**Appendix 2. Specific Site Visit Outcome Summaries**

1. **DC**

Trusted Broker: In contrast to other sites, the DC model engenders sharing of this role among Jane Bancroft Robinson Foundation (JBRF, convener), Quantified Ventures (bidding and pricing), and the Institute for Public Health Innovation (management of vendor contracts).

Intervention: The goal is to reduce racial disparities in breast cancer mortality using patient navigators. This focus is geographically concentrated in the 7th and 8th wards of the District. The specifics of intervention will be developed in an ongoing process of various coalitions with the target end date November 2020.

Range of stakeholders engaged: Main MCO (Ameri-Health) has indicated a willingness to talk. We need to follow up post-COVID. Otherwise, stakeholder engagement is broad.

Credible vendors: Multiple FQHCs and hospitals employ navigators now.

Data management capacity: DC Primary Care Association (association of local FQHCs), has excellent data capacity and track record of analysis and cooperation. Excellent local researchers involved with Breast Health Equity Coalition as well, e.g., Mandi-Pratt Chapman, Ph.D.

Local philanthropy: More than one attended meetings during site visit, JBRF was convener. Cafritz and Komen are also possibilities.

1. **Anne Arundel**

Trusted Broker: Partnership for Children, Youth, and Families (the Partnership), with ED Pam Brown, is widely respected and would be the ideal trusted convener. The Partnership currently administers some grant funding to local initiatives but may not be suited for all fiduciary responsibilities of the TB.

Intervention: Two options are being considered: (1) creation of a sustainable funding stream and expansion of the current, valued behavioral health (BH) Crisis Response System (CRS) or (2) construction of and supportive services to a neighborhood of “Tiny Homes” for the Homeless (TH). The CRS consists of Mobile Crisis Teams of BH clinicians and Crisis Intervention Teams of clinicians partnering with trained police officers, who are called in as first responders to BH crises in homes, schools, or the community, and who can diffuse situations and divert individuals to needed services more effectively than under the usual law enforcement protocol.

Range of Stakeholders engaged: Deep engagement from public sector and public/private organizations such as the Partnership, including health, education, law enforcement, various social services, and critical support from the county executive (CE); however, range of private sector stakeholders is limited. Two hospitals were willing to meet with the team, but neither was close to committing resources. No health plans have engaged to date, although Health Commissioner believes they can be brought to the table individually or through the state Medicaid agency. Education and law enforcement benefit from BH CIT program but it would be difficult to divert funding streams.

Credible vendors: BH CRS program is operating successfully now. Vendors to construct neighborhood of tiny houses would need to be chosen. Organizations to provide associated supportive services would need to be identified among current social services infrastructure. If TH program is chosen, it will be important to get active participation from the Housing Director of Arundel Community Development Services, who has knowledge of potential building sites, experience with local builders willing to partner on affordable housing, and an understanding of related social service connections.

Data management capacity: Public and public/private service organizations are willing to share data and have provided data on CRS operations, but more work is needed to develop data streams suitable for building the business case, and tracking impact and outcomes. Some sophistication about data and sharing agreements exists among staff at health department and CE office.

Local Philanthropy: No local philanthropic funders identified. Community Foundation of Anne Arundel County distributes funding to local organizations in alignment with donor goals and is currently focused on children’s issues but could be revisited as a means for an interested donor to provide start-up funding.

1. **Cleveland**

Trusted Broker: United Way of Greater Cleveland is very able and willing to play all roles. They are also the backbone of a CMMI ACH.

Intervention: Probably medically tailored meals (MTM), but some would like to pursue a variation of housing first. They were on target to have achieved “functional zero” chronically homeless by mid-2020, COVID-19 may have derailed that but nonetheless substantial progress has been made there in the last 10 years. Still, there are many remaining housing insecure people and the appetite for additional investment in this domain is being investigated.

Range of Stakeholders engaged: very good. Four health plans met with us in Cleveland and one more did a phone interview right after our visit, and we are starting to engage with them around business case templates on May 12. Hospitals engaged except for Case Western (CRWU). President and CEO of United Way is very engaged, he can help at highest levels of Cleveland Clinic, CWRU.

