Yamhill COMMUNITY CARE

Community Prevention & Wellness (CPW) Fund

2023-2026 Strategic Plan

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Yamhill Community Care (McMinnville, Oregon)

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Jordan Robinson (Chair) - District Director, Lutheran Community Services
Jeff White (Vice Chair) - Co-Chair, Community Advisory Council
Gil Munoz (Secretary/Treasurer) - CEO, Virginia Garcia Memorial Health Center
Suey Linzmeier (ELC Co-Chair) - Executive Director, Head Start of Yamhill County
Alexis Avery - Co-Chair, Community Advisory Council
Dennis Gray - Administrator, Physicians Medical Center
Paul Kushner - Community Member-at-Large
Lindsey Manfrin, DNP, RN - Director, Yamhill County Health and Human Services
Michael Mulkey - CEO, Willamette Valley Medical Center
Raji Mathew Samuel, DDS - Smile Keepers/Capitol Dental
Commissioner Mary Starrett - Yamhill County Board of Commissioners
Vickie Ybarguen - Executive Director, Housing Authority of Yamhill County
Joe Yoder - CEO, Providence Newberg Medical Center

1.2 // Acknowledgement of the 2023 CPW Fund Committee Members

Lindsey Manfrin, DNP, RN (Chair) – Director, Yamhill County Health and Human Services
Jordan Robinson (Vice Chair) – District Director, Lutheran Community Services
Shannon Buckmaster – YCCO Wellness Fund Development Director
DeAnn Carr – YCCO Behavioral Health & Integration Director
Emily Johnson – YCCO Community Health Supervisor
Russell Mark – President & CEO/Executive Director, Juliette's House
Dr. Seamus McCarthy – YCCO President & CEO
Bill Michielsen – Public Health Division Manager, Yamhill County Health and Human Services
Jenn Richter – YCCO Early Learning Director
Larry Soderberg – YCCO Chief Financial Officer
Raji Mathew Samuel, DDS – Smile Keepers/Capitol Dental
Olivia Williams - CPW Coordinator, Yamhill County HHS
Carrie Zimbrick - Willamina School District

The CPW Committee additionally recognizes Silas Halloran-Steiner (Past Chair and Yamhill CCO CPW Fund Consultant 2021-2022) for his work as author to the 2021 CPW Fund Sustainability Plan, which informed the 2023-2026 CPW Strategic Plan.

1.3 // Narrative Summary

Yamhill Community Care (YCCO) and its unique Community Prevention & Wellness (CPW) Fund are poised to make significant progress in enacting evidence-based primary prevention strategies to improve the long-term health and wellness outcomes for local communities, with the possibility to set a precedent nationally for innovative strategies around social determinants of health and equity (SDOHE).

In the past decade since the adoption of the State of Oregon's Coordinated Care Organization (CCO) model for providing Medicaid services through the Section 1115 Federal Waiver with the Social Security

Act and expansion of the Affordable Care Act (ACA), the YCCO team and Board have increasingly faced challenges of a monumental scale; governmental public health has been stretched like never before; healthcare providers have stepped up and deployed additional resources; community based organizations have answered the call to serve despite numerous obstacles; educators have learned new technology to keep students learning as best they can in a non-traditional setting; and community members have volunteered time to protect the most vulnerable.

Due to the global COVID-19 pandemic, health inequities have been highlighted and leaders are reimagining infrastructure to prioritize systems like mental and behavioral health support, childcare, affordable and accessible housing, sustainable intergenerational wealth-building, and equitable support of marginalized populations. President Trump and President Biden have successively authorized federal relief packages, including the 2020 Coronavirus Aid, Relief, and Economic Security (CARES) Act (2020) and the 2022 American Rescue Plan Act (ARPA) funds, allowing additional investments in these social and public health systems.

The adoption of the 2023-2026 CPW Fund Strategic Plan signifies the commitment of the YCCO Board of Directors to explore and invest in sustainable expansions of primary prevention efforts through the CPW Fund, contributing to effective, innovative solutions to public health and community challenges. The Oregon Health Authority (OHA) has never been more focused on using the coordinated care organization (CCO) model to drive investments in social determinants of health and equity as it is right now. CCO 3.0, the next phase of CCO contracting, will require communities to address health inequities and social determinants with enhanced strategies.

Evidence-based population health and primary prevention is at the core of why the Board formed the CPW in 2015. The Board established a model, based on prevention science, for the CPW Fund that would improve long term health in the region, serving a base population of members located in Yamhill, Washington, and Polk Counties. Currently, the CPW projected fund balance is $4.7 million dollars at the end of fiscal year 2023. With strategic planning support from Dr. Karen Minyard and Dr. Chris Parker from the Georgia Health Policy Center (GHPC) at Georgia State University through their Robert Wood Johnson Foundation partnership, YCCO partners identified emerging opportunities to leverage additional sources of funding for the CPW which are consistently aligned with proven national strategies. The CPW Fund is well-positioned to sustainably grow through increasing diversified funds, expanding the programming scope, and setting a national precedent for holistic primary prevention strategies.

The CPW Fund Strategic Plan will help prepare YCCO for the upcoming Oregon Health Authority CCO 3.0 RFP, expected within two years of this plan's adoption, and includes the possibility of introducing new CCO investments opportunities, such as housing support, workforce development, and entrepreneurial support through micro loans, as determined prudent by the CPW Fund Committee.

2.0 // CPW History

Yamhill Community Care Organization (YCCO) formed in the summer of 2012 after a series of community meetings. The stakeholders decided to create a local 501(c)3 organization to respond to the emerging opportunity in Oregon to coordinate publicly-funded healthcare more effectively at the local level. The newly formed YCCO Board immediately adopted the following ten guiding principles:

Health Education; Accountability; Innovation; Evidence-Based Clinical Care; Transparency; Shared Responsibility; Member Empowerment; Wellness Promotion; Equity; and Stewardship.

2.1 // Board Stewardship and Allocation of Funds (Incorporation to 2015)

The official YCCO responsibility to improve member's health and steward public funds began on November 1, 2012. After two successful operating years in calendar years 2013 and 2014, the Board was in a good financial position due to moderately high payments on the Affordable Care Act (ACA) expansion population and lower initial rates of utilization of care. This led to a series of policy considerations and decisions that were related to the long-term stewardship of YCCO funds and informed by the Board's guiding principles.

One Board policy approach was to utilize a formula for Risk Based Capital assessment and potential community reinvestment. Some reinvestment strategies were already in place such as an enhanced Patient Centered Primary Care Home (PCPCH) payment, a handful of transformation grants, and other Oregon Health Authority approved payments such as the Pay-for-Performance (P4P) funds. The Board understood the need to improve payments for primary care and target investments in clinic level transformation, and the Board was also deepening its understanding of the root causes of poor health.

The research pointed to the value in making investments into upstream prevention and the social determinants of health and equity (SDOH-E) as a wise way for community health plans to improve the health of its members and also ensure cost containment. In early 2015, a few Board members reached out to a prevention scientist named Tony Biglan, PhD. Dr. Biglan agreed to come and present to the Board on some possible areas to make long term evidence-based population health investments. After discussion over several meetings, the Board was unanimous in its support to form a Community Prevention and Wellness Committee. YCCO made an initial allocation of one and a half million dollars out of 2014 earnings as seed capital.

Several Board members agreed to join the CPW Committee, including Jordan Robinson; Dan Dale, MD; Raji Mathews, DDS; and Suey Linzmeier and it was chaired by then Yamhill County Health and Human Services Director Silas Halloran-Steiner. The CPW Committee began its work by establishing a charter which has largely remained the same since inception (see Appendix A). Operationally, YCCO contracted staff support from Yamhill County Public Health and also asked YCCO Staff Member Emily Johnson to keep alignment across various YCCO committees. All funds were tracked internally at YCCO which meant that accounting and grant dispersal was done via a managed services agreement (MSA) with CareOregon.

2.2 // Early Implementation (2016-2018)

The CPW Committee expanded its membership and established a working core group of committee members in 2016 and, after an inventory of current local prevention programs, the CPW began its first round of community investments with a focus on the nexus between health and education. The goal was to establish several pilot sites for an evidence-based prevention approach called the Good Behavior Game. Data collection and analysis was a central component of the initial investment strategy.

Several CPW members were added in 2016-2017, including Carrie Zimbrick, Russell Mark, Denise Bacon, Shannon Buckmaster, Melissa Ivey, and Tanya Tompkins. Lindsey Manfrin assumed the role of CPW chair in 2017. The CPW members focused on infrastructure development; one of the primary goals was to have a clearly defined grant solicitation process with consistent evaluation criteria. Several new elementary schools implemented the Good Behavior Game in 2017. Another evidence-based middle school prevention program was added in 2017 called Positive Family Supports. The Board's initial financial allocation lasted until the end of 2018 with a carryover balance of $95,985 at the beginning of fiscal year 2019.

With support from Georgia Health Policy Center, this time period also included a healthy discussion between CPW members about the structure of the CPW Fund and whether it would make any recommendations to the Board about forming an independent 501(c)3 corporation to manage the Fund. As a result of this process, CPW members developed a cohesive identity and a strengthened sense of purpose and decided against any spin off recommendations; the strength of ongoing affiliation and oversight from YCCO outweighed any perceived benefit, as seen by foundations and outside funders, by forming a new entity. The CPW members also solidified their desire to avoid the CPW Fund disrupting or competing with existing local non-profit grant opportunities which is sometimes a challenge when working with local and regional foundations.

