March 2020

Preliminary Findings on the Role of Health Care in Multi-Sector Networks for Population Health: Notes from the Field

By Debbie I. Chang; Allison Gertel-Rosenberg; Kate Burke Blackburn; Bilal Taylor

Nemours

I. PROJECT BACKGROUND

In 2012, Nemours led a group of stakeholders in writing a short paper entitled "Integrator Role and Functions in Population Health Initiatives[1]" The paper noted that the Affordable Care Act spurred payment and delivery reform in health care, and that achieving the Triple Aim of better quality of care, better health for populations, and lower costs became a critical area of focus for reform. The paper went on to note how different entities engaged in multi-sector networks — including hospitals, health systems, and federally-qualified health centers can carry out integrative roles that contribute to improved health for entire populations and achieve the Triple Aim. The paper proposed 11 integrative roles and functions that a range of partners[2] within population health networks must play in order to ensure that their efforts have the best opportunity for achieving their population-level health goals, and made the point that integrative activities are often shared by network members since it is difficult, if not impossible, for one entity to provide all the supports a network needs to address the complex issues (often referred to as the "social determinants of health"[3]) that comprise health and wellness. These 11 integrative roles and functions fell under three broad headings:

Leadership and Partnership Engagement

- Engage members from multiple sectors and/or connect with other integrators
- Serve as a trusted leader in the community and accept accountability for carrying out integrative functions
- Facilitate agreement among multi-sector stakeholders on shared goals and metrics
- Assess the community resources that are available to reach shared goal(s); determine what gaps need to be filled and what duplication needs to be reduced; and work with members to make appropriate adjustments

Spread, Scale, and Sustainability

- Work at the systems level to make policy and practice changes in both the public and private sectors that impact populations
- Serve as a source for spreading what works at both the policy/systems level and at the practice level to reach sufficient scale
- Sustain change by impacting policies and practices
- Pursue financial sustainability via various methods

Continuous Learning and Improvement to Promote Population-Level Solutions

- Gather, analyze, monitor, integrate, and learn from data at the individual and population levels
- Identify and connect with system navigators to harvest and aggregate data from individual cases and use the data to promote population-level solutions
- Develop a system of ongoing and intentional communication and feedback at multiple levels

[1] Nemours defines "population health integrators" as entities that serve a convening role and work intentionally and systematically across multiple sectors in a region to achieve a common purpose specific to health outcomes of an entire geography of people. Integrators ensure that essential integrative activities are happening throughout the network.
[2] For the purpose of this paper, the terms partners and partnerships are used informally and are not intended to convey formal, legal arrangements.
[3] For more on "social determinants of health," click here.

In November 2018, The Kresge Foundation awarded[4] Nemours a two-year grant to further work that began with that 2012 paper. The goal of this project is to advance the field's knowledge of the ways that health care can and should contribute to multi-sector networks that advance population-level health goals (referred to as "multi-sector population health networks" through the rest of the document). The work will be carried out along two dimensions:

- **Modernizing the "Integrator" Concept:** The project will allow Nemours to expand on its 2012 paper by conducting a brief literature scan and interviews with national experts who have insights related to integrative roles and functions within multi-sector population health networks, as well as the ways health care is involved in carrying out these roles and functions in support of networks' shared goals. Beginning in early 2019, Nemours scanned the literature and conducted formal interviews with 40 experts representing 30 organizations, consulting with additional experts informally. (See appendix for list of organizations interviewed.) In general, the scan and interviews confirmed that the integrative roles and functions identified in Nemours' 2012 paper were correct and complete. However, the process uncovered gaps in field-level understanding of how health care members in these networks are currently joining, catalyzing, and sustaining the work. As such, Nemours expansion of its 2012 work will include lessons, recommendations, tools, and resources related to how integrative activities can best be deployed to strengthen the functioning and effectiveness of multi-sector population health networks. This project will culminate in sharing implementation strategies with the field to inform and accelerate the work of other health care organizations and multi-sector population health networks.
- **Using an Integrator Learning Lab to Accelerate Adoption of Best/Promising Practices for Integrators:** Nemours has selected nine multi-sector population health networks from communities around the country to participate in a six-month Integrator Learning Lab between January and June 2020. As "leaders and learners" in the Integrator Learning Lab, these community initiatives will be paired with technical assistance providers to identify, test, and adopt best practices for deploying integrative activities to enhance the efforts of multi-sector population health networks in their regions. The Integrator Learning Lab will build upon the successful Policy Learning Lab model that Nemours developed as part of its Moving Health Care Upstream initiative in 2017.

This issue brief updates our understanding of the interplay of integrative roles and functions based on the scan and interviews completed in 2019, and identifies barriers to, and accelerators for, health care to carry out these roles in a sustained fashion. The brief also includes recommendations for the field and for the provision of technical assistance to health care partners that are seeking to strengthen their integrator role over the longer-term. The 2020 Integrator Learning Lab will allow multi-sector population health networks to test these recommendations in the real world. Following the close of the 2020 Integrator Learning Lab, lessons, resources, and recommendations will be shared with the field as a follow up to this brief.

