboration. However, leaders may change. Document partnerships through memoranda of agreement (MOA) or memoranda of understanding (MOU) so that collaboration and coordination efforts can survive the departure of the leaders who initiated them.
- Commit to transparency and honest reliable communication. Candid and honest conversations among potential partner organizations can result in clear expectations and role delineations. Effective communication processes and sources will decrease misunderstandings.
- Leverage use of existing data sources to inform meaningful initiatives. Organizations can use existing information, such as needs assessments and electronic health record (EHR) data, to identify patient populations and the organizations that can best meet those needs.
- Utilize community health needs assessment and hospital needs assessment to capture population health and community factors.
- Involve patients or patient care advocates, sharing their story can add depth and reality.
- Take a "community-minded" approach, this helps recognize that no single organization can address all of the community's needs.
- Develop a collective strategy. Collaborations are more effective when designed collectively by all participating organizations, rather than being initiated and dominated by a single organization.
- Set realistic expectations and prepare for potential changes. Not every strategy will be successful, failed strategies and partnerships can provide valuable learning experiences that enhance the success of future partnerships.
- Effective project management processes and tools help keep goals, activities and actions move towards completion.
- Performance measures data can help garner sustainability support from others in the community.

# COMPONENTS

## Understand the Community

Before health collaboratives can coordinate effective programs and projects they should identify their demographics, geographic spaces, services areas, neighborhoods, cultures and businesses. Data and stories that highlight potential disparities, community perception of issues and values held by community members are important.

| LINK | RESOURCE |
|---|---|
| **Iowa Healthcare Collaborative** | An interactive map to locate specific healthcare delivery facilities, state programs and local organizations in Iowa. The Resource section supports the map and includes links to organizations, systems, programs and demographic maps. |
| **Iowa Public Health Tracking Portal – Population** | Understanding a community is essential to understanding population health. Health equity is having the environmental, social, economic and other conditions in which all people have the opportunity to achieve their highest possible level of health. |
| **County Health Rankings and Roadmap** | Interactive maps can be used to understand health disparities in your geographical area. However, these should be used with caution when examining potential gaps due to limitations in each data source used. |

*Table 1 – Community Resources*

## Strategically Align the Collaborative

Aligning efforts by utilizing resources, elements and strategies can heighten stakeholder understanding and directly impact buy in, goals and successes.

| LINK | RESOURCE |
|---|---|
| **Evidence-Based Toolkit** | Step-by-step guides to help build effective community health. Resources and examples are drawn from evidence-based and promising programs. By learning from programs that are known to be effective, you can make the best use of limited funding and resources. |
| **Principles of Community Engagement** | Includes detailed practical information about application strategies and how they respond to changes in the larger social context. |
| **Rural Health Networks and Coalitions Toolkit** | Provides resources, strategies and examples to communities who are considering developing a new or expanding an existing health network or coalition. |
| **Increasing Participation and Membership** | This toolkit provides guidance for increasing participation and engaging stakeholders. |
| **Economic Impact Analysis Tool** | The Economic Impact Analysis (EIA) tool shows how a community health project's spending on staff, supplies, equipment and other expenses benefits the community. The EIA tool can be used by any community health organization wanting to understand how its activities affect the community. |
| **Mobilizing for Action through Planning and Partnership (MAPP)** | MAPP is a community-driven strategic planning process for improving community health. Facilitated by public health leaders, this framework helps communities apply strategic thinking to prioritize public health issues and identify resources to address them. |
| **Developing Strategic and Action Plans** | For organizations that do not currently have strategic plans, this resource can help develop a mission and vision and create strategies and activities to move toward health equity. |
| **State of Minnesota Department of Health Logic Model Tools** | Logic Models are recognized as a tool for accountability. If you begin with the goals of the initiative, it can also help flesh out needed partners/stakeholders and is a graphic depiction of shared relationships and resources. |