2.3 // Fund Diversification and Targeted Impact (2019 – 2021)

As YCCO continued to expand community involvement and health impact, the YCCO and Yamhill County Public Health Community Health Assessments (CHA) and Community Health Improvement Plans (CHIP) drove strategic work. The CPW Committee made more connections between CHIP priority areas and grant funding decisions, and added a requirement in all requests for proposals (RFP) that included tying grant requests to at least one CHIP objective. RFPs also include a preference for programs impacting populations that are historically or systemically underserved or those experiencing health disparities. New investments included broader reach within McMinnville and Willamina School Districts, as well as targeted work to increase community impact with FamilyCore.

This period of time in CPW history also marked a significant shift in CPW Fund sources, starting in 2019. It was the first year where funds were contributed by a few key partner organizations. This was largely done through contract negotiations led by Dr. Seamus McCarthy with a few Board members and the Executive Committee of the Board providing advice. The central approach was to add an account reconciliation at year end based upon the total paid premium changes with the larger risk accepting entity (RAE) contracts. For instance, this calculation was 1% of the total payment made in 2019 for the primary Health and Human Services (HHS) and Capitol Dental Care contracts, and was increased to 2% in 2020 and 2021 for HHS. Yamhill County also made a one time investment of clean tax funds following the dispersal of funds related to statewide marijuana taxes that have since been repurposed and no longer come to the county for prevention efforts. PHTech and Providence made contributions through

the primary MSA. Willamette Valley Medical Center agreed to make a contribution in 2019 as part of the provider contract received in 2020.

The transition of the MSA led to accounting changes and improvements. Once Lane Roemmick and Larry Soderberg joined the organization, additional attention to internal accounting practices led to CPW Fund tracking improvements. The YCCO fiscal team is currently tracking and reporting all CPW Fund activities that are allowable under Health Related Services (HRS) Community Benefit Initiative (CBI) investments definitions per the Oregon Health Authority (OHA) contract. From a sustainability standpoint, this is key because these investments will now be included in the rate setting process used by OHA. Some of these changes are due to evolving guidelines from OHA and others are a result of YCCO making the transition away from CareOregon's contract when the Board made a commitment to hire a local fiscal team.

The pandemic has not delayed the strategic funding priorities of the CPW and several grant awards were recommended for Board approval between 2020 and 2022. On the national level, GHPC continues to support several standout organizations who are building successful wellness funds, including YCCO. Emily Johnson has continued to provide ongoing support to the CPW Committee even as her role and responsibility have grown in scope through well-deserved promotions at YCCO. Olivia Williams is the contracted CPW Coordinator and shares a passion for the vision of the CPW and community health improvement.

2.4 // CPW Sustainability Plan Implementation and 2023-2026 Strategic Planning (2022-2023)

In 2021, the YCCO Board approved the CPW Fund Sustainability Plan, which included funding and hiring a Wellness Fund Development Director, elevating CPW Fund work to the status of an independent department within YCCO, and sharing overlapping resources internally from YCCO health services, behavioral and mental health services, finance, and administration departments. The initial priorities for the Wellness Fund Development Director were to successfully onboard with YCCO, building rapport with volunteers and community members while internalizing the culture of YCCO; coordinate a strategic planning event with GHPC; and to draft a 2023-2026 CPW Fund Strategic Plan for YCCO Board adoption.

The YCCO Team welcomed Dr. Karen Minyard and Dr. Chris Parker from GHPC to the YCCO Oregon offices in October 2022 for 2 days of strategic planning that included listening and feedback sessions with YCCO Leadership Staff, YCCO Board of Directors, and the CPW Committee, with the objective to renew and deepen the Board's commitment to investments in primary prevention and impacting SDOH-E through the CPW Fund. Through the exposure to the Georgia Health Policy leadership team, and their skillful facilitation in smaller groups, YCCO explored new topics together with the CPW Fund committee and Board members such as lending for SDOH-E impact; external Fund partner goals and how they fit into the proforma; current and future grant options; and staffing needs. The topics were targeted for their impact on the Strategic Plan and Budget.In July 2022, Shannon Buckmaster was hired as the first Wellness Fund Development Director.

During the facilitated strategic planning sessions, partners identified programs to continue and prioritize for future investment opportunities, as well as identified SDOH-E and primary prevention-focused strategies or programs to investigate and consider adding to existing CPW investments. During a "Money Whispering" workshop, Dr. Minyard also helped the CPW team identify opportunities for diversifying and expanding external investments into the CPW Fund.

CPW programs that were prioritized for retention reflect the historical success of CPW Fund-supported investments. The Wellness Fund has invested more than $2.2 million into its schools and communities. At least 6,023 students have been impacted by CPW prevention programs, reaching 100% of Yamhill County School Districts. Behavioral referrals were reduced by 75% in Yamhill-Carlton School District after GBG implementation. More than 95% of Willamina School District students had good attendance during COVID-19 adjustments. The Responder Life program has trained 5 first responder agencies. The most conservative estimate for the 5-year Return on Investment (ROI) for the PAX Good Behavior Game is more than $10 million at an estimated cost of $85/child.

In the next stages of CPW Fund work, this Strategic Plan identifies the YCCO Board-approved process and calendar for CPW Fund expansions, including budget and programming projections and goals.

3.0 // Financial Details & Summary

The fiscal information below reflects the current state CPW Fund balance sheet, and it also outlines obligated grant funds anticipated in 2023.

3.1 // 2019-2023 CPW Fund Income (Projected)

Contributions Received						
	2019	2020	2021	2022	2023	Total
Fund Balance at YE2018	95,985	-	-	-	-	95,985
YCCO-P4P Funds	313,886	698,087	854,633		-	1,866,606
YCCO-PMPM Allocation	-	-	-	690,769	-	690,769
YCHHS -PY Contract Contributions	317,332	767,253	592,784		-	1,677,369
YCHHS - Marijuana Prevention	261,000	-	-	-	-	261,000
WVMC - Contribution	-	125,000	-	-	-	125,000
Capitol Dental - PY Contract Contributions	75,879	88,834	90,092			254,805
Georgia Health Policy Center	56,125	7,500	-		-	63,625
TOTAL REVENUE RECEIVED	1,120,207	1,686,674	1,537,510	690,769	-	5,035,160
Amounts Due/Budgeted/Deferred						
	2019	2020	2021	2022	2023	Total
YCCO-P4P Funds	-	-	-	852,846	633,431	1,486,277
YCCO-PMPM Allocation	-	-	-	52,970	619,500	672,470
YCHHS -PY Contract Contributions	-	-	-	633,316	618,415	1,251,731
Capitol Dental - PY Contract Contributions	-	-	-	148,749	169,061	317,810
PH Tech/PPP - Contract Rate Savings	51,936	71,729	86,881	82,349	-	292,895
TOTAL REVENUE DUE	51,936	71,729	86,881	1,770,230	2,040,407	4,021,183
Total Received and Due	1,172,143	1,758,403	1,624,391	2,460,999	2,040,407	9,056,343

3.2 // 2019-2023 CPW Fund Expenses (Projected)

Grant Payments in Accounting Records

Payee	2019	2020	2021	2022	2023	Total
McMinnville SD 40 - RULER, Triple P, Etc.	-	128,444	171,258	-	-	299,702
Willamina SD - RULER, Triple P, Etc.	-	250,000	62,500	208,333	-	520,833
Madison Ave. Collective - FamilyCORE	-	8,415	76,500	-	-	84,915
PAX Good Behavior Games	34,847.83	9,356	-	31,619	-	75,823
ORBIS GBG Evaluation Costs	8,521.47	684	-	-	-	9,206
YCHHS Contracted Support and Evaluation	124,362.48	127,471	130,020	130,020	-	511,873
Georgia Health Related Costs	56,125.00	7,500	-	-	-	63,625
Peer Navigator - LCSNW	-	-	46,140	46,140	-	92,280
Family Well Being Council	-	-	29,557	4,926	-	34,483
Universal Home Visiting	-	-	-	298,532	-	298,532
Peer Support - Responder Life	-	-	18,752	-	-	18,752
CPW Admin Support	-	-	-	177,261	-	177,261
TOTAL SPENT	223,857	531,870	534,727	896,831	-	2,187,285
Projected Fund Balance	948,286	1,226,533	1,089,664	1,564,167	2,040,407	6,869,058

CPW Related Projects Budgeted But Not Expensed

Payee	2019	2020	2021	2022	2023	Total
PAX Good Behavior Games	-	-	-	2,680	35,000	37,680
Willamina SD	-	-	-	20,833	250,000	270,833

McMinnville SD	-	-	-	-	256,887	256,887
Responder Life	-	-	-	7,000	14,778	21,778
YCHHS Home Visiting	-	-	-	-	298,531	298,531
YCHHS Contracted Support and Evaluation	-	-	-	-	133,921	133,921
Other Investments TBD	-	-	-	-	543,282	543,282
CPW Admin Support	-	-	-	25,000	508,008	533,008
TOTAL SPENT	-	-	-	55,513	2,040,407	2,095,920
Projected Fund Balance	948,286	1,226,533	1,089,664	1,508,654	-	4,773,137

3.3 // 2022/2023 Budget Summary and Financial Goals

	2022	2023	
Projected Income:	$2,460,999	$2,040,407	
Projected Expenses:	$1,508,654	$2,040,407	
2023 Projected Fund Balance:			$4,773,137

2023-2026 Goals for New External Revenue, reflecting 1-3 new funding partners each year. New revenue will prioritize cash asset investments (restricted or unrestricted), but may include in-kind contributions and external and/or internal matching funds.