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[4] For a full description of the two-year investment, click here

II. INTRODUCTION

Networked approaches to tackling complex social challenges are not new, yet practitioners and researchers are continually working to share frameworks for how to support, fund, and sustain work that cuts across sectors. One powerful contribution to this field of knowledge came by way of John Kania and Mark Kramer's landmark 2011 article in the Stanford Social Innovation Review that offered "collective impact" as a new model for understanding the conditions under which multi-sector groups can come together to help confront complex, "adaptive" challenges in communities that no one organization or entity can solve on their own[5].

While collective impact literature describes how efforts can be better coordinated to achieve a range of systems-level changes at scale, others (including Nemours Children's Health System and the Rippel Foundation's "ReThink Health[6]" initiative) theorize about, and test, approaches that can help member organizations navigate the unique challenges that exist for networks that have a specific emphasis on population health. In researching and understanding the structure, function, and impact of these networks, the field is grappling with some of the challenges to collective impact that have been raised by those working in this space, including:

- A model with one "backbone," "quarterback," "anchor," or "integrator" that disproportionately holds resources and steers the vision of a multi-sector network is difficult to sustain long-term.
- The voices of those most impacted by issues in a community can be drowned out such that a network's proposed solutions do not correspond to their lived reality.
- The model may underestimate the long-term commitment needed to achieve structural changes that influence the wellness of residents.

In the face of these and other barriers, researchers of multi-sector population health networks are diving deeper and exploring the accelerators that are more likely to help them mount a challenge to community health issues in an equitable, sustainable manner. A growing consensus is emerging that multi-sector population health networks with the most potential for long-term impact should:

- Be designed with widely distributed leadership tables.
- Feature community resident voice throughout the planning, implementation and evaluation of efforts.
- Have robust systems-change goals connected with shorter-term indicators to assess progress in real-time.

This brief distills findings from 40 interviews (conducted July-September 2019) to further the field's understanding of how health care organizations carry out integrative roles in multi-sector population health networks. This emphasis aligns with conversations among field experts regarding gaps in knowledge of how health care organizations join, catalyze, and sustain multi-sector networks for population health.

THE REMAINDER OF THE BRIEF IS ORGANIZED AS FOLLOWS:

- **Findings:** What early lessons can be learned from the 40 interviews with field leaders?
- **Focus on Success:** What communities can we look to for work that illustrates findings presented in this brief?
- **Recommendations:** What are the implications of these learnings for the field and for the design of the 2020 Integrator Learning Lab?

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[5] For more on collective impact, click here
[6] For more on ReThink Health, click here

III. FINDINGS

A. *Integrative Functions (How have health care organizations and their partners taken on shared responsibility and accountability for the integrative functions that advance network goals?)*

A1. **The three categories and eleven essential functions presented within Nemours' 2012 paper should be expanded to more explicitly reflect issues related to equity and inclusion.** All experts concurred that the essential functions highlighted in the 2012 paper are still relevant for the field. Taking a look deeper into the description of the functions, however, some respondents noted that the functions should be more explicit when it comes to broader issues of inclusion in two key ways. First, organizations carrying out integrative functions must ensure that health equity[7] is at the center of efforts if the work is to be truly transformative for the most disadvantaged people living in its defined geography. Second, network conveners have the responsibility of building trust with residents who have been marginalized by current systems, and should prioritize resident voices to ensure that coalition efforts are "people-centric." This people-centric approach includes the integration of voices of people with lived experiences as partners in the process of setting and operationalizing the multi-sector population health network's vision and goals.

This finding is supported by Focus on Success example #7.

A2. **Health care's role in multi-sector population health networks is often focused on individual patient social needs, though the upstream movement is growing**[8]**.** All experts noted that health care organizations play a crucial role in carrying out integrative functions in multi-sector population health networks. Health care may be the lead/convener for short-term collaborations focused on meeting social needs linked to health outcomes among patients and/or grant-specific collaborations (for example, a network launched to focus on food insecurity for patients served by a health care entity). However, several experts noted that health care's perceived power differential and traditional clinical focus has historically not led to health care entities serving as a "lead" or "convener" of networks focused on health and well-being for the entire community. In such networks, health care partners have tended to step up to take the lead on tasks when objectives are clearly linked to measurable health changes among patients, and step back for tasks and objectives linked to broader, more holistic views of community health and wellness. Having said that, each interviewee held out the possibility for visionary health care partners to lead in work that is upstream and less proximal to health care, and emerging examples were cited, including those included in the Focus on Success section.

This finding is supported by Focus on Success examples #2, #3, #4, #5, #8, #9, and #10.

