ACMHA The College for Behavioral Health Leadership
CULTIVATING LEADERS
FOSTERING INNOVATION

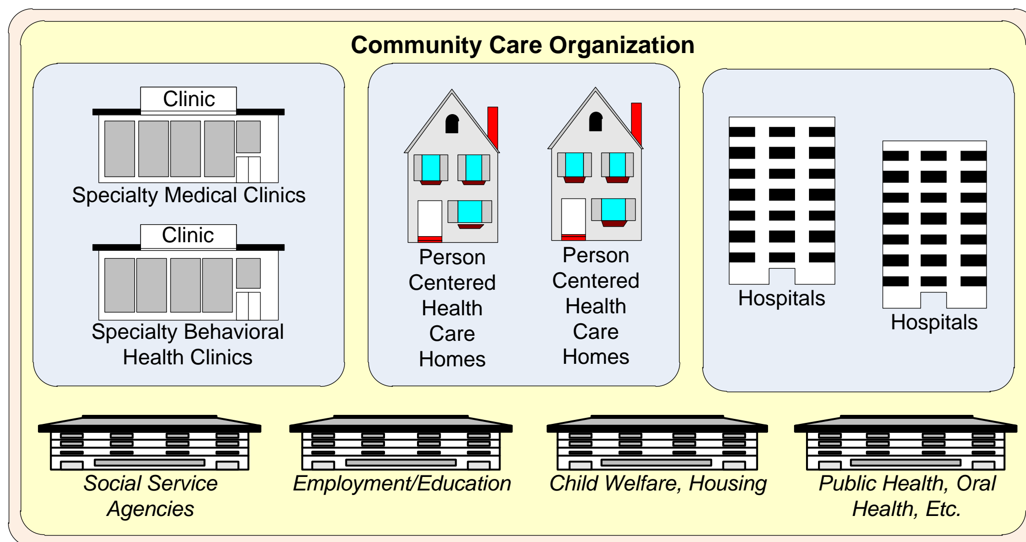
2011 Summit Innovations Worksheet

Title of Innovation
Community Care Organization

Brief Description
A Community Care Organization (CCO) builds on the emerging Accountable Care Organization (ACO) work being piloted by the Dartmouth-Brookings ACO Learning Network, the Premier Healthcare Alliance, and other pioneers in the field.
A Community Care Organization is an ACO that is designed to focus on the needs of the safety net population in a community, with a special emphasis on addressing the social determinants of health such as poverty, unemployment, homelessness, poor housing, neighborhood violence, etc. Designed by a broad cross-section of community residents and community partners, the core of the CCO is made up of existing community service agencies including:

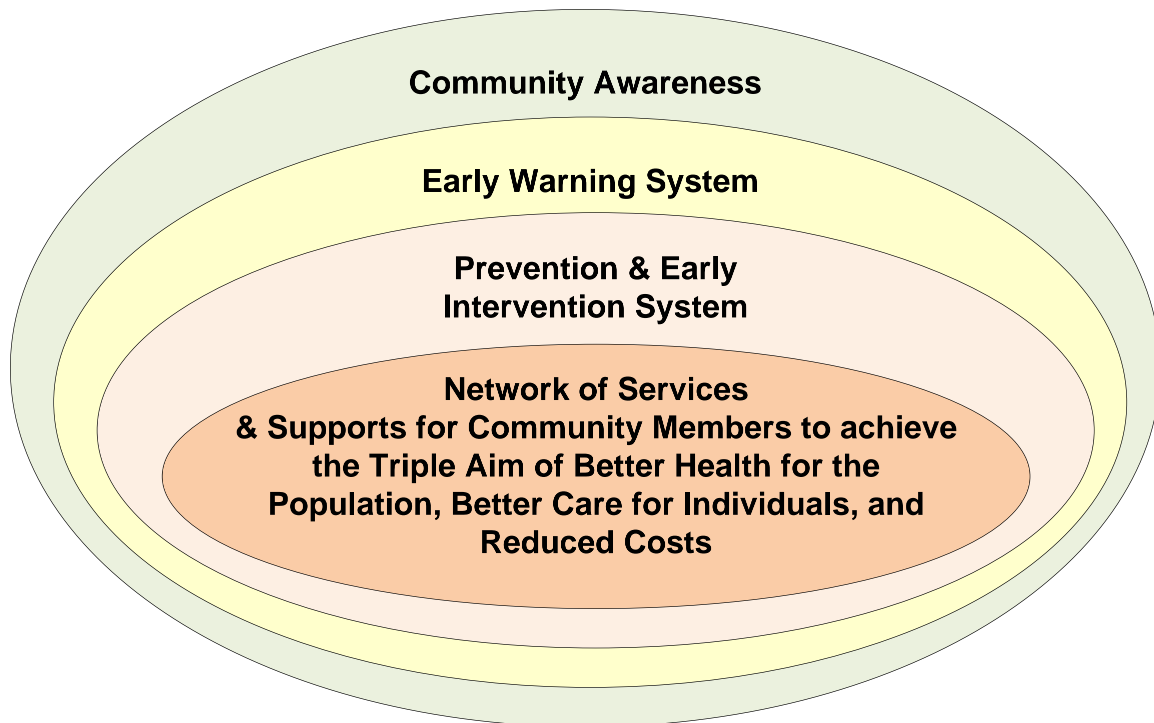
- Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs)
- Community Mental Health and Substance Use Disorder Treatment Providers
- Public Health Departments and Hospitals
- Social Service Agencies
- Child Welfare Providers and Family Resource Centers
- Housing and Homeless Services Providers
- Oral Health Providers
- Pre-Schools and Schools
- Job Training and Employment Support Organizations

The diagram below illustrates the participants in a CCO.