*Table 2 – Collaboration Resources*

### Project Vision

| INPUTS | OUTPUTS | | OUTCOMES – IMPACT | | |
|---|---|---|---|---|---|
| | **Activities** | **Lead** | **Short** | **Medium** | **Long** |
| Resources dedicated to or used by your program.<br>Examples:<br>+ External and internal partnerships – who does it take to make the project work?<br>+ How is it funded and is there additional funding?<br>+ Materials<br>+ Equipment<br>+ Technology | Strategies, techniques and interventions that direct your actions. Sometimes activities are referred to as approaches.<br>Examples:<br>+ Recruitment<br>+ Education<br>+ Outreach<br>+ Advocacy<br>+ Coalition building<br>+ Creating healthy environments<br>+ Communication<br>+ Training | Who will be involved with the activity? | Changes that you can observe and measure immediately after an intervention or at the end of your program.<br>Examples:<br>+ Partnerships are established<br>+ Improvement in knowledge or skills | Changes that happen in several months or a few years.<br>Examples:<br>+ Planning in process<br>+ Workflows adapted and implemented<br>+ Data is collected and analyzed<br>+ Improvements and best practices identified | Changes that take place several years after your program ends. This may include organizational or system-wide change.<br>Examples:<br>+ Outcomes are improved<br>+ Policies are established and implemented |
| **Assumptions**<br>Your underlying beliefs about how your program will work.<br>Examples:<br>+ Staff can be found to do the work, program resources are adequate, knowledge change will lead to behavior change and the program will be implemented | | | **External Factors**<br>These are conditions in the environment where the program exists over which you have little control, but they can influence the program's success.<br>Examples:<br>+ Organizational or political climate, health priorities of the target population, capacity to meet the identified need and forces that limit outreach | | |

*Figure 2 – Iowa Health System Project Logic Model, adapted from* the Minnesota Department of Health at http://www.health.state.mn.us/communities/practice/resources/phqitoolbox/logicmodel.html#how

# SECTION TWO: ACCOUNTABLE COMMUNITIES FOR HEALTH

Accountable Communities for Health (ACH) is a model comprised of entities from a broad range of sectors integrating health care, behavioral health, public health, social services and community-based supports to address the medical and non-medical factors that influence health, particularly the SDOH. ACH provide care for individuals through partnerships that extend beyond clinical offices, integrating medical and non-medical services to achieve greater health equity among all residents. This emerging model can be used to leverage public health activities to address the community-level factors shaping population health, including social, economic and environmental determinants. Nationally, CMS SIM programs that implemented ACH models connected with broader population health, delivery system and payment reform plans. In Iowa the SIM C3 initiatives entrenched ACH elements into their program and projects.

**"To ensure long-term success, community collaboratives should build their mission around a model that integrates evidence-based concepts."**

*Gloria Vermie, RN, MPH, Community Services Analyst, Iowa Healthcare Collaborative*

## WHY ACCOUNTABLE HEALTH COMMUNITIES?

- Largest drivers of healthcare costs fall outside the clinical care environment
- Social and economic determinants, health behaviors and the physical environment significantly drive utilization and costs
- Evidence that addressing health-related social needs (HRSN) through enhanced clinical-community linkages can improve health outcomes and impact costs
- ACH model seeks to address gaps between healthcare delivery and community services

## STRATEGIC APPLICATION

While different ACH models have unique elements, below are seven core elements identified across models, recognizing incorporation of all elements takes time:

1. Geography – defined area
2. Mission and vision – mutual among partners (revisit routinely)
3. Governance – representative of partners and mission
4. Multi-sector partnerships – representative of area and population to be included
5. Strategies and implementations – tier focuses starting with most important and impactful
6. Data and measurement – utilize established data system and analytics
7. Financing and sustainability – design budget model, determine reimbursements, use established sustainment model

In Iowa, ACH implementation often turns to **Statewide Strategies** and community health needs assessments to align with state healthcare transformation priorities.