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[7] Per the Robert Wood Johnson Foundation: "Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care." click here

[8] Upstream efforts seek to create community-level impact and improve community conditions by addressing social determinants of health through policy, laws, and regulations. Midstream efforts seek to create individual-level impact by meeting individuals' social needs through screenings, referrals, and other individually-focused processes/protocols. Downstream efforts seek to create patient-level impact by providing clinical care. For more, click here

B. *Strategies for Taking on Integrative Functions (What approaches and tactics have health care organizations and their partners used to operationalize integrative functions across their networks?)*

B1. **Health care entities in strong multi-sector population health networks tend to have deliberate, complementary alignment of midstream and upstream efforts**[9]. Most health care representatives who were interviewed made note of their organization's efforts to conduct screenings and referrals to meet the social needs of patients and families (i.e., midstream work). Additionally, most noted that trends from screenings and referrals were being used to identify areas for policy, systems, and environmental change work carried out in collaboration with partners. For example, data from screenings in health care settings might demonstrate that a large majority of patients/families in a particular neighborhood lack easy access to affordable fruits and vegetables. These data might then be shared with the rest of the multi-sector population health network so that members can create shared strategies for increasing access and quality of fruits and vegetables-such as establishing farmers markets in the neighborhood, allowing SNAP dollars to be doubled when spent at the farmers market, or converting vacant land to community gardens. The pattern of midstream work led by health care organizations pointing the way to upstream campaigns to be led by other network partners and supported by health care was cited by nearly all interviewees as a way to allow health care partners to go further upstream and contribute to larger systems-change efforts for entire populations.

This finding is supported by Focus on Success examples #2, #3, #4, #6, #7, and #8.

B2. **Health care integrators in strong multi-sector population health networks have re-imagined their approach to hiring and training of staff based on the needs of the networked approach to population health.** Interviewees acknowledge that ongoing partnership in multi-sector population health networks requires their organizations to consider the type of staff that is needed to support the work. For some, this has included training colleagues about their organization's role in multi-sector population health networks. For others, this has included redefining the staff competencies needed to do midstream and upstream multi-sector population health work as well as the creation of new positions within existing departments that have institutionalized integrative functions into the day-to-day workflow of their organizations.

This finding is supported by Focus on Success examples #2, #3, and #10.

[9] Upstream efforts seek to create community-level impact and improve community conditions by addressing social determinants of health through policy, laws, and regulations. Midstream efforts seek to create individual-level impact by meeting individuals' social needs through screenings, referrals, and other individually-focused processes/protocols. Downstream efforts seek to create patient-level impact by providing clinical care. For more, click here

C. *Accelerators & Barriers to Taking on Integrative Functions (What institutional and geographic contextual factors have accelerated or decelerated the operationalization of integrative functions for health care partners?)*

C1. **Networks must develop a shared mission and vision in order to come together to advance shared population health goals in a geographically-defined community.** Researchers and academics noted that members of multi-sector population health networks share the same issues of mission alignment, data-sharing and trust that participants in any multi-agency or multi-sector network face. Partners in multi-sector population health networks must also be aware of the need to periodically come together to ensure that health care and other partners are aligned with how they are using language to frame the issues, vision, goals, and metrics that the network has adopted. Networks must also consider the fact that complex health issues often do not fall under the purview of any one member organization, and understand how to build-in shared financial accountability, outcomes, and incentives to ensure that partners see the value in on-going participation in the network.

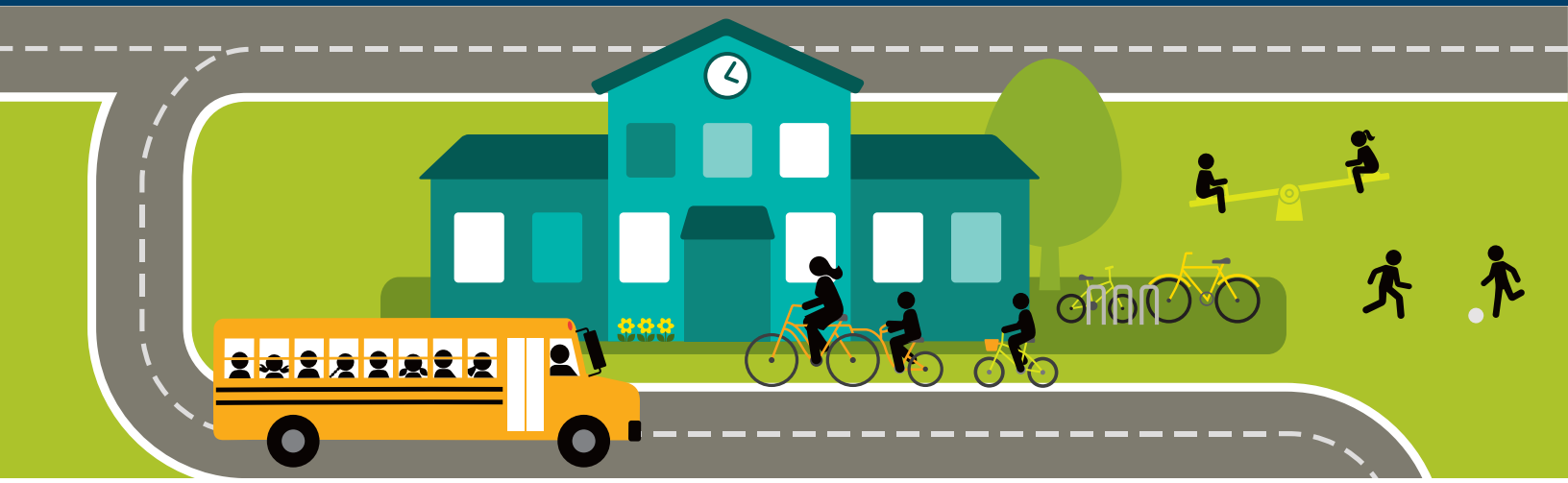
This finding is supported by Focus on Success examples #5, #7, #8, and #9.