2023: $250,000

2024: $500,000

2025: $500,000

2026: $800,000

3.4 // Sources of Funding to Explore and Potentially Pursue

Financial contributors to the CPW Fund in 2023 include YCCO Pay For Performance (P4P) funds at an average of 10% of total funds awarded. The percentage allocation is subject to annual Board approval and the total allocation is subject to annual CCO performance metrics and the resulting (if any) award. Per Member Per Month (PMPM) from the YCCO global budget began in 2022 at a rate of $1.50 PMPM, and is also subject to annual Board approval. The total allocation is a variant on actual CCO membership. There is also a continued year-end reinvestment of contract portions from Yamhill County Health and Human Services and Capitol Dental Care (CDC) premium reinvestments, the percentage of which is

subject to change upon annual contract negotiations and system drivers. The total of the reinvestment varies in response to total membership and premiums paid under each contract. PHTech/Providence Plan Partners (PPP) investments are made from a percentage of perceived contract savings for partners and contract terms are variable, negotiated annually. Yamhill County Marijuana Tax Funds were a limited duration commitment, but illustrate the benefits of short-term financial opportunities. Ad-hoc opportunities, including grant funds and other provider commitments have been leveraged, when available.

In order to maximize community health impact and plan for sustainability, the CPW Fund will explore additional funding sources beyond the YCCO allocated and existing partner funds. As a reminder, there are several areas of YCCO mission that focus on community impact outside of the traditional concept of health plan membership. Population health approaches show up in the YCCO Community Health Improvement Plan (CHIP), the Early Learning Hub work where YCCO supports families throughout the region, and in many of the clinical innovations where healthcare providers are implementing system changes to improve patient health regardless of payor type. All reasonable effort will be made to avoid competing for funds with partners and programs that would be eligible for funding by the CPW Fund.

If we look beyond the current sources of YCCO funds , then the following sources will be considered:

Public funds. These are often in the form of competitive and non-competitive grants for programs. These funds may be available at the local, state, and federal levels. Most public funds are categorical in that they are contractually defined for a special purpose or population. Some public funds, however, such as local county tax dollars are not restricted. These funds may include unallocated ARPA funds from the State of Oregon and State economic development funds available for housing, behavioral and mental health support, workforce development, and grants to subsidize CPW entrepreneurial wealth-building loans, including the possibility of microloans. Workforce development can include both the recruitment and training of other industry or underemployed individuals, as well as supporting YCCO members to enter healthcare-specific careers to provide upward socioeconomic ability, all in alignment with positive responses to SDOH-E.

Typically, these State-issued funds are in the form of governmental grants (or sometimes relief of tax burden or fees) to encourage business development and job opportunities within a community. Sometimes investors will target a special area of a municipality or county for development or a special demographic of people who might benefit from small business loans or grants.

Private funds. These are made by corporations and private foundations that are mostly non-profits who are interested in a specific area of community benefit, but may include private for-profit organizations and companies who recognize that a well-supported workforce is a prudent investment for attraction and retention of workers. With the heightened socioeconomic disparities of the COVID-19 pandemic, more employers are focusing on mental health, childcare, and retention.

YCCO provider delivery system funds. These funds may come directly from the healthcare delivery system partners who provide oral, behavioral or physical health services and they may also come from administrative plan partners.

Hospital community benefit funds. Non-profit hospitals are required to invest in community benefit annually; for-profit hospitals can also choose to make community investments.

Pooling of funds for collective impact. If public or private partners have resources to impact health or wellbeing and share a common mission or objective then two or more entities can align their resources to add resources and enhance the outcome or impact. This can happen without pooling the funds in a central account or it can happen when one organization acts as the fiscal agent for a multi-stakeholder project.

Matching funds for specific grants. Matching funds is often considered a way to leverage resources and may include a variety of ratios. Often non-profit fundraising is done with an appeal to donors for dollar-for-dollar matching funds. Federal grants sometimes require a cash match of 25% in order to draw down the remaining 75% of the funding. Requests for proposals (RFPs) done via YCCO could also require providers and partners to match the grant funds in order to receive the award; this could include a cash match or in-kind resources.

Partner contributions such as schools, education service districts, and education foundations. Similar to the ways in which YCCO is already leveraging healthcare partner and provider contributions, the YCCO's ability to fund health and education projects could bring another education funder to the table. One concrete example is the Student Success Act funds.

Research Institutions and university investments. One of the significant goals of the CPW Fund is to build stronger support for evidence-based prevention strategies with external and internal data. Through in-kind, matching, or independent grant opportunities, we'll explore partnerships with universities, particularly those with programs that focus on SDOH-E, primary prevention, or healthcare workforce development. Similarly, we'll develop relationships with research institutions like the Oregon Research Institute (ORI), the National Institute of Health (NIH), CDC, and a continued partnership with GHPC at Georgia State University.

Specific topics to explore before recommendations will be made to the CPW Committee regarding grants and loans include:

- Prioritizing existing and new multi-year investments for current CPW-grant-funded programs. The Committee will consider 3/5/10 year investment plans beginning for contracts issued in 2024.
- Utilizing updated CHIP/CHA plans to evaluate new projects.
- Staying in alignment with the Early Learning Hub and YCCO Strategic Plans, particularly around Health Related Services (HRS).
- Any loan programs will thoroughly investigate risk-management and underwriting options to mitigate risks, recognizing that loans require significant capital on-hand. The CPW Committee will review the strengths of potential partnerships with financial institutions to asses incorporating Community Development Investments (CDIs) and with foundations or private investors to fully reimburse or subsidize interest rates for low- or no-interest rates, which could also be a source of sustainable income for the CPW Fund.
- CCO 3.0 and the new 1115 Waiver may create additional opportunities for investment strategies, including potential changes to the Supporting Health for All through REinvestment (SHARE) program, a program that comes from a legislative requirement for CCOs to invest a portion of their profits into community initiatives that reflect SDOH-E efforts.
- All funding strategies must be justified as primary prevention strategies.

4.0 // Additional Strategic Plan Goals

In addition to the outlined financial goals, the Strategic Plan will also address opportunities for greater efficiency, formalized process, and growth through an internal YCCO alignment of grant processes and timeline, additional CPW Fund staff, and increased CPW Fund outreach and visibility. Finally, it's likely that the impact of changes to the CPW Fund will result in a comprehensive review and revision of the CPW Charter.

4.1 // Grant Processes and Timeline Realignment

In order to better facilitate the ability of the CPW Fund to efficiently and professionally grant financial awards, apply for and track new sources of external funding, and cooperate with other YCCO departments and programs (specifically CHIP grants, ELH grants, and other HRS projects funded by YCCO), an internal working team (established in January 2023), will review and reconcile our grant processes and annual/bi-annual award calendars. This committee will draft a new, universal RFP to evaluate all grantees against all available YCCO funds, so that the most appropriate and/or matched/braided funds may be awarded by each department or program.

By November 2023, in advance of Fiscal Year 2024 and the adoption of the 2024 YCCO General Budget, this workgroup will launch a unified application, available online and hard copy, in English and Spanish, while offering additional translation services. In coordination with the ELH and HRS-SDOH-E Committee, the CPW Fund will evaluate and potentially adopt software that tracks externally funded projects, reporting and compliance, funding partners, and contracts where the CPW Fund has attracted new investments. An ad-hoc grant evaluation committee composed minimally of CAC, ELC, and CPW Fund Committee members will review all RFPs, with consideration for transparency, fairness, and consistency.

For the RFP process, CPW Fund staff will work with YCCO Communications and other departments for equitable and widespread recruitment and visibility.

The goals for this process are to:

- Improve project monitoring, grantee accountability, and internal YCCO communication and coordinated efforts.
- Build more supportive and transparent relationships with grantees and funding partners.
- Exercise greater efficiency with existing and new YCCO staff resources.
- Create funding process consistency between the CPW Fund, ELH, CHIP, and other YCCO processes.
- Expand outreach to current and potential partners.
- Capture data to demonstrate the impact of funding opportunities.
- Continue investing in the diverse range of existing CPW Fund projects while identifying new opportunities.
- Replace YCCO allocated funds at an eventual 50/50 rate with partner and outside funds matching.

4.2 // Staff Expansion

The CPW Fund will expand its staff from 1 FTE (Wellness Fund Development Director) to include 1.5-2 additional FTE by the end of 2023. New positions will include a YCCO/CPW Fund Contract Coordinator, who will supplement the work of existing YCHHS Staff partnerships. This position will support reporting, evaluation, and school district coordination. Additionally, the CPW Fund will hire a .5-1 FTE Grant Coordinator, depending on applicant availability and workload. This Coordinator will coincide with the evaluation and potential adoption of grant-management software and will be responsible for CPW grant applications to new funding sources and management of applicants to the CPW Fund. The CPW Fund will maintain an openness to Independent Contractor work if the position cannot be permanently filled by EOY 2023. The CPW Fund will continue to utilize shared YCCO resources across departments, including the YCCO Community Health Supervisor, Government Affairs, Public Affairs, Finance, and Administrative Staff. The CPW Fund additionally commits to increased professional development for YCCO Staff and CPW Committee Members.