# COMPONENTS

## Determine ACH Structure

Without realizing, successful collaboratives may already be implementing ACH elements. ACH concepts are utilized nationwide in community initiatives and business plans. When the SIM C3 projects were charged with implementing the ACH, they determined the elements were familiar. However, the ACH model had not been executed as a program model. The table below lays out C3 involvements with ACH over the course of three years. One of the lessons learned was it takes time, persistence and effort to integrate each of the elements into an initiative that has already initiated.

| ELEMENT | C3 ACH STRATEGIES | OUTCOMES – LESSONS LEARNED |
|---|---|---|
| **Geography** | Implement in counties designated in SIM contract | Each C3 determined the geographical space for their projects.<br>+ It was recognized that healthcare/hospital service areas overlap in a collaborative project |
| **Mission and Vision** | A community-based organization will convene partners, carry the vision of the C3, build trust among partners, convene meetings, recruit new partners, shepherd the planning, implementation and improvement efforts and build responsibility for these elements among collaborative members | Each C3 convened a community coalition. The C3 role was as "integrator" – a neutral body that guided the coalition but did not necessarily lead all efforts.<br>+ **Coalition charters** help establish commitment<br>+ Determining consensus for collaborative projects was key |
| **Governance** | Maintain C3 steering committee, reflective of community and population | Each C3 convened a steering committee.<br>+ Representatives from key stakeholder groups were vital<br>+ Identifying a patient/public representative was sometimes challenging |
| **Multi-Sector Partnerships** | Demonstrated in the C3 Community Care Coalition and other project committees | Each C3 involved individuals from the project target population (diabetes).<br>+ Involving these individuals was vital for the project to be recognized by the public sector |
| **Strategies and Implementations** | Utilize community-based care coordinators to provide community-clinical linkages to social service supports | Each C3 partnered with hospitals and public health to case manage services for high-risk individuals with diabetes.<br>+ Closed loop and electronic referral services proved valuable and built trust among coalition partners |
| **Data and Measurement** | Utilize supporting Health IT and IHC data portal | Each C3 collected and submitted client data in a variety of ways including Excel spreadsheets and electronic software. C3s submitted monthly SDOH data.<br>+ Overcoming legal and contractual issues with data transfer required "in-depth" conversations and signed agreements |
| **Financing and Sustainability** | Perform financial and administrative functions and use tactics from Statewide Strategies that link to established services | Each C3 completed their program value-propositions to declare their financial role with care coordination projects.<br>+ Four collaborative steps for sustainment were identified<br>1. Identify and charter the community organization accountable for healthcare coordination<br>2. Create database with target populations and responsible primary care and payer<br>3. Set the service delivery package "what will be done"<br>4. Arrange the community coalition financing package and offer to payers and community investment organizations |

*Table 3 – SIM C3 ACH Involvement*

## Accountable Community for Health Logic Model

The ACH as a logic model for healthcare transformation makes sense. When community care coalitions collaborate with a commitment to population health at the community level, new options become apparent and attainable.