C2. **Systems changes require long-term, joint strategic planning efforts that may represent a new way of working for multi-sector population health network members.** Several experts noted that the scope of problems that multi-sector population health networks tend to address call for long-term, sustained efforts that will certainly run beyond the tenure of any organizational leader or political administration. Successful networks need to continue to make the case to successive administrations and leaders about the value of their efforts. One approach that staff of health care institutions in multi-sector population health networks have taken to institutionalizing their work has been to build network activities and goals into the multi-year strategic plans of their organizations so that this work exists beyond one department or committed leader (see discussion under "sustainability" below).

This finding is supported by Focus on Success example #7.

TIPS FOR PRACTITIONERS

- Infuse competencies around social determinants of health and population health networks into hiring, training/ professional development, and advancement of staff across departments in a health care institution.
- Create new positions (or amend existing positions) to include competencies related to working effectively with multi-sector networks and/or coalitions.
- Align existing screening efforts to better understand the non-medical needs of health care institutions' patients with the efforts that networks are undertaking to improve the health of entire communities.



C3. **For many health care entities seen as exemplars in this space, entrée into multi-sector population health networks has been facilitated by their organization's commitment to population health prior to the field-wide movement to value over the last decade.** Multiple interviewees noted that the significant unmet needs of residents in their communities (including their employees) led them to commit to an approach that contributes to the health and wellness of entire populations (in addition to serving their individual patients) for decades. For some groups this has meant that their hospitals developed anchor institution strategies[10] before the wider conversation on moving to value that has emerged in the last few years. Others have established in-house capacity through centers and institutes that serve as resource and data providers for networks. Having history in, and institutional memory of, this work in early stages appears to be an enabling factor that has allowed health care organizations to remain in collaborations that have increasingly required greater cross-sector integration to address the complex social determinants of health impacting communities.

This finding is supported by Focus on Success examples #1, #2, #3, #4, #5, #7, #8, #9, and #10.

TIPS FOR PRACTITIONERS

- Create regular opportunities for network members to check in about continued relevance of network goals and make recommendations about mid-course corrections as needed.
- Include population-level health goals of the network into the multi-year strategic plans of health care partner institutions.
- Articulate a value proposition for multi-sector population health work that addresses how this work is aligned with the mission of network members from the health care sector and how the network's efforts can help the system meet its financial goals.

C4. **Connection to mission has been as impactful as return on investment when health care entities have made the case to C-Suite and clinical leaders in their organizations about the value of participation in multi-sector population health networks.** Having a mission-driven culture was listed by most as a key factor in joining networks. In some cases, this mission alignment was accompanied by a need for the organizations to collaborate with competing health care organizations and other institutions to fill a void created by the closing of another health provider. Interviewees noted that the mission-driven aspects of their organizational culture have been just as essential in making the case for staying committed to networks as the data that they have been able to provide about the effect of network activities on patients and their organization's financial bottom line.

This finding is supported by Focus on Success examples #2, #3, #7, and #9.

[10] For a concise definition of anchor institutions, click here

D. *Sustainability (How have health care organizations and their partners made the case, within their own organizations and to external stakeholders, for institutionalizing new ways of working over the long-term?)*

D1. **Health care entities are increasingly contributing to policy-level changes that impact residents of entire communities.** While health care organizations appear to take more leadership roles in midstream activities, there are several examples of these organizations playing a role in policy change. In each case, interviewees played a key role in translating the importance of these policies to health care leadership and in making the case for utilizing their resources to attain population-level health goals (see discussion in the "accelerators and barriers" section above).

This finding is supported by Focus on Success examples #2, #3, #4, #5, #7, #8, #9, and #10.

D2. **Strong multi-sector networks for population health are devising new ways to collaborate for sustainability.** Developing shared goals and metrics for the network's collective success has allowed some interviewed networks to demonstrate impact and engage philanthropic entities- which are the most common funding source for multi-sector networks[11]. A commonality among these networks was that each had a neutral, trusted organization serving a fiduciary role to ensure that dollars are equitably distributed among network members. Networks that have had success in this regard also spoke to their networks' ability to build the trust necessary for individual members to think about collective projects over their own interests, including not applying for funding when other network members appear to be a better fit.

This finding is supported by Focus on Success examples #8 and #9.