4.3 // Outreach and Visibility

To build financial, outreach, and partner relationships, CPW Staff will pursue stronger connections with similar public health and Medicaid community organizations, with the priority of learning from and adopting best practices for similar projects and primary prevention priorities that the CPW Fund has and will implement. The Wellness Fund Development Director will work with the YCCO CEO to identify professional advancement and continuing education opportunities, as well as site visits and professional networking opportunities. CPW staff also recognizes the importance of and will cultivate more robust relationships with educational institutions and research communities, in order to support better coordination around Medicaid, YCCO, and ELH initiatives, especially for the purposes of connecting funding and research opportunities.

By focusing on stronger private sector relationships within the business community, CPW Fund staff will cultivate private investors, particularly when SDOH-E and prevention strategies align with business development opportunities around workforce development, housing, behavioral and mental health support, and other business retention and expansion (BRE) identified within those relationships.

With a strong utilization of the YCCO Outreach Campaign Plan and guidance from the YCCO and ELH Strategic Plans, the CPW Fund will elevate YCCO and CPW projects and community partnerships. Communications will celebrate local, regional, and national collaborations, building new and existing partnerships that reflect the strength of the CPW Fund, YCCO, ELH, and broader affiliations with GHPC, PAX Good Behavior Game, and RULER. Using these expanded networks, CPW staff will widely promote CPW Fund RFPs and investment opportunities. CPW Fund outreach strategies will align with YCCO communications and branding strategies.

5.0 // Summary and Recommendations

The YCCO Board made a commitment to the health of an entire community when it created the Community Prevention and Wellness Fund in 2015. There have been distinct phases within CPW Fund history: 1. Incorporation to CPW Fund start up in 2015; 2. Early Implementation 2016-2018; and 3. Fund Diversification and Targeted Impact 2019-2021; and 4. Sustainability Plan Implementation and 2023-2026 Strategic Planning (2022-2023). As the YCCO Board considers long range plans for the entire organization, it will be a significant expansion of the strength, sustainability, and influence of the CPW Fund through enactment of the Strategic Plan, which will prepare the organization for CCO 3.0.

The Board is in a key position to evolve the CPW model in order to sustain the work that began in 2015, as well as prepare for the future landscape of CCO 3.0. Long term community health improvement can be realized within the YCCO region as a result of the Board's vision for the CPW.

During the facilitated strategic planning sessions with GHPC, partners identified programs to continue and prioritize for future investment opportunities, as well as SDOH-E and primary prevention-focused strategies or programs to investigate and consider adding to existing CPW investments.

- Current and future Community Health Improvement Plan (CHIP)/Community Health Assessment (CHA) identified priorities
- Alignment with the YCCO Early Learning Hub Strategic Plan
- FamilyCore
- Family Wellbeing Council
- PAX Good Behavior Game
- "Responder Life" Trauma-Informed Peer Support Training
- RULER Social Emotional Learning (SEL) Program
- Universal Home Visiting
- Yamhill County Health and Human Services Contracted Support

Additionally, partners identified SDOH-E and primary prevention-focused strategies or programs to investigate and consider adding to existing CPW investments.

- Affordable housing, including rent and mortgage assistance, first-time homebuyer funds, and essential home repair support to keep homeowners in safe homes, either through grants or zero/low-interest loans
- Suicide prevention programs
- Expanded early childhood and education programming
- Alternative organizational and financial systems for greater flexibility and security in managing outside funds.
- Stronger community engagement
- More family support programs
- Consideration of food security solutions
- Strategic government affairs advocacy
- Expand pre/post-natal and maternal wellbeing programs
- Retention and training of network providers as an extension of workforce development
- Tribal support
- Offering wealth-building opportunities, including microloans

With the YCCO Board of Directors' support and at the recommendation of the CPW Fund Committee, while protecting our existing programs and honoring our priorities for exploring an expansion of the scope in services the CPW Fund provides, the 2023-2026 Strategic Plan will generate new sources of sustainable revenue while making a significant impact in primary prevention strategies in SODH-E.

Appendix A: CPW Charter

Yamhill Community Care Organization
Community Prevention and Wellness Board Committee

PURPOSE: The Yamhill CCO Community Prevention and Wellness Board Committee (CPW) will develop a comprehensive population-based plan for wellness for Yamhill community members to be presented to the Board of Directors. The plan will outline recommendations for strategy and options for resource allocation with the principal goal to improve long term population health.

TASKS:

1. Assessment of current prevention and wellness activities and the scientific research supporting interventions and strategies.
2. Assessment of current financial resources supporting such activities, including where funding originates and total costs per program.
3. Study other models for community health and wellness, including both organizational and programmatic approaches.
4. Identify best practices that are currently available in other community settings, but unavailable in Yamhill CCO region.
5. Develop a strategy for improved prevention and wellness activities at every developmental phase for Yamhill Community members, including both individual and population-based intervention.
6. Make recommendations for ways to track intermediate outcomes, programmatic and health indicators, return on investment, and overall community health improvement.
7. Make recommendations on funding of initiatives, activities, programs and interventions.
8. Develop strategies to secure and leverage external funding and resources.

REPORTING RELATIONSHIPS: The CPW submits the proposal to the Yamhill CCO Board for its approval and recommends allocation of resources necessary to accomplish its objectives. The recommendation will be presented by the Chair or YCCO CEO.

MEMBERSHIP: The CPW includes broad cross-agency and community representation. The CPW should have no fewer than 5 and no more than 9 members.

MEMBERSHIP TERMS:
A member term is 2 years, beginning on the first of January. Terms will be staggered to avoid excessive members leaving in any year. The initial members appointed will be randomly assigned to 1-, 2-, or 3-year terms. Members completing their first term may apply to continue serving indefinitely; renewal application will be considered by the Nominating Committee along with those of others applying.

MEETINGS: Meetings are held monthly at a time chosen by the CPW. Ad hoc and standing subcommittees may be created as needed to complete the work of the Committee, and may include individuals who are not CPW members.

ATTENDANCE: Members of the CPW should commit to attending at least 80% of the CPW's meetings. An absence should be reported prior to the meeting to the CPW Chair or assigned YCCO staff. After the first missed meeting in a year, a member will be contacted by the Co-Chair or staff. After the second missed meeting, the member may be subject to removal. On an infrequent basis CPW members may appoint an alternative to participate as a non-voting member in their absence.

MINUTES: Minutes must be taken at each CPW meeting. The minutes shall be reviewed and approved at the next regular CPW meeting.

DECISION MAKING: A majority of the members of the CPW constitutes a quorum. The Yamhill CCO will use consensus decision making processes to the extent possible. At the discretion of the Chair or Co-Chair(s) or at the request of any CPW member, a show of hands vote may be conducted. Initiatives, activities, programs and interventions funded through the CPW Committee shall be:

- Evidenced-based or promising practice
- Aligned with a community health improvement plan or the YCCO strategic plan
- Meet obligations or contractual requirements based on the specific funding stream

COMPENSATION: No salary shall be paid to a member for his/her services as a member of the CPW. Yamhill CCO staff will be compensated in their duties to staff the CPW.

CONFLICT OF INTEREST: It is recognized that CPW members and the organizations they represent will be personally, professionally, and financially impacted by the decisions of the CPW. Transparency in sharing potential conflicts of interest is essential to ensure the integrity of the Committee's decision making. CPW members are required to disclose any potential conflicts of interest by completing a conflict of interest declaration form, submitting it to Yamhill CCO staff and updating it as necessary.

ROLE OF YAMHILL CCO STAFF: Yamhill CCO staff shall provide support to the CPW to:

- Ensure appropriate processes are in place to allow the CPW to succeed in their role
- Attend all CPW meetings; record and disseminate minutes
- Provide administrative resources to the CPW
- Provide Yamhill CCO data and reports for consideration
- Provide information on significant issues or developments within or impacting Yamhill CCO
- Provide oral and written information as needed/requested in a timely fashion
- Ensure follow through on CPW decisions

ADOPTION AND AMENDMENT OF CPW POLICIES: These policies are adopted and may be amended by a majority vote of the Yamhill CCO Board of Directors. Amendments to be considered at a meeting of the Yamhill CCO Board of Directors must be provided to CPW members in written form at least 7 days prior to a CPW meeting so that the CPW may make recommendations regarding the proposed changes.

Appendix B: CPW By the Numbers and Program Overview

COMMUNITY PREVENTION & WELLNESS BY THE NUMBERS

Since 2016, the Wellness Fund has invested more than

$2.2M

into its schools and community .