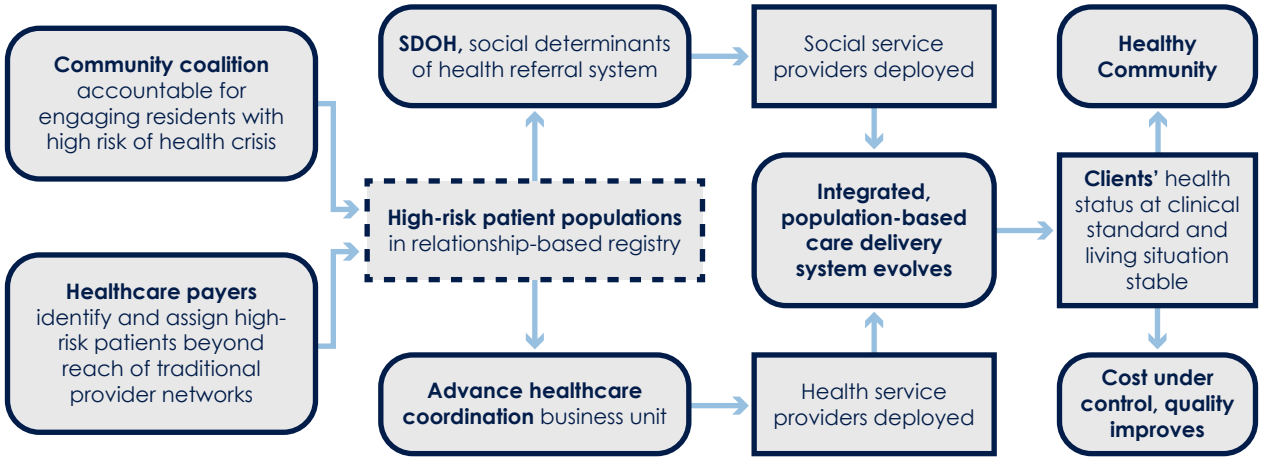


*Figure 3* – Logic Model, Alliance for Integrated Medication Management: C3 Community Investment Ensuring Sustainment Training (2019, April)

## ACH Resources

| TOOL | RESOURCE |
|---|---|
| **Standardized Screening for Health-Related Social Needs in Clinical Settings: The Accountable Health Communities Screening Tool** | With providers increasingly incentivized to improve outcomes and the patient experience, and as the incidence and cost of managing chronic diseases increases among the nation's aging population, healthcare leaders are putting a premium on preventive care. An ACH screening tool that looks at health-related outcomes is required.<br>+ **Guidance on Legal Challenges and Regulatory Obligations for Clinical Data Registries**<br>+ **Federal Public Health Laws Supporting Data Use and Sharing** |
| **CMS AHC Models** | The Accountable Health Communities Model addresses a critical gap between clinical care and community services in the current healthcare delivery system by systematically identifying and addressing health-related social needs. |
| **SHADAC – Minnesota's Accountable Communities for Health** | Minnesota's Accountable Communities for Health are community-led models of delivering medical and non-medical care and services to improve the health of a target population with substantial health and social needs. |

*Table 4 – Accountable Communities for Health Resources*

# VALUE OF COMMUNITY ENGAGEMENT FOR HEALTHCARE COLLABORATION

The Robert Wood Johnson Foundation and American Hospital Association – Health Research & Education Trust partnered to better understand ways communities and hospitals can develop and sustain partnerships and build a "**Culture of Health**." One value found of community engagement for health partners is development of shared missions and mature relations. These key stakeholders then become able to determine when new partners and initiatives are needed to meet community health needs. This process of continued partnerships is a pillar of sustainment.

Currently, identifying and targeting high-risk, high-cost populations through concentrated multi-sector collaborations has resulted in national excitement and innovation.

- Medicare beneficiaries now have covered access to: meal delivery, non-medical transportation, air filters and carpet cleaning for asthma control and other services that address social needs.
- Healthcare systems are investing and managing housing and transportation programs.
- Organizations are utilizing electronic systems for SDOH assessment and referral.
- Starting 2020 Medicare Advantage plans can cover vital non-medical service, e.g., transportation, pest control and home modifications for safety, for older adults with chronic conditions.
- National philanthropic organizations are awarding population health research grants and community service organizations are marketing their care coordination value propositions.

## Iowa Community Engagement Success Story

Iowa community health collaborations are utilizing evidence-based strategies, intense project management skills and engaging community stakeholders to make a significant difference in community healthcare transformation.

### SIMplify Newsletter Spotlight on Linn County Public Health

The following article was included in the **September 2018 SIMplify newsletter**:

> *Linn County Public Health (LCPH) was honored at the 2018 annual conference of the National Association of County and City Health Officials (NACCHO) with the "Local Health Department of the Year Award – Medium Category." The award recognizes and honors the outstanding accomplishments of local health departments for their innovation, creativity and impact on their community.*
>
> *The award specifically recognized the State Innovation Model (SIM) community care coordination (C3) project in which partners created a standardized cross-sector referral system to improve health outcomes. The closed-loop referral occurs between health and social service agencies serving residents and creates a "no wrong door" system – allowing agencies to better identify and address social determinants of health issues while reducing the burden on the client to navigate community resources.*
>
> *"We're proud of all the hard work and commitment our community partners have put into improving the way we collaborate," said Hayley Hegland, Linn County's SIM C3 Project Manager. "We hope to continue enhancing this network to improve the way we support and provide care for our residents."*
>
> *To date, more than 700 clients have been supported by the new collaborative platform with 18 organizations and nearly 200 end-users who can make and document referrals.*
>
> Spotlight, Iowa SIMplify, (2018, September)

Since this article Linn County, Iowa expanded the project to "**My Care Community**."