D3. **Health care entities in strong multi-sector networks have institutionalized their work in ways that support the new networked style of working longer-term.** Creating new positions focused on population health and expanding the number of existing positions were cited as examples of institutional commitment to working within multi-sector population health networks. In addition, several interviewees noted that their organizations had established institutes, centers, etc. that are the hub for the organization's population health efforts. Institutes and the like were viewed as a signal of the commitment of the health care entity to the work, and a signal of a commitment to collaboration with other community organizations and sectors. Several interviewees noted that their optimism for the work continuing over the longer-term is based on the inclusion of network-related goals in the strategic plans of their organizations; as well as the fact that the work was being funded across multiple departmental budgets (e.g., not strictly Community Benefit dollars). This allows health care staff on these networks to demonstrate their value to a range of internal stakeholders. One set of interviewees went further to note that, were their organization to pull out of their network, there would be a clamor among community residents and organizations demanding that they maintain their commitment to the work.

This finding is supported by Focus on Success examples #2, #7, and #10.

TIPS FOR PRACTITIONERS

- **Find champions within multiple departments at a health care institution to serve as "early adopters" to infuse population health activities in addition to traditional community benefit dollars.**
- **Develop fundraising plans for distinct network efforts that are outside of the purview of any one partner agency in a multi-sector population health network.**
- **Make a clear connection to how achieving population health goals will increase the long-term health and wellness of communities. Support network members' ability to more effectively manage (and bring in additional) resources.**

[11] ReThink Health's study of 237 multi-sector partnerships for population health can be found here.

IV. Focus on Success Examples

Examples in this document are drawn from the work of 10 expert population health integrators who were interviewed as part of this brief.

FOCUS ON SUCCESS #1

Restoring the Village and Enhancing Community Wellness in Boston

Boston Medical Center (BMC) is a private, not-for-profit, 514-bed academic medical center that emphasizes community-based care, with a mission to provide health services to all in need regardless of ability to pay. BMC serves a wide range of patients, approximately 57% are from under-served populations in the Boston metro area.

Beyond its high-quality medical services, BMC engages in a range of programs to support the overall wellness of the community. One such effort is the multi-sector Vital Village Network. Vital Village fosters partnerships between residents and organizations to co-design community systems improvement efforts. A core element of the success of Vital Village is the intentional focus on community capacity building as a strategy for systems change—they prioritize community resident leadership and enhancing existing community assets and solutions, rather than bringing their own ideas for communities to rubber-stamp.

The Boston Medical Center example supports the following findings: C3

FOCUS ON SUCCESS #2

Community Health Center of Southeast Kansas' New Role for Population Health

The Community Health Center of Southeast Kansas (CHC/SEK) has been working for more than 15 years to marry its provision of primary care for patients with its mission as a federally-qualified health center to care for the overall health of the most underserved residents in its region. CHC/SEK has more recently carried out this work as part of the THRIVE effort that won a Robert Wood Johnson Foundation Culture of Health Prize for cross-sector population health work in Allen County.

CHC/SEK's cross-sector work led staff to identify the need for the creation of a new position that accumulates, processes and distributes the heavy volume of health and demographic data that it collects about residents in Allen County. What emerged, as part of its practice transformation effort, was the creation of a new role of "Population Health Manager." This position goes further than previous community based-roles, such as "Community Health Workers," by having in-house staff that analyze internally collected and publicly available data to help CHC/SEK strategize around how it can transform its practice to meet the emerging needs of residents.

The CHC/SEK example supports the following findings: A2, B1, B2, C3, C4, D1, and D3

FOCUS ON SUCCESS #3

Children's National Takes its Population Health "Show" on the Road

Children's National Hospital has an established history of working in partnerships, including the work it does as a founding partner in the multi-sector DC Health Matters Collaborative. The Collaborative is a coalition of eight local hospitals and community health centers that have joined forces to elevate health equity among DC communities. The majority of the work that Children's does in the multi-sector space is led by the Child Health Advocacy Institute (CHAI), the advocacy arm of the Children's National Hospital.

In 2018, CHAI received approval from the C-suite to ensure that 90% of Children's leaders (managers and above) were trained on the value that the hospital's multi-sector work has on the health and well-being of the community.
In order to reach its ambitious 90% goal, CHAI developed a "roadshow" to share across their hospital titled "Improving Child Health in the Community." This roadshow began with a presentation for leaders and moved on to hospital-wide sessions that provided critical awareness and support for Children's community health initiatives. The training is now available on-line for all of Children's new hires as part of their orientation to Children's National Hospital.

The Children's National example supports the following examples: A2, B1, B2, C3, C4, and D1

FOCUS ON SUCCESS #4

Kaiser Permanente of Northern California to Help Meet the Needs of Sonoma County Youth & Families

Kaiser Permanente is an integrated health system that serves millions of people across the United States. A key element of Kaiser's approach is to give leeway to its leaders in service areas around the country to generate innovative strategies that meet the particular needs of the regions they serve.

A closing of a local hospital a decade ago led leaders in Kaiser Permanente's Northern California service area to join multi-sector partners in the Health Action Sonoma County. As a key member of the Council's Committee for Health Care Improvement, Kaiser staff have worked with institutional partners and residents to establish tighter controls on tobacco sales so that retailers are less able to target local youth.