The CPW Committee selects evidence- or research-based prevention programs to improve population health on a county-wide scale

6023

students impacted by CPW prevention programs, reaching

100% of school districts

2021 saw expansion to programs across the lifespan. Responder Life peer support has trained

five first responder agencies

Behavioral referrals reduced **75%** in Yamhill-Carlton

>95% of Willamina students had good attendance during COVID

Projected 50-year return on investment for the community, for Good Behavior Game alone is more than **$10M**

Including extensive evaluation, cost per child is around **$85**

"...Our kids come in and they don't know how to do math and we teach them; our kids come in and they don't know how to read and we teach them; our kids come in and they don't know how to act, and what is our response? We kick them out.... That's something we never had in our studies, teaching these kids social skills. "-

School staff and teacher listening session 2017

Program	Description	Scope
PAX Good Behavior Game	Classroom prevention program based on a set of tools and activities designed to reward leadership and attention. Increases social regulation and improves classroom behavior. Has longitudinal evidence for short and long term impacts on behavior and success measures.	K-5 School-based
Collaborative Problem Solving	School-wide program training staff and parents to coach students in finding solutions as a team, sharing resources to reach a common goal and developing positive communication skills.	K-12 School and family-based
RULER	Evidence-based emotional intelligence program incorporating a set of SEL practices, improving both teacher and student relationship and well-being.	K-5 School-based
Sources of Strength	Suicide-prevention program based on identifying staff and student leaders to change peer social norms and develop personal strengths.	6-12 School-based
Positive Family Supports	Program aimed at improving families' relationships with the school system. Offers resources, a resource space, and regular engagement with families and caregivers.	K-12 School-based
Responder Life	Peer support program specific to first responders, offering training in responding to and addressing trauma and vicarious trauma in first responders. Also offers crisis supports and mental health resources to reduce burnout and improve wellness.	Adult Workforce
Home visiting expansion pilot	Home visiting is an evidence-based way to improve outcomes for infants and their families or caregivers, connect them to resources, and provide health and prevention education.	Infant Home-based
Family Well-Being Council	The Family Well Being Council reviews evidence to make recommendations for high-impact interventions to reduce negative childhood outcomes and reduce abuse and neglect.	Prenatal-8 Research

Appendix C: Trust for America's Health White Paper

Options for Financing Community Prevention Initiatives to Improve Health

Grant Funding

There are many sources of grant funding for community health improvement, from private and public (government) sources.

Public Grants

The Centers for Disease Control and Prevention at HHS is a central resource for community prevention grant funding. Other federal Health and Human Services agencies directly or indirectly support community prevention, including the Health Resources and Services Administration, the Substance Abuse and Mental Health Agency, the National Institutes of Health and the Centers for Medicare and Medicaid Services. Additional federal agencies that have grants aimed, at least in part, at health outcomes include Housing and Urban Development (e.g., Healthy Homes Program's Healthy Homes Demonstration Program and Healthy Homes Technical Studies), Department of Education (e.g., Carol M. White Physical Education Program, Promise Neighborhoods, Promoting Student Resilience Program, School Climate Transformation Grants, Project SERV, Project Prevent Grant Program, Title IV-A Block Grants[1]), United States Department of Agriculture (e.g., Healthy Food Financing Initiative, Children, Youth and Families at Risk Program[2] and Food Insecurity Nutrition Incentive Program), and the Environmental Protection Agency (Healthy Communities and Healthy Places for Healthy People). In addition, many public and private programs may not appear to fund health directly, but they work to address social determinants that are aligned with those that impact health.

Federal Innovation Funds

The Innovation Center at the Centers for Medicare and Medicaid Services (CMS) in HHS has targeted some of its funds to prevention and population health, particularly focusing on strengthening linkages between health care, public health and community. Past awards with this focus include Health Care Innovation Awards, State Innovation Awards and Accountable Health Communities. A new demonstration to address the social determinants of health is expected in 2020.

Private Grants

Private grants are made by both private and corporate foundations. A **private foundation** is A nongovernmental, nonprofit organization established to aid social, educational, religious, or other charitable activities serving the common welfare, primarily through grantmaking. U.S. private foundations are tax-exempt under Section 501(c)(3) of the Internal Revenue Code and must make charitable expenditures of approximately 5 percent of the market value of their assets each year. Grantmakers in Health is a membership organization of health funders.

[1] See also https://aasa.org/uploadedFiles/Policy_and_Advocacy/files/AASA%20NAFEPA%20WBA%20ESSA%20Title%20IV%20Survey%20FINAL%20061818.pdf

[2] See also https://nifa.usda.gov/program/children-youth-and-families-risk-cyfar

Corporate Foundations

A corporate foundation is a private, company-sponsored foundation that derives its grantmaking funds primarily from the company's profits. It may maintain close ties with the donor company, but it is a separate, legal organization, sometimes with its own endowment, and is subject to the same rules and regulations as other private foundations.

Program-Related Investments

Some foundations make **Program-Related Investments (PRIs) (also called Foundation Investment Funds)** to support charitable activities that involve the potential for return of capital within an established time frame. PRIs include financing methods commonly associated with banks or other private investors, such as loans, loan guarantees, linked deposits, and even equity investments in charitable organizations or in commercial ventures for charitable purposes. A large portion of PRI dollars support affordable housing and community development. For the recipient, the primary benefit of PRIs is access to capital at lower rates than may otherwise be available. For the funder, the principal benefit is that the repayment or return of equity can be recycled for another charitable purpose.[3] For more information, see:

Grantmakers in Health Guide to Impact Investing, April 2017

Leveraging Resources, Including In-kind Support

Community prevention programs can leverage resources in their communities by soliciting and accepting in-kind donations. An in-kind donation is a gift of goods and services that your organization would have to otherwise buy if they hadn't been donated. The value of the donated supplies or services may be recorded as the amount that your organization would have to pay for similar items. For example, a local company might donate the use of their conference space for meetings or events. A local printing company might donate their printing services to produce a brochure, annual report or event program.

Not-for-Profit Hospital Community Benefit Requirements

The Internal Revenue Service (IRS) requires non-profit hospitals to meet certain requirements to retain their non-profit status and some states have additional requirements. Hospitals must conduct programs or activities to address community need and meet at least one of the following community benefit objectives:

- Improve access to health care services
- Enhance the health of the community
- Advance medical or health care knowledge
- Relieve or reduce government burden

Non-profit hospitals meet their obligations by providing financial assistance to patients; writing off the unpaid costs of care provided to patients enrolled in government-sponsored insurance; and through community benefit services, which include:

- Community Health Services

[3] http://grantspace.org/Tools/Knowledge-Base/Grantmakers/pris

- Health Professional Education
- Subsidized Health Services
- Research
- Financial Contributions
- Community Building Activities (defined as support for physical improvement and housing, economic development, community support, environmental improvements, leadership development and training for community members, coalition building, community health improvement advocacy and workforce development)[4]

Non-profit hospitals are required to conduct Community Health Needs Assessments every three years (including input from the community and public health) and develop implementation strategies based on identified community needs. Hospitals are increasingly interested in community benefit strategies that address the social determinants of health. For more information, see:

Hospital Community Benefits after the ACA: Leveraging Hospital Community Benefit Policy to Improve Community Health

About Community Benefit, Catholic Health Association

Developing Braided and Blended Funding Streams

It is widely recognized that multiple sources of funding are needed to sustain successful community health improvement initiatives and fund continued innovation. Braiding and blending are terms used to describe how initiatives can leverage separate funding streams in more coordinated and flexible ways.

- **Braiding** – Coordinating funding and financing from several sources to support a single initiative or portfolio of interventions (usually at the community level). Braiding keeps different funding/financing streams in distinguishable strands, so each funder can track resources.
- **Blending --** Combining different funding/financing streams into one pool, under a single set of reporting and other requirements. Blending makes dollars from different streams indistinguishable from one another as they are combined to meet the needs on the ground that are unexpected or not covered by other sources.

There are a few federal initiatives designed to encourage braiding and blending of federal funding streams, such as Performance Partnership Pilots for Disconnected Youth, and Promise Neighborhoods. In addition, local community health improvement initiatives often blend public and private funding sources. For more information and examples, see:
Braiding and Blending Funds to Support Community Health Improvement: A Compendium of Resources and Examples, Trust for America's Health

Supporting Healthy Communities: How Rethinking the Funding Approach can Breakdown Siloes and Promote Health and Health Equity, Trust for America's Health and Monitor Deloitte

Promoting Effectiveness and Sustainability of Initiatives to Improve Health and Social Outcomes: Methods that Federal Agencies Can Use to Facilitate Coordination and Integration of Funding Streams, Trust for America's Health

[4] http://preventioninstitute.org/component/jlibrary/article/id-332/127.html

Prevention and Wellness Funds or Trusts

Wellness Trusts are locally controlled pools of funds created to support community well-being and clinical prevention efforts that improve population health outcomes and reduce health inequities.[5] Massachusetts health plans and large hospital systems paid into a fund administered by the State Department of Public Health. This Prevention and Wellness Trust was established as a component of the State's cost containment strategy. Competitive grants were awarded for evidence-based community prevention strategies. Wellness Funds are emerging across the nation, many following the establishing of Accountable Health Communities. For more information, see:

The Massachusetts Prevention and Wellness Trust: An Innovative Approach to Prevention as a Component of Health Care Reform

Sustainable Fund for Healthy Communities. Local Health Trusts: Structures to Support Local Coordination of Funds, Trust for American's Health

Local Wellness Funds, Georgia Health Policy Center, 2019

Establishing a Local Wellness Fund: Early Lessons from the California Accountable Communities for Health Initiative, July 2019

Health Care Delivery and Financing Mechanisms

Accountable Care Organization (ACO) – An ACO is a model of care that distributes accountability for performance on cost and quality metrics across groups of health care providers, tying shared savings and other financial rewards to maintenance or improvement of care quality.[6] Since an ACO is accountable for a designated population of patients, it stands to gain from preventing illness and reducing health care utilization. An ACO could invest in community prevention to both improve the health of the population and decrease costs. For an example, see Case Study: Nationwide Children's Hospital: An Accountable Care Organization Going Upstream to Address Population Health, Appendix A, National Academies of Medicine Discussion Paper, 2017.