# SECTION THREE: APPENDICES

## APPENDIX A: SDOH

### Resources

- Iowa Social Determinants of Health Toolkit
- The Power of Social Determinants of Health Data in Improving Community Health (video)
- Social Determinants of Health in Medicaid Managed Care
- AHA Screening for Social Needs to Improve Care – Advancing Health Podcast
- Standardizing Social Determinants of Health Assessments

### SDOH Screening Tool Resources

- Accountable Health Communities Screening Tool
- PRAPARE
- Social Determinants of Health ICD-10 Z Codes

# APPENDIX B: CARE COORDINATION

## Resources

- Iowa 211 with App Information
- Aunt Bertha
- Care Coordination Statewide Strategy
- Amy's Coordinated Care Story Infographic
- Amy's Coordinated Care Story Letter-Size Handout
- Care Coordination Canvas at a Glance
- Community Care Coordination
- Rural Care Coordination Toolkit – RHIhub Toolkit
- Community-Based Care Coordination – Toolkit

# APPENDIX C: COMMUNITY HEALTH NEEDS ASSESSMENT AND HEALTH IMPROVEMENT PLANNING

Information Brief: Two major policy changes directly affected states' and localities' Community Health Needs Assessment (CHNA) activities. The Public Health Accreditation Board (PHAB) adopted policies to establish a national system of public health accreditation. On the local level, PHAB requires local health departments to complete a Community Health Assessment and Community Health Improvement Plan every three to five years. In 2015, the Internal Revenue Service (IRS) modified the IRS Code to require tax-exempt hospitals to complete an assessment and implementation strategy every three years and provide proof of community engagement.

Intersection of PHAB and IRS community assessment requirements is apparent. Both types of assessments aim to establish a clear documentation of needs and response. Both refer entities to collaborate to complete these projects rather than work independently.

**Health Centers** are also required to complete a community needs assessment every three years.

Identifying a gateway for population health endeavors and joint inspection of healthcare costs are benefits to collaborating.

## Resources

- **Community Health Needs Assessment: A Tool for Improving Community Health**
- **Using Driver Diagrams to Improve Population Health**
- **Health Systems Transformation: Community Health Needs Assessments**
- **Community Health Needs Assessment Toolkit**
- **IA Dept. of Health – CHNA**
- **CAHs CHNA and Implementation Plans: How Do They Align?**

# APPENDIX D: FISCAL SUSTAINABILITY APPROACHES

## Resources

- Developing Your Value Proposition: A Step-By-Step Guide for Behavioral Health Providers
- Sustainability Strategies for Community-Based Palliative Care (2019)
- The Community Development Financial Institutions Fund
- Developing a Plan for Financial Sustainability

## Example Model: Identify Target Population and Determine Value Proposition

**Model for Scale of Care Coordination (Estimates)**
**Identify High-Risk High-Cost Individuals for Case Management**

**County Population = 221,700**

***Hospital Utilization***

| | |
|---|---|
| ED visits | 96,700 |
| Avoidable ED visits | 15,470 |
| Cost of avoidable | $21,751,000 |
| Hospital Admits | 27,300 |
| 30 Day Readmissions | 3,790 |
| Avoidable 30 Day | 1,020 |
| Cost of avoidable | $14,688,000 |

***Social Services***

| | |
|---|---|
| Poverty | 20,840 |
| Need Social Services | 6,880 |
| Number in Crisis | 2,270 |