The Kaiser Permanente example supports the following findings: A2, B1, C3, and D1

FOCUS ON SUCCESS #5

Massachusetts General Helps Change the Narrative on Healthy Eating in Chelsea

The Mass General Healthy Chelsea Coalition is a multi-sector partnership that seeks to help enhance the wellness of families in Chelsea (MA) through promoting healthy eating, active living, substance use prevention, trauma mitigation, and early childhood education across the city. Two policy victories that will benefit all the city's youth and families include:

- Instituted a trans-fat ban in Chelsea. Mass General worked with the Chelsea Board of Health to research successful efforts to ban fatty prepared foods and established 0% trans-hydrogenated oil legislation on prepared foods in Chelsea in 2013; the first of its type in the country.
- Improved the quality of school food in Chelsea. Healthy Chelsea also coordinates an active group of high school students, called the Youth Food Movement, who advocate for healthier and more culturally diverse menu options based on feedback from their peers. These youth administer an annual school food survey to all students and present the results directly to the school food provider. The result was the removal of chocolate milk, juice, fried foods, and other unhealthy items on school lunch menus in the city, illustrating the importance of having the student voice be heard.

The Massachusetts General example supports the following findings: A2, C1, C3, and D1

FOCUS ON SUCCESS #6

Saint Joseph's Hospital and Medical Center- Dignity Health Moves Upstream by Adding On

Located in the heart of Phoenix, Dignity Health St. Joseph's Hospital and Medical Center (SJHMC) is a 593-bed, not-for-profit hospital that provides a wide range of health, social and support services with special advocacy for the poor and underserved.

Addressing social determinants of health (SDOH) is a critical step in lowering healthcare costs and improving health equity. In 2017, Saint Joseph's received funding from the Center for Medicare and Medicaid Innovation to launch the 2MATCH project (To Match through Community Hubs). The program is designed to screen Medicare and Medicaid beneficiaries seeking health services for unmet SDOH needs. Those individuals who are deemed high-risk, screen positively for five specific SDOHs, and provide consent are then connected with a 2MATCH Advocate who aids in addressing these needs. Leaders of the work say that 2MATCH was "built on top of the ACTIVATE program." ACTIVATE is a program that provides transitional care services for Medicaid and uninsured patients, provides transitional care services to patients with complex health and social factors, and provides assistance in navigating health and human services for individuals.

Saint Joseph's is taking a thoughtful, data-informed approach to expand the program to serve a greater portion of the community and to use upstream policy, environmental, and systems change strategies to address needs surfaced via data sources such as the gap analysis awardees are required to complete:

- The cooperative agreement funded work originally targeted 13 zip codes where need was more concentrated. In response to data showing that, though less concentrated, significant need exists in the remaining zip codes in Maricopa County. Saint Joseph's requested and recently received approval from the Center for Medicare and Medicaid Services to expand to an additional 22 zip codes.
- Expansion of work similar to 2MATCH will require a sufficient number of community health workers to fill positions. Saint Joseph's tapped into the connections and expertise of an advisory board member who is a champion of community health workers and who supported a recent policy change within the AZ state legislature to have the state health department create a process of self-certification for community health workers.

Dignity Health's example supports the following findings: B1

FOCUS ON SUCCESS #7

Sky Lakes Takes the Lead on Environmental Changes that Promote Health & Wellness in Klamath County

Sky Lakes Medical Center is a not-for-profit, community-owned, internationally accredited acute-care teaching hospital dedicated to meeting the holistic needs of residents in Klamath, Oregon.

Staff at Sky Lakes and Klamath County Public have worked together since 2012 as part of the Healthy Klamath coalition to develop a unified Community Needs Assessment and improve Klamath's consistently poor county health rankings. Part of what has emerged from the partnership is an understanding that many of the issues that compromise the county health are non-medical issues. Sky Lakes has used data from Healthy Klamath to include economic development and built environment changes into its strategic plan. Their strong example as an anchor institution has also contributed to more institutional partners focusing on economic development as a driver for the shared health outcomes the coalition is attempting to achieve.

The Sky Lakes Medical Center example supports the following findings: A2, B1, C1, C2, C3, C4, D1, and D3

FOCUS ON SUCCESS #8

Trenton Health Team Serves as a Hub for Population Health Improvement in Central New Jersey

Trenton Health Team (THT) is an innovative non-profit collaboration dedicated to the health and well-being of the greater Trenton community in New Jersey. THT health sector partners includes Trenton's two hospitals, its only Federally Qualified Health Center, and Trenton's Department of Health. THT acts as an integrator and catalyst, forging partnerships between health care and other sectors in the community.

THT's successful cross-sector work led to its being named as one of four Regional Health Hubs in the state of New Jersey. This designation has allowed the team to be able to aggregate and share data (through a local Health Information Exchange and analytics dashboards) on critical health issues for residents. This designation has also left the THT in position to secure funding to address upstream health issues as they arise. THT also took a lead role in having the integrator role institutionalized through the adoption of a new state statute formalizing the structure and funding model. Funding will still be determined in each annual appropriations bill.