Health Care and Social Service Delivery and Financing Mechanisms

Accountable Health Communities (AHC) are multi-sector alliances of health care providers, public health and community organizations that embrace the concept that there is shared responsibility for the health of a community across sectors. They work collaboratively to implement an integrated approach to health, health care and social needs. They differ from ACOs in that they are not solely focused on clinical conditions in a specific patient population, but more broadly focused on what is needed to improve the health of a community, with a focus on prevention.[7] For more information, see:

Mongeon, M., J. Levi, and J. Heinrich. 2017. Elements of accountable communities for health: A review of the literature. NAM Perspectives. Discussion Paper, National Academy of Medicine, Washington, DC

[5] Georgia Health Policy Center and Funder's Forum 2019 meeting materials.

[6] http://changelabsolutions.org/sites/default/files/Financing_Prevention-NASHP_FINAL_20140410.pdf

[7] Adapted from https://nam.edu/elements-of-accountable-communities-for-health-a-review-of-the-literature/

Accountable Communities for Health: A Regional Approach to Integrating Community-Wide Prevention Strategies, Prevention Institute

State Approaches to Addressing Population Health Through Accountable Health Models, National Academy for State Health Policy

Community Development Funding

Community Economic Development (CED) is a process by which a community uses resources to attract capital and increase physical, commercial, and business development and job opportunities for its residents.[8] Community development helps low-income people and their neighborhoods by providing access to financing and other tools to build affordable housing, launch small businesses, and construct facilities in the community. These investments help to make communities more robust, both economically and socially. The Community Reinvestment Act sets requirements for banks and other financial institutions to help meet the credit needs of the local communities in which they are chartered, particularly low- and moderate-income neighborhoods.[9] Community development funds are often funneled through Community Development Corporations and Community Development Financial Institutions and come in many forms (low-interest loans, tax credits, etc.). To learn more about partnerships between the community development and health sectors, see:
Build Healthy Places Network
How is Community Development Related to Health? County Health Rankings and Roadmaps

Social Impact Investments

Through social impact investing, organizational assets can be effectively used to meet a social mission and serve people in needs, while also achieving a financial return.[10] Social impact investing takes the form of equity, debt, working capital lines of credit, micro financing and loan guarantees to early-stage companies.[11] In 2018, Congress passed the Social Impact Partnerships to Pay for Results Act (SIPPRA) creating a $100 million fund at the U.S. Treasury to make outcome payments in social impact partnership projects. A notice of funding availability was issued in 2019.

Pay for Success Financing

Pay for success (PFS) is an innovating financing mechanism that provides up-front capital to scale proven social programs. PFS shifts financial risk from a traditional funder – usually government – to a new investor who provides the upfront capital to scale; if the agreed-upon outcomes are achieved, then the traditional funder repays the investor and, if not, the investor takes the loss.[12] In South Carolina, investors are supporting expansion of the Nurse-Family Partnership model to mothers enrolled in Medicaid. If the reductions in pre-term birth and in child hospitalization and emergency department utilization are realized, and there is an increase in healthy spacing between births and an increase in the

[8] http://www.acf.hhs.gov/programs/ocs/resource/community-economic-development-definition-of-terms
[9] http://hria.org/uploads/reports/PPReport_r3_011614_pages.pdf
[10] https://www.gih.org/files/FileDownloads/GIH_Impact_Investing_Report.PDF
[11] http://health.citizing.org/data/projects/citizen-solve-health/Health%20Capital%20Market%20FINAL%20March%202012.pdf
[12] https://pfs.urban.org/

number of first-time moms served in the targeted areas, the State of South Carolina will repay the investors.[13] For a library of Pay for Success projects, see:

Urban Institute Pay for Success Website, Projects at a Glance

Social Impact Bonds

Recently, one form of impact investing or pay for success financing that has gained traction in health -- the Social Impact Bond. In a Social Impact Bond (SIB), or Health Impact Bond (HIB), capital is raised from private investors to invest in prevention interventions, capturing the healthcare cost-savings that result from the interventions, and then returning a portion of those savings to the investors as profit.[14]For more information, see:

Grantmakers in Health Guide to Impact Investing, April 2017

Social Impact Bonds and the Search for Ways to Finance Public Sector R&D, Nonprofit Quarterly, March 2018

Health Care Reimbursement Mechanisms

While health insurance reimbursement for community prevention is not common in either the public or private markets, pockets of innovation exist and are increasing. For example, Medicare, Medicaid agencies and Medicaid Managed Care Organizations (MCOs) are increasingly reimbursing for non-traditional services (such as home remediation of environmental triggers), particularly those that address health-related social needs, provision of services in non-traditional settings (such as schools or the YMCA), and services provided by non-traditional (unlicensed) providers. For more information, see:
Leveraging Medicaid to Address Social Determinants and Improve Child and Population Health, Georgetown University Health Policy Institute Center for Children and Families
Medicaid Payment Strategies for Financing Upstream Prevention, Academy Health and Nemours

Section 1115 Waivers (Research & Demonstration Projects)

States can apply for program flexibility to test new or existing approaches to financing and delivering Medicaid and the Children's Health Insurance Program (CHIP) (for an inventory of waivers, see NCSL's Medicaid 1115 Waivers by State. Waivers must be cost neutral over the demonstration period, which is typically 5 years. In October 2018 the Centers for Medicare and Medicaid Services (CMS) approved North Carolina's Section 1115 waiver which will finance "Healthy Opportunity Pilots," to cover non-medical services that address social needs linked to health outcomes. Pilots will address housing instability, transportation insecurity, food insecurity, and interpersonal violence and toxic stress.[15] A Texas 1115 waiver set aside 5% of the annual Medicaid budget for local public health. A New York 1115 waiver reimburses supportive housing service providers via a bundled or case rate payment for services delivered in housing to high-acuity chronically homeless beneficiaries. For more information, see:

[13] https://pfs.urban.org/pfs-project-fact-sheets/content/south-carolina-nurse-family-partnership-project

[14] http://preventioninstitute.org/component/jlibrary/article/id-332/127.html

[15] https://www.kff.org/medicaid/issue-brief/a-first-look-at-north-carolinas-section-1115-medicaid-waivers-healthy-opportunities-pilots/

Schlenker, T. Paying for Population Health: A Texas Innovation, NAM Perspectives. Discussion Paper, National Academy of Medicine, Washington, DC 2014

For an example of an asthma program with a home-based environmental assessment reimbursed under an 1115 waiver, see the Massachusetts example in A Case Study in Payment Reform to Support Optimal Pediatric Asthma Care (The Brookings Institution) and Sustainable Funding and Business Case for GHHI Home Interventions for Asthma Patients.

Medicare

In April 2019 the Centers for Medicare and Medicaid Services (CMS) finalized Medicare Advantage payment policies, providing increased flexibility in what Medicare Advantage insurance plans can provide, specifically allowing them to pay for supplemental benefits that are not covered under Medicare Parts A or B but that have a reasonable expectation of improving or maintaining the health or overall function of a beneficiary (e.g., meal delivery, transportation, etc.).[16]

Medicaid

Fee-for-Service Reimbursement

Medicaid services can be delivered in community settings, including homes and schools. For more information and examples, see Health investments that Pay Off: Strategies for Addressing Asthma in Children (National Governors Association) and Asthma Self-Management Education and Environmental Management: Approaches to Enhancing Reimbursement (Centers for Disease Control and Prevention).

A 2015 rule change in Medicaid permits states to reimburse for preventive services delivered by a non-licensed provider, when referred by a licensed provider. State Medicaid offices must submit a State Plan Amendment to CMS to implement this change. This change has the potential to fund services of community health workers, health educators and other non-licensed providers who provide preventive services. For more information, see
Medicaid Reimbursement for Community Prevention Meeting Summary, Trust for America's Health and Nemours

Medicaid Targeted Case Management

Case management consists of services which help beneficiaries gain access to needed medical, social, educational, and other services. "Targeted" case management services are those aimed specifically at special groups of enrollees such as those with developmental disabilities or chronic mental illness.[17]
For a chart of Medicaid targeted case management benefits by state, see Kaiser Family Foundation Chart Medicaid Targeted Case Management Benefit by State. For an example of targeted case

[16] https://www.cms.gov/newsroom/press-releases/cms-finalizes-medicare-advantage-and-part-d-payment-and-policy-updates-maximize-competition-and

[17] https://www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/downloads/CM_Fact_Sheet.pdf and http://www.chcs.org/media/CMS_Medicaid_Targeted_Case_Management_Rule.pdf

management support of an asthma program that conducts home assessments, see Sustainable Funding and Business Case for GHHI Home Interventions for Asthma Patients.

Medicaid Managed Care Reimbursement

Managed care organizations (MCOs) typically have the flexibility to support evidence-based community prevention interventions, particularly for those patients/population considered to be high utilizers. As opposed to a fee-for-service Medicaid program, a State Plan Amendment is not required for an MCO to reimburse for non-traditional services, or to reimburse for a service outside of a clinical setting, or provided by a non-licensed provider. States can encourage MCO investment in community prevention by imposing requirements or establishing incentives in the managed care contracting process (for more detail on how states are doing this, see NASHP's How States Address Social Determinants of Health in Their Medicaid Contracts and Contract Guidance Documents.