***Health Status***

| | |
|---|---|
| Diabetes | 22,170 |
| DM NAG | 6,650 |
| DM Crisis | 650 |
| Obesity | 55,810 |
| Obesity Crisis | 4,300 |
| Tobacco User | 25,370 |
| Tobacco Crisis | 2,540 |
| High Risk, Chronic Conditions (≥ 3) | 47,356 |
| Number in Crisis | 4,470 |

Value Proposition for Integrated Care Coordination

| 1. PROGRAM VOLUME | |
|---|---|
| Total Number of Annual Patients Screened | 989 |
| Total Number of Annual Patients Enrolled | 500 |
| Total Number of Annual Patient Encounters | 5,347 |

| 2. PROGRAM COSTS | |
|---|---|
| Clinical Pharmacists | $147,961 |
| Advanced Care Coordination | $32,106 |
| Social Services | $23,716 |
| Other Overhead Costs | $50,946 |
| ***Total Costs*** | ***$254,729*** |

| 3. PROGRAM REVENUES | |
|---|---|
| Amount Billed | $285,506 |
| Less: Allowance for Uncollectible | ($9,992) |
| ***Total Revenue*** | ***$275,514*** |

***4. Net Revenue over Expense $20,785***

***Expected Cost of ED & IP Services for Population = $3,374,000***

| 5. VALUE PROPOSITION | | | |
|---|---|---|---|
| Rate of Cost Reduction | Expected Costs Cut | Equivalent # of Admits | Equivalent # of ED Visits |
| 5.0% | $168,717 | 8 | 120 |
| 8.2% | $275,514 | 13 | 196 |
| 10.0% | $337,435 | 15 | 240 |

*Alliance for Integrated Medication Management: C3 Community Investment Ensuring Sustainment Training (2019, April)*

# APPENDIX E: TELEHEALTH

**Telehealth** is defined as the delivery and facilitation of health and health-related services including medical care, provider and patient education, health information services and self-care via telecommunications and digital communication technologies.

## Telehealth Modes of Delivery

| MODE | HOW DOES IT WORK? | EXAMPLES |
|---|---|---|
| **Live (synchronous audio-video connection)** | Patients receive healthcare live at an originating site. | Patients are able to receive care from their regular providers or in the case of direct-to-consumer telehealth, be connected with the next available clinician in patient-initiated telehealth visit via personal devices, such as mobile phones. |
| **Store-and-forward** | Healthcare providers or patient at an originating site forwards the patient's records or images to a healthcare provider at the distant site who provides treatment recommendations. | These "electronic consultation" services involve a delay in treatment and are often used in dermatology, radiology and other clinical specialties. |
| **Remote patient monitoring** | Patients' health data regularly transmitted from their homes to healthcare providers. | Providers monitor patients' health data and alter treatment as needed. This type of telehealth is often used for patients with chronic conditions such as asthma and diabetes to reduce unnecessary hospital or emergency department visits. |
| **Mobile health (mHealth)** | Technology such as tablets and cell phones are used to convey information. | Patients or other public audiences with public health information and education. |

Peter W. Roberts, Elizabeth MacLaren, and Michael H. Samuelson (2018). Introducing design thinking to enhance population health management. Healthcare Transformation, 3(1),17-26.

### Resources

- **Health Information Technology Model**
- **MHIF Rural Health Transformation Center: Using Telemedicine to Reach Your Population Target**
- **Pathways Community HUB: A Guide to Identify and Address Risk Factors, Reduce Costs, and Improve Outcomes**

## Care Coordination Software/Platform Services

The information below does not imply a recommendation or endorsement as there are numerous additional services to consider.

| PRODUCT | HOW IT WORKS |
|---|---|
| **Signify Community™** | Signify Community (Previously TAV HEALTH) helps you collaborate with an alliance of community partners to better manage and improve client outcomes. The platform provides helpful tools for delivering electronic referrals, coordinating service delivery and collaborating with your community on a shared record. |
| **PRAPARE** | The PRAPARE assessment tool consists of a set of national core measures as well as a set of optional measures for community priorities. It was informed by research, the experience of existing social risk assessments, and stakeholder engagement. It is the primary software for community health clinics and federally qualified health centers. |
| **Unite Us** | Software platform capability for integration and software connecting health and social services providers. |
| **Eccovia Solutions** | SDOH software with multi-platform capacity and a variety of social services supports. |
| **NowPow** | Multi-sided platform generates three types of referrals to manage full spectrum of self-care and support people's needs. |
| **Healthify** | Healthify Search is a SDOH platform supporting healthcare organizations in finding community organizations, social services and closing the referral loop through coordinated referrals with community partners. |