The Trenton Health Team example supports the following findings: A2, B1, C1, C3, D1, and D2

FOCUS ON SUCCESS #9

University Hospitals and its Partners Assess the Bigger Picture of Health in Cleveland's University Circle

University Hospitals (UH) has spent the last 15 years asking what it can do to be a stronger anchor in Cleveland beyond the provision of high-quality primary and tertiary care. This led to UH being one of the first dozen or so health systems to create an Accountable Care Organization that brings multiple sectors together to attend to the greatest wellness needs of the population.

This early work has contributed to a greater understanding of the connection between transportation and health for Cleveland residents. In order to help close this gap, UH has expanded their work with other anchors and public agencies (as part of the larger Greater University Circle Initiative) to ensure that Cleveland's most disadvantaged residents have access to modes of transportation that provide them access to the places they work, live, and play.

The University Hospitals example supports the following findings: A2, C1, C3, C4, D1, and D2

FOCUS ON SUCCESS #10

University of Vermont Medical Center and its Partners Show that "Housing is Health Care"

The University of Vermont Medical Center (UVMMC) has been working with Champlain Housing Trust and other stakeholders in the Housing is Health Care initiative since 2013. This partnership has successfully repurposed local motels to serve as transitional housing for its patients who also receive wrap-around services and supports on site. The success of these efforts has also led the Medical Center to be a trusted partner in the push for a "zero homelessness strategy" that has up-scaled the model as part of a statewide effort.

A few key outcomes from the UVMMC's involvement in this population health partnership include:

- A roll out of a full screening for housing stability, mental health, and food security in its Emergency Room, and across its entire population of pediatric, family, and adult medicine.
- An increase in Social Work staff in the Medical Center's Emergency Room.
- Implementation of a unified care coordination strategy across its outpatient and inpatient settings.
- Participation in a shared process and platform for managing and prioritizing a waitlist of individuals needing housing.
- Involvement in a national collaborative through the American Hospital Association and a Hospital Community Collaborative with foci on housing.

The University of Vermont Medical Center example supports the following findings: A2, B2, C3, D1, and D3

V. RECOMMENDATIONS FOR APPLICATION

Responses from 40 interviews with academics, payers, and health care entities within established multi-sector partnerships have elevated a number of emerging lessons on how health care institutions join, catalyze, and sustain multi-sector population health networks. They are shared below, and will be pressure-tested within the 2020 Integrator Learning Lab.

A) **Focus on health equity.** Most population health networks call out health equity as a goal of their initiatives. What can be more complicated is developing a clear definition of the term; as well as devising strategies for prioritizing the voices of people with lived experience with non-medical issues that greatly compromise their health and well-being. Health care institutions can play a role as leaders and learners in the health equity space by first listening to the wants and needs of community residents in structured informal and formal conversations (town halls, focus groups, and design sessions). This listening process should start from a vision of community wellness that is not medicalized, since residents and community-based organizations are not likely to think in terms of social determinants of health or disease/conditions. Health care organizations in multi-sector population health networks would do well to utilize tools that also facilitate structured conversations around the potential unintended impacts of any upstream, systems-level strategies that the network is implementing. As the networks begin to implement plans, health care partners also have a role to play in helping to disaggregate the network's data to ensure that those most underserved by systems are enjoying the benefits of their interventions.

B) **Build a robust leadership table.** There is broad consensus among many leaders that it will take an entire community to address the non-medical ("social determinants") needs that contribute to negative outcomes for so many residents. However, there is no one playbook for how to take shared accountability for these efforts with partners. Multi-sector partners in population health networks must establish a leadership table that widely distributes accountability for achieving network goals. Configurations that have a range of sub-committees and broad representation (as opposed to a single "lead," "anchor," or "integrator" organization) can also create the buy-in necessary for members to stay committed to systems change work over the long-term. This can also create clarity about roles and responsibilities that will bring competitors and unfamiliar collaborators together on equal footing by allowing each group to do what they do best.

C) **Connect mission and merit.** Health care representatives seeking to make an internal case for their institutions to devote staff time and other resources to multi-sector population health networks may do well to develop two-pronged strategies to communicate the value of these networks to leadership based on mission and merit. On one hand, health care institutions of various types and sizes have missions that often speak to lofty population-level goals that cannot be achieved alone. As such, connecting the multi-sector population health network's population level goals to the health care organization's mission can help the C-suite understand the synergistic potential of such a collaboration. Abstract conversations around vision should be complemented by tangible benefits of a population-level health strategy that addresses social determinants of health at both the midstream and upstream levels while delivering high-quality health care. Rather than removing a potential funding stream (vis-à-vis fewer patients needing care and generating less fee-for-service revenue), an effective population health strategy (combined with payment reform that changes the incentives for health care providers) may help free up hospital resources, allowing health care organizations to continue to meet individual patients' acute medical needs.