Medicaid Administrative Claims

Medicaid administrative claims, as opposed to service claims, are a way that states can get federal matching dollars for activities that support the administration of their Medicaid program, such as enrollment and monitoring. In Texas, administrative claiming supports some of the activities of their Childhood Lead Poisoning Prevention Program. For more information, see:
Pathways to Reimbursement: Understanding and Expanding Medicaid in Your State, National Center for Healthy Housing

Appendix D: John Kitzhaber Article April 9, 2021

Universal Coverage, Health, Equity, and Value: Moving Beyond a Divided Congress

On March 11, President Biden signed the $1.9 trillion American Rescue Plan, sending much-needed economic relief to individuals, businesses, states, and local governments—as well as resources for COVID containment and to support the national vaccination effort. This legislation also includes billions of dollars to increase the size and the scope of the public subsidies in the Affordable Care Act (ACA) market, thus fulfilling a central element of the health policy agenda the president **laid out in his campaign**. This represents the largest expansion of coverage since 2010—an incredibly important accomplishment, especially at this point in time. In addition to expanding the size and scope of the public subsidies in the ACA insurance exchanges, the legislation eliminates the income cap on these subsidies. This means that regardless of income, age, or location, no one will be required to pay more than 8.5 percent of their income for insurance on the exchanges. In other words, individuals are no longer at the mercy of the market—which is a good thing.

The problem is that the American Rescue Plan did nothing to constrain the market itself, and there is nothing to suggest that unfettered market forces will solve this problem—on the contrary, they are fueling it. This past year alone—in the midst of the pandemic and a terrible economic downturn, when millions of Americans were losing their health insurance, when one in six people were going to bed hungry and millions faced unstable housing—health care IPOs raised more money during the first three quarters, than during each year from 2015-2019—almost $30 billion.

There is nothing wrong with making a profit, but we are talking about *public resources* here. Remember that every public dollar that goes to feed a Wall Street investor or pad a hospital margin, is a public dollar *not* available to expand coverage or lower premiums. Every public dollar that goes to pay for unnecessary, low-value, or overpriced care, is a public dollar *not* available to invest in education, food security, and affordable housing. In short, we must demand *value* from our health care system—we should not be spending our public resources on overtreatment, unnecessary care, inflated prices, or care that is inefficient, uncoordinated, or ineffective.

Making health care more affordable to individuals by increasing public subsidies is not the same as reducing the total cost of care. It simply uses the public treasury to subsidize a business model, in which the incentives are aligned to maximize revenue rather than to maximize health, and **wastes up to thirty percent** of every dollar it spends. The cost of our unconstrained health care system—now further underwritten by taxpayer dollars—will continue to escalate, forcing us to spend or borrow ever more money to pay for it—while other important social investments critical to our health, remain woefully underfunded.

The World Health Organization defines *health* as "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity." If we could write a prescription for America that would surely be it. And if we could fill that prescription by spending more money on the U.S. health care system, we would already be there. Yet, fifty years of evidence tells us that the promise of health care for all Americans is not the same as a healthy America. In 1968 the U.S. was spending 6.2% of its

GDP on health care. Today we are spending almost 18%, yet life expectancy has declined three years in a row, driven largely by inequality and economic hardship, particularly in working-class America.

We know that among the factors that contribute most to lifetime health status, our medical system is a relatively minor contributor. Far more important are healthy pregnancies, affordable housing, good nutrition, safe communities, education, and living-wage jobs. These are the pillars of family stability, success—and of health. Our failure to adequately invest in these "social determinants of health" is a central cause, not only of the declining health of our population but also of the growing social unrest and political polarization that is undermining the effectiveness of our public institutions.

Since the enactment of Medicare and Medicaid in 1965, the central strategy to expand coverage in the U.S. has been to increase public subsidies—the same strategy used in both the ACA and the American Rescue Plan. And this strategy has unquestionably benefited millions of Americans. The problem is that neither Democrats nor Republicans have assumed any change in the underlying health care business model—we either pay for it or we don't, creating a false choice between cost and access.

The cost of this business model—driven by fee-for-service reimbursement, inefficacy, and excess profit-taking—is approaching $4 trillion a year. It grew from $2.6 trillion in 2010 to $3.9 trillion in 2020 and is projected to grow another to sixty percent to $6.2 trillion by 2028. This relentless drain on public budgets undermines the social investments necessary to improve the health of the population and to address the long-standing racial and ethnic inequities, reflected in growing health disparities and diminishing economic and educational opportunities, disproportionally afflicting communities of color.

Certainly, universal coverage for affordable medical care is essential to the health of our nation and is a basic measure of a just society. But so too are the social investments, that can help struggling families succeed, thus sparing children the toxic stress that fuels a cycle of generational poverty, condemning them to lives of economic struggle and early death. These investments weave the very fabric of social justice.

The American Rescue Plan was enacted through the reconciliation process with no Republican votes. The same process will be required to make the new health care subsidies permanent, but the structural changes to the underlying health care system necessary to reduce the total cost of care, including a public option, are unlikely to fit under the rules of reconciliation. It is clear that while this congress can increase public subsidies for health care, it is not politically possible to take the steps needed to reduce the total cost of care itself. The Democratic margins are too thin and the partisanship too deep. What is also clear, is that without changing the payment model, the total cost of care will continue to increase, and the subsidies will eventually have to be increased once again, adding to the national debt and further constraining our ability to invest upstream in the community.

We cannot afford to simply wait another two years, hoping that the 2022 midterm elections will change the political dynamics in Congress. Nor can we solve this problem by continuing to go further into debt to fund the current system. Our nation needs definitive action that will pave the way toward universal

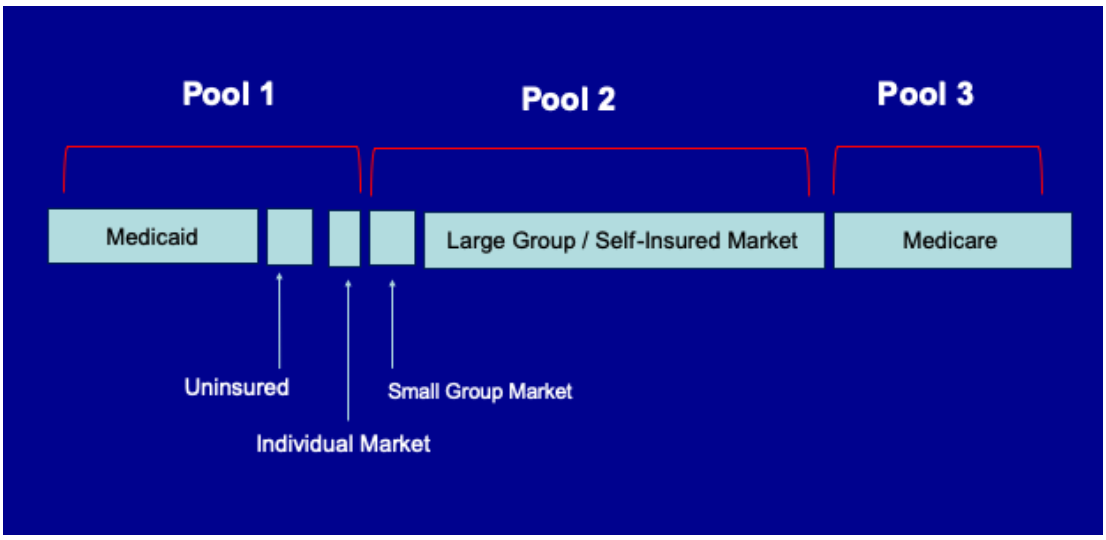
coverage—but coverage that is financially sustainable and creates space in our public budgets for the social investments that can keep people out of the medical system in the first place—investments in health and equity.

The way beyond congressional gridlock is to unleash state innovation around delivery system reform. By using facilitated 1115 and 1332 waivers—in a coordinated and well thought out strategy—the Biden Administration can encourage six or seven carefully selected states to demonstrate models that redefine competition within the boundaries of sustainable fiscal constraints while maintaining access and quality. I know from my direct experience with both the original **Oregon Health Plan** waiver in 1993 (President Clinton), and the waiver for Oregon's **Coordinated Care Organizations** in 2012 (President Obama), that the ultimate decision on bold waiver proposals such as the ones described below, is a political decision driven from the White House, rather than an administrative decision driven by CMS.

So, even as the Biden Administration pursues health policy reform through the congressional reconciliation process, here are a few thoughts on how to move the national health policy agenda forward administratively —including a "public option"— through 1115 and 1332 waivers.

Universal Coverage / Reducing the Total Cost of Care

Let's start by looking at the health care system in terms of three "pools" organized by the nature of the public subsidies involved. Medicaid (Pool 1) and Medicare (Pool 2) are financed with *direct* public subsidies, while Pool 3 is financed with indirect public subsidies—the ACA market is indirectly subsidized with premium tax credits and cost-sharing reduction subsidies, while the large group and self-insured markets are indirectly subsidized through the tax exclusion for employment-based coverage.



Pool 1 is where the coverage problem is most acute, primarily because of the total cost of care. Those most at risk are those earning more than 138% of the federal poverty level (FPL), who are not eligible for Medicaid but cannot afford the growing cost of premiums, copayments, and deductibles in the individual market. Furthermore, twelve states have not yet expanded Medicaid. Certainly, there are legitimate challenges/problems in Pools 2 and 3— but they are not primarily *coverage* problems. Everyone on Medicare has coverage and, notwithstanding the rise in unemployment, the majority of Americans are still receiving coverage through their employer.