# APPENDIX F: FEDERAL AND NATIONAL RESOURCES

| LINK | RESOURCE |
|---|---|
| Administration for Children and Families (ACF) | Promotes the economic and social wellbeing of families, children, individuals and communities |
| Agency for Healthcare Research and Quality (AHRQ) | Mission is to improve the quality, safety, efficiency, research and effectiveness of healthcare |
| American Academy of Family Physicians (AAFP) | Exists to improve the health of patients, families and communities by serving the needs of members with professionalism and creativity |
| American Dental Association (ADA) | Exists to power the profession of dentistry and to assist our members in advancing the overall oral health of their patients |
| American Health Care Association (AHCA) | A federation of 50 state health organizations, together representing nonprofit and for-profit assisted living, nursing facility and subacute care providers that care for elderly and disabled individuals nationally |
| American Hospital Association (AHA) | Represents and serves all types of hospitals, healthcare networks and their patients and communities |
| American Medical Association (AMA) | Promotes the art and science of medicine and the betterment of public health |
| American Nurses Association (ANA) Enterprise | Supports, promotes and ensures the needs and requirements of nurses |
| American Public Health Association (APHA) | Organization that combines a nearly 150-year perspective, a broad-based member community and the ability to influence policy to improve the public's health |
| Bureau of Primary Health Care, Health Resources and Services Administration | HRSA's Primary Health Care Programs |
| Centers for Disease Control and Prevention (CDC) | Protect America from health, safety and security threats, fighting disease and supporting communities |
| Centers for Medicare & Medicaid Services (CMS) | Administers Medicare, Medicaid, related quality assurance programs and other programs |
| Grants.gov | Established as a governmental resource to improve government services to the public and help organizations find, apply and succeed at accessing federal funding |
| Health Resources and Services Administration (HRSA) | The primary federal agency for improving access to healthcare services for people |
| National Alliance on Mental Illness (NAMI) | Nation's largest grassroots organization dedicated to improving the lives of individuals and families affected by mental illness |
| National Association of Community Health Centers (NAC) | Serves as the leading national advocacy organization in support of community-based health centers and the expansion of healthcare access for the medically underserved and uninsured |
| National Association of Emergency Medical Technicians (NAEMT) | Serves as the professional organization for EMTs, paramedics, instructors and administrators |
| National Center for Health Statistics (NCHS) | Compiles statistical information to guide actions and policies to improve the health of Americans |
| National Committee for Quality Assurance (NCQA) | An independent, not-for-profit organization dedicated to measuring the quality of America's healthcare |
| Office of Minority Health (OMH) | Primary responsibility is to improve health and healthcare outcomes for racial and ethnic minority communities by developing or advancing policies, programs and practices that address health, social, economic, environmental and other factors which impact health |
| RxAssist.org | A comprehensive resource center for patients, providers and patient advocates to find free and low-cost medications to help manage chronic disease |
| SARADD | The country's leading nonprofit dedicated to helping all people live mentally healthier lives |
| School Based Health Alliance | Dedicated to promoting accessible, quality school-based primary health and mental healthcare for children and youth through interdisciplinary and collaborative efforts |
| Visiting Nurses Association of America (VNAA) | Supports, promotes and advocates for community based, nonprofit home health and hospice providers that care for individuals |