D) **Change the narrative on the role of health care in communities.** The experts interviewed for this project conceded that health care has a vital role to play in catalyzing efforts throughout the life of a muli-sector population health network. However, success in this catalytic role requires trust among partners and those who are most impacted by the issues being addressed. To build trust, health care organizations need to create mechanisms (listening sessions, community forums, opportunities for co-design, etc.) to gather input from their own organizational leaders, community residents, and partners across sectors to understand the historical and current obligation that anchor institutions have to help ameliorate these conditions. Further, this process could illuminate the role these stakeholders feel is most appropriate for health care to play and to strategize around how to carry out this role as good stewards over the long-term. Building trust also includes checking in for opportunities for health care leadership to stretch to support broad systems-goals in networks that may not always be proximal to obvious heath care issues (e.g. changes to housing policy and public transportation systems). This work of being a good partner, and helping internal and external stakeholders to connect this role of partner to the effective stewardship of the resources within health care can help health care and partners change the narrative on what "health and wellness" means, while simultaneously changing the expectations of how health care can be one of many drivers pushing this new wellness agenda.

TIPS FOR PRACTITIONERS

- Ground multi-sector population health networks in equity, including the active leadership and participation of people in the communities most affected by the network's targeted issue(s).
- Be strategic and deliberate about when each organization will lead network strategies versus play a supporting role. Health care partners are natural leads for strategies that link back to health outcomes. Health care organizations are also well-positioned to leverage their anchor institution stature and influence to lead the network's advocacy efforts as well as the policy, systems, and environmental change strategies of the network.
- Involve residents with lived experiences in co-design and implementation of initiatives, for example, setting up the goals for the network.

E) **Embed networked approaches throughout the health care organization for sustainability.** Several of the experts interviewed for this project cautioned against shoe-horning all of a health care organization's population health activity into a single department budget (such as community benefit). Staff that are interested in institutionalizing a more networked and integrated approach to community health would do well to assess their organization's current strategic plan to better understand which departments and institutes within a health system may be most appropriate to house elements of this work. This assessment should serve as a precursor to conversations with their leadership team early in the budgeting process around how to reallocate dollars so that population health activities are the province of multiple departments with clear roles, responsibilities and accountability. Embedding these activities across multiple departments can help make the work more real, more integrated, and more shared with multiple champions understanding how it positively impacts the work and the shared goals.

VI. NEXT STEPS

Nemours launched its 2020 Integrator Learning Lab in January 2020, providing technical assistance to nine networks around the country seeking to strengthen their use of integrative roles and functions within networks and increase strategic partnerships with health care partners. Following the close of the 2020 Integrator Learning Lab, lessons, resources, and recommendations will be shared with the field as a follow up to this brief.

VII. APPENDIX: ORGANIZATIONS INTERVIEWED

This issue brief represents synthesized input from 40 formal interviews with representatives of 30 organizations ( ). Interviewees were a mixture of academics, payers, health care organizations with expertise in serving as a population health integrator, and other experts. Representatives from an additional 3 organizations ( )provided informal but valuable insights. Nemours is grateful to those who generously gave their time to share wisdom, expertise, and insights to inform the field through this project. Examples in this document are drawn from the work of 10 expert population health integrators ( ).

100 Million Healthier Lives (an initiative of the Institute for Healthcare Improvement)
Aetna
California Accountable Communities for Health (CACHI)
Capital Health, as a core partner of the Trenton Health Team
Center for Community Investments
Center for Health and Research Transformation
Center for Health Care Strategies
Centers for Medicare & Medicaid Services (CMS)
Children's Hospital Association
Children's National Hospital
Community Health Center of Southeast Kansas
Data Across Sectors for Health (an initiative of the Illinois Public Health Institute and Michigan Public Health Institute)
Dignity Health- St. Joseph's Hospital & Medical Center
Federal Reserve Bank of San Francisco
Kaiser Permanente of Northern California
Massachusetts General Hospital
National Association of Community Health Centers
Network for Regional Healthcare
Public Health Institute
ReThink Health
Robert Wood Johnson Foundation
Sky Lakes Medical Center
Social Interventions Research & Evaluation Network (SIREN)
Stewards of Change
The BUILD Health Challenge
The Kresge Foundation
Trenton Health Team
Trust for America's Health
University Hospitals
University of Vermont Medical Center
Visible Networks Labs; University of Colorado Denver
Vital Village (an initiative of Boston Medical Center)
Wilder Research Group

THE KRESGE FOUNDATION

The work described in this document was funded through generous support from The Kresge Foundation.

Suggested Citation:

Nemours Children's Health System, Nemours National Office of Policy & Prevention. White Paper: Preliminary Findings on the Role of Health Care in Multi-Sector Networks for Population Health: Notes from the Field. www.movinghealthcareupstream.org Published March, 2020. Accessed: (insert date).

Nemours

Nemours National Office of Policy & Prevention
1201 15th Street NW, Ste. 520, Washington, DC 20005 | 202.457.1440 | 202.649.4418 | www.nemours.org

For more information, questions or comments please contact us at MHCU@nemours.org