The purpose of the CCO is to organize a Healthcare Neighborhood that will help all community members move toward the Triple Aim of better health for the population, better care for individuals and reduced costs. A core objective of the CCO is to develop a network of integrated hospital and institution prevention organizations, helping prevent admission and readmission to acute care and psychiatric hospitals; nursing homes; youth residential treatment facilities; jails prisons, and juvenile justice facilities; and other restrictive, high cost, non-community based institutions.

Health, wellness and recovery are at the center of the CCO and major changes will be needed to update the existing service delivery paradigm. The following diagram illustrates what the new paradigm.



Major design efforts will be needed to implement the CCO including:

- ✓ **Community Awareness Plan:** A plan to inform the community about the impact of the social determinants of health, resources that can counter these effects
- ✓ Early Warning System: A set of tools and technologies to help identify at-risk and vulnerable neighbors and friends an how to help them obtain needed, culturally competent services
- ✓ **No Wrong Door:** Bring services to the community through a many door, no wrong door model that includes community teams, storefront wellness centers, school-based services, and other alternative care delivery models
- ✓ **Clinical Integration:** Clinical integration of primary care, behavioral health, medical specialties, and other services and supports
- ✓ **System of Care:** Widely deploy and embed system of care values and principles that have been developed and refined by Georgetown University and other leaders in the field
- ✓ **Recovery:** Build on the philosophy and practices in the National Empowerment Center's cycle of recovery, cycle of healing, spiral of development and wellbeing

- ✓ **Workforce Development:** Broaden the workforce through retraining of existing professionals and widespread use of peers, navigators, health coaches and other types of paraprofessionals
- ✓ **Best Practices:** Use of best-practice clinical and service delivery workflows and practices throughout the CCO
- ✓ **Value-Based Purchasing:** Value-based purchasing models for paying service providers based on value, not volume
- ✓ **Value-Based Benefit Design:** Value-based benefit design models for creating incentives for community members to actively participate in moving toward health, wellness and recovery
- ✓ **Health Information:** Development of a Community Health Information Network (CHIN) that is organized around a Personal Health Record (PHR) controlled by the individual that allows information to be available to providers into the CCO, based on permission given by the individual
- ✓ **Performance Measurement:** The CCO will implement a performance measurement system, drawing from three sources: the National Quality Forum for clinical measures; broader public health rankings from the Commonwealth Fund and the University of Wisconsin's Population Health Institute; and recovery-oriented systems measures from leaders in the recovery movement.

The CCO will be a Learning Organization that has a deep understanding of the human side of change, both for those working in the CCO and those served by the CCO. The CCO will necessarily change over time as new approaches are identified and implemented that support movement toward the Triple Aim. One measure of success will be the measurable creation of the cycle of resilience and recovery in communities, illustrated by the following diagram developed by Comas, a Scottish community development organization working to promote recovery and resilience amongst individuals and communities.

Target Population and Funding
The Community Care Organization will be designed and implemented in four phases. The target population will begin with three to five safety net communities in the U.S. and spread as the model is refined.
Design: A Design Team will be created that represents a cross-section of those with expertise in each aspect of creating a Healthcare Neighborhood for a safety net population. The Design Team will be sponsored by an organization such as the Georgetown University Center for Child and Human Development. The Design Team will create linkages with the Dartmouth-Brookings ACO Learning Network, the Premier Healthcare Alliance, the Institute for Healthcare Improvement, and the Center for Medicare and Medicaid Innovation (The Innovation Center).
Funding: The Design Team will apply for grants from The Innovation Center as well as health foundations focusing on safety net populations. The funding will support the design process, the Implementation Team, three to five pilots throughout the country, and a rapid cycle evaluation process. Ongoing funding of CCOs will be through current funders of health and social services and support such as Medicaid health plans, health plans operating through the Exchanges, and public and private funders of services that will be provided through the CCOs.
Pilots: The Design Team will hire an Implementation Team that will develop an application process to identify three to five pilots throughout the country. The applications will be solicited from communities that are already developing CCO-like entities. Each application will require co-sponsorship by the part of the state's executive branch that is working on healthcare reform implementation. Part of the scoring will be based on the perceived willingness and ability of the state to spread all or parts of the model that prove successful.
Spread: The Design Team will also hire a Rapid Cycle Evaluation Team that works closely with each pilot CCO, completing rapid cycle evaluations to identify and disseminate findings in order to support the spread of designs and lessons learned throughout the country. We expect that, because a great deal of state budgets are allocated to the populations served by CCOs, CCO successes will provide important strategies to states that are dealing with long-term structural fiscal problems.

First Steps to Take?
Participants from the Child & Family and Peers Innovations Workgroups will begin a dialog to merge their two innovation ideas and organize a Design Team that will focus on the needs of vulnerable and at-risk children, youth, families, single adults and elders. This group will convene their first meeting within the next 90 days and begin work on the project.
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