As incoming CMS Administrator Chiquita Brooks-Lasure has pointed out: "coverage for the lowest-income Americans remains the most significant unfinished business of the ACA."**[2]** So, given the deeply partisan landscape of Congress, the place to start beginning to fundamentally change the delivery model across the system is with Pool 1. Let me use Oregon as an example.

We know that if even 80% of those in Oregon who are currently eligible for Medicaid, or for subsidies in the ACA market, were actually to enroll, we could reduce the number of Oregonians without coverage to less than 1%.**[3]** To do so, we must reduce the total cost of care by:

- Ensuring that the Oregon "**Coordinated Care Organizations**" (CCOs)**[4]** continue to operate on a true global budget (1115 waiver).
- Moving the ACA individual market from fee-for-service to a capitated model (1332 waiver).
- Using the restructured ACA individual market as the public option, open first to people enrolled in the small group market.

Move the ACA Individual Market from FFS to Capitation

Unlike every other public health care program that is heavily subsidized with taxpayer dollars (including Medicaid, Medicare, the VA, and Tricare) the ACA market has no uniform fee schedule. It is a wide-open fee-for-service payment model with no constraints on the total cost of care. Fees are negotiated annually between insurers and providers and those fees mirror rates in the rest of the commercial market and can be 300 to 400% higher than Medicaid rates. This means, for example, that a provider giving care to someone earning 138% of the FPL will get paid the Medicaid FFS rate, but will receive three or four times as much reimbursement for someone earning 140% of the FPL, who is getting care through an ACA policy in the individual market. This is very difficult to justify in our current fiscal environment.

The solution is to use a 1332 waiver to move the ACA individual market from fee-for-service to capitation, with the global budget indexed to a sustainable growth rate, and integrated delivery systems accountable for meeting rigorous metrics around quality, outcomes, and patient satisfaction.

Use this Restructured Individual Market as the Public Option

To date, most public option proposals, including those in Colorado and Washington—as well as the Biden proposal—maintain FFS payment and seek to control cost through rate caps. This approach does not realign the incentives in the payment model and can result in an increase in utilization. However, two recent papers, published in **Health Affairs** and the **Milbank Quarterly**, recommend a risk-adjusted, capitated public option.

I am not proposing simple rate caps here, but rather a capitation rate built on some *assumptions* around the fee schedule, utilization, and benefit. Integrated delivery systems could earn more than the fee assumed in developing the capitation rate through good utilization management. I would suggest using the ACA essential benefits package and assuming moderately well-managed utilization. What we learned from the CCOs in Oregon is that the real cost savings are not in the rates but in *reducing trend*. Even starting with a fairly generous fee assumption, say 200% Medicare plus, as long as the resulting global budget is tied to a growth rate of 2.5 to 3% per member per year, there will be substantial savings, which will increase over time.

This delta of savings, in turn, not only helps finance the cost of the expanded ACA market subsidies in the American Rescue Plan but creates room in the budget to invest upstream in the community to improve population health and address long-standing racial and ethnic inequities.

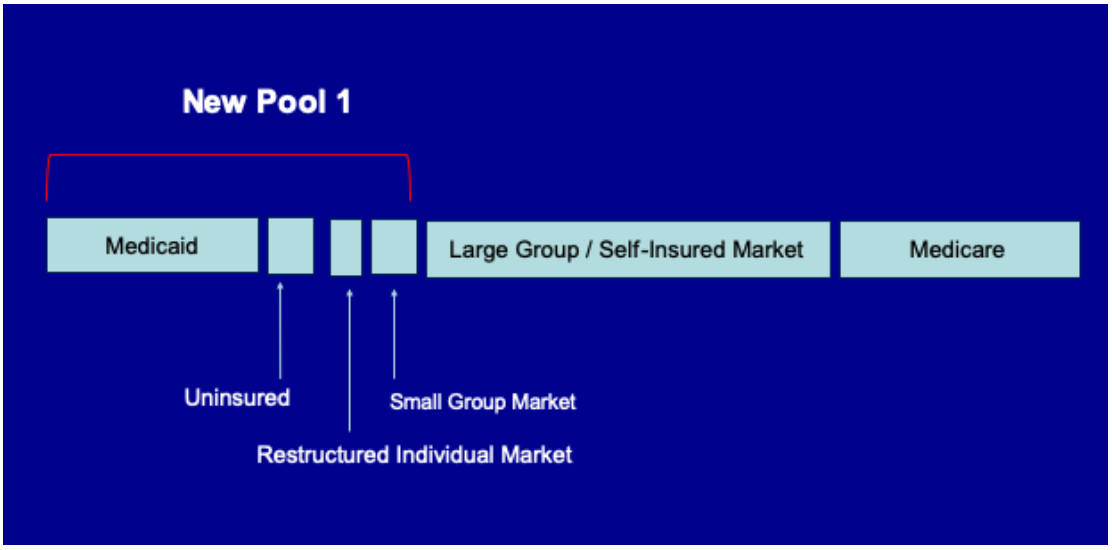
This approach eliminates the need to create an entirely new entity. The ACA market is already heavily subsidized with public resources and commercial insurers are already involved. Initially, this market should be opened to employers in the small-group market. There are a number of reasons to recommend this.

- Under current law, small group employers can receive tax credits for enrolling their employees in a plan through the exchange.
- Both the individual and small group markets come under state regulatory authority.
- The vast majority of employers in the United States are in the small group market. It is these employers and their employees, often at the lower end of the income scale, who have suffered the most during the pandemic. Giving them the ability to purchase affordable, high-quality health care with a predictable rate of inflation, would give them a huge boost as we pull out of the current economic crisis.

To illustrate, let's look at the enrollment numbers in Oregon:

- Medicaid 1,180,000
- Uninsured 300,000
- Individual 220,000
- Small Group 175,000
- Total 1,875,000

Taken together, Medicaid, the uninsured, the individual market, and the small group market includes 1,875,000 lives or 44% of the population— and would include 95% of all Oregon employers and 39% of the workforce.



This approach would require a new risk relationship between payers and providers, so that risk would not be held at the plan level with cost managed through denials and prior authorization. Instead, the risk would flow downstream to integrated delivery systems, which would manage utilization risk, while the health plans would manage true insurance risk (e.g. catastrophic care, exceptionally high-cost individuals).

Another significant difference between this approach and other public options is that this public option is not set up to compete with private commercial insurers but, rather, to force private commercial insurers to *compete with each* other in a restructured market.

If the administration were to put its weight behind giving six or seven carefully selected states facilitated 1115 and 1332 waivers, the main elements of the President's health care agenda could begin to be implemented, notwithstanding the paralysis and deeply partisan debate in Congress. The waivers would allow the selected states to:

- Move their Medicaid programs towards a CCO-like model operating under a true global budget, indexed to a sustainable growth rate, and accountable for meeting quality and outcome metrics.
- Move the ACA individual market from fee-for-service to capitated contracts, indexed to a sustainable growth rate, and accountable for meeting quality and outcome metrics.
- Use that restructured market as the public option.

Moving the Model to Medicare

If the state demonstration projects are successful, it could set the stage not only for a different national debate, but also a window through which to move this model into Medicare. By restructuring Medicare Advantage to look more like the delivery model in Medicaid and the new public option—and by creating incentives to move the rest of Original Medicare from FFS into restructured Medicare Advantage Plans that are linked to a sustainable growth rate, accountable for meeting quality and outcome metrics— we would dramatically increase the percent of the market in capitated, risk-based (value-based) contracts.

Again, using Oregon as an example, we currently have 880,000 Medicare beneficiaries:

- Original Medicare 468,820 (53%)
- Medicare Advantage 411,000 (47%)

With the changes described above in Pool 1, plus our current Medicare Advantage population, we would have 2,286,000 Oregonians in capitated risk-based care or 53% of the population. If we could create incentives to move the rest of Original Medicare into these restructured Medicare Advantage plans, we would have 2,754,800 Oregonians in capitated risk-based care or 64% of the population.

The transition to this restructured Medicare delivery model, now aligned with the accountable models used to organize and deliver care in the other major programs subsidized with public resources—Medicaid and the ACA market—also offers the opportunity to reevaluate and update the Medicare benefit which fails to cover many things important to an aging population. For example, Original Medicare does not cover routine dental care. While it covers corneal transplants and cataract surgery, it does not cover glasses or contact lenses. It covers cochlear implants but not hearing aids. And, outside a skilled nursing facility, Original Medicare does not cover long-term care, whether in a nursing home, an assisted living facility or home-based care to help elderly people with activities of daily life, such as bathing, dressing, eating, and going to the bathroom.

By adding transparency to this new Medicare delivery model to prevent gaming through up-coding and the manipulation of risk score determinations, cost-shifting to Pool 1 and Pool 2 would be *dramatically reduced* but the cost shift into Pool 3 would go up sharply. This would provide a powerful incentive for employers to become much more engaged purchasers, and perhaps aligning themselves with what is happening in Pools 1 and 2 to create a public/private purchasing consortium. This powerful consolidated purchasing pool could offset the consolidation that is taking place in both the hospital and commercial insurance sectors.

The Biden Administration can move this approach forward without getting caught up in the partisan politics of a deeply divided Congress. Not only would it begin to address the underlying structural problems in our health care system, and help offset the cost of the new health care subsidies in the American Rescue Act, it can free up resources to address both the social determinants of health and long-standing racial and ethnic disparities by investing in chronically under-resourced communities—particularly in very young children, their families, and neighborhoods.