# APPENDIX G: ACRONYM LIST

## Glossary of Healthcare Acronyms

| | ACRONYM | REPRESENTS |
|---|---|---|
| **A** | **AAPM** | Advanced Alternative Payment Model |
| | **ACH** | Accountable Communities for Health |
| | **ACO** | Accountable Care Organizations |
| | **ADE** | Adverse Drug Event |
| | **ADT(s)** | Admissions, Discharges and Transfer(s) |
| | **AMH** | AssessMyHealth |
| | **APM** | Alternative Payment Model |
| **B** | **BRFSS data** | Behavioral Risk Factor Surveillance System |
| **C** | **CAH** | Critical Access Hospital |
| | **CDC** | Centers for Disease Control and Prevention |
| | **CDSMP** | Chronic Disease Self-Management Program |
| | **CEHRT** | Certified Electronic Health Record Technology |
| | **CHIP** | Children's Health Insurance Program |
| | **CHNA** | Community Health Needs Assessment |
| | **CMMI** | Center for Medicare & Medicaid Innovation |
| | **CMS** | Centers for Medicare & Medicaid Services |
| | **COB** | Coordination of Benefits |
| | **CQM** | Clinical Quality Measure |
| **D** | **DHS** | Department of Human Services |
| | **DSME** | Diabetes Self-Management Education |
| **E** | **eCQMs** | Electronic Clinical Quality Measures |
| | **ED** | Emergency Department |
| **F** | **FFS** | Fee-for-Service |
| | **FOA** | Funding Opportunity Announcement |
| | **FPL** | Federal Poverty Level |
| | **FQHC** | Federally Qualified Health Center |
| **H** | **HAC** | Hospital-Acquired Condition |
| | **HEN** | Hospital Engagement Network |
| | **HHS** | Health and Human Services |
| | **HIIN** | Hospital Improvement Innovation Network |
| | **HIP** | Health Improvement Plan |
| | **HIPAA** | Health Insurance Portability and Accountability Act |
| | **HIT** | Health Information Technology |
| | **HRA** | Health Risk Assessment |
| **I** | **IDPH** | Iowa Department of Public Health |
| | **IHC** | Iowa Healthcare Collaborative |
| | **IME** | Iowa Medicaid Enterprise |
| | **IPOP** | Inpatient Outpatient |
| | **IT** | Information Technology |

| | ACRONYM | REPRESENTS |
|---|---|---|
| **L** | **LBOH** | Local Boards of Health |
| | **LTC** | Long-Term Care |
| | **LTSS** | Long-Term Services and Supports |
| **M** | **MACRA** | Medicare Access and CHIP Reauthorization Act |
| | **MBHO** | Managed Behavioral Healthcare Organization |
| | **MCO** | Managed Care Organization |
| | **MIPS** | Merit-Based Incentive Program System |
| | **MSSP** | Medicare Shared Savings Program |
| **N** | **NDPP** | National Diabetes Prevention Program |
| | **NQF** | National Quality Forum |
| **O** | **ONC** | Office of the National Coordinator for Health Information Technology |
| | **OP – AAPM** | Other Payer Advanced Alternative Payment Model |
| **P** | **PCCM** | Primary Care Case Management |
| | **PCMH** | Patient-Centered Medical Home |
| | **PCP** | Primary Care Provider |
| | **PDSA** | Plan Do Study Act |
| | **PHI** | Protected Health Information |
| | **PMPM** | Per Member Per Month |
| | **PPC** | Public Policy Center |
| **Q** | **QI** | Quality Improvement |
| | **QIN** | Quality Improvement Network |
| | **QIO** | Quality Improvement Organization |
| | **QPP** | Quality Payment Program |
| **R** | **RCPI** | Rapid Cycle Performance Improvement |
| | **RFP** | Request for Proposal |
| | **RHC** | Rural Health Clinic |
| | **RTI** | Research Triangle Institute |
| **S** | **SDOH** | Social Determinants of Health |
| | **SFTP** | Secure File Transfer Protocol |
| **T** | **TA** | Technical Assistance |
| | **TCI** | Total Cost Index |
| | **TCOC** | Total Cost of Care |
| | **TCPi** | Transforming Clinical Practice Initiative |
| **V** | **VBP** | Value-Based Purchasing |
| | **VIS** | Value Index Score |
| **Y** | **YRBSS** | Youth Risk Behavior Surveillance Survey |