Credible vendors: Some MA plans are providing meals now, the Rose Center for Aging Well is doing a pilot for MTM to social isolated now. Housing sector is very sophisticated, respected locally.

Data management capacity: Sophisticated. Between Better Health Partnership (an NRHI affiliate) CWRU researchers, and Chris Nowak of CHN Housing Partners if they go the housing route, they have experience getting and using de-identified confidential data from hospitals, employers, health plans, etc. So requisite trust and capacity exists.

Local Philanthropy: Two met with us, both more interested in food than housing going forward.

1. **Springfield**

Trusted Broker: The Trusted Broker roles are likely to be served by a collaboration of community stakeholders: the Healthy Living Alliance (HLA) as the convener and one of the major local foundations (either United Way, Community Foundation of the Ozarks, or Community Partnership of the Ozarks) as the fiduciary and contracting organization. The local county health department, Springfield-Greene County Health Department (SGHD), is also a trusted broker candidate, but is likely best suited to the vendor with their current staff of nurses and ability to manage the Family Connects intervention. Tn that case, SGH could not be the Trusted Broker if also the vendor due to a conflict of interest.

Intervention: Springfield would like to pursue their own implementation of a previously-tested home-visiting program for families of newborns, [Family Connects](https://familyconnects.org/). This intervention was developed and evaluated by Duke University includes light-touch components of educational information, household assessments, and social service resource-connection services administered by Registered Nurses (RNs) over a series of 1 to 4 visits. The program is currently being implemented in 42 sites across the country (in at least 16 states) and has been rigorously evaluated in multiple settings. These evaluations included randomized-controlled trials (RCTs) and found statistically-significant reductions in preventable health care utilization, a decreased need for Child Protective Services interventions, and overall improved household parenting behaviors and family well-being outcomes. The Family Connects model is “universal and voluntary” meaning it is offered to all new families in the community. This encourages uptake, decreases stigma, and is also particularly well-suited to the politics and social norms in Springfield, MO.

One of the key parts of the Family Connects model is in its purpose to serve as an interconnection point to existing social service resources already available in the community. Therefore, ongoing assessments of other necessary services will be important, and is a role the HLA and SGHD can effectively oversee. Transportation and affordable housing are both areas of concern, where both resource availability and coordination is lacking. Another key community asset is the [Parents as Teachers](https://dese.mo.gov/quality-schools/early-learning/parents-teachers) program that has seen great success in Springfield. Leaders of the program see Family Connects as a potential handoff organization and coordinator of other social services that could co-exist and improve outcomes of both interventions.

Range of Stakeholders engaged: Local philanthropy, local government, and other community leaders have all been effectively engaged and are in support of the model. Local health system providers, particularly Cox Health, are also aware and in support of the initiative. The area Medicaid and Commercial health plans are not yet sufficiently engaged as at the time of the site visit were in the midst of Medicaid expansion political issues (expected to be on the ballot in November). Local and state political leaders will likely also need to be engaged pending the outcome of the Medicaid expansion referendum. SGHD leadership sees Family Connects as a possible way for state Republicans to “save face” and more easily stomach the Medicaid expansion costs.

Credible vendors: SGHD is prepared to implement and serve the role of vendor of the Family Connects initiative. This would involve hiring and managing the nursing staff that would run the home visiting program and assist in collecting the data on the families involved. SGHD is already working on a “feasibility study” of Family Connects for Springfield-Greene County (results expected August 2020, and will be released at that time pending political considerations of the Medicaid expansion issue).

Data management capacity: The community has available data management capacity and software capabilities for this intervention, but the resources are disjointed as this time. Family Connects involves the use of a salesforce-like software to aid in the interconnection of community resources, but this would need to be integrated with the local health systems, existing health department software, other government data, and health plan claims to optimally support the CAPGI project. While integration may take time, the structure embedded in the Family Connects model should ease some of the data collection and sharing problems once the major payers and health systems are on board.

Local Philanthropy: Missouri Foundation for Health, a CAPGI feasibility study funder, is very engaged and in support of the idea. They are a strong supporter of Springfield and could likely fill the role of an overarching local supporter of Technical Assistance needs for a full implementation test. Local foundations are already engaged and will be excellent community partners, although have not yet been asked about their interest to directly contribute to the pool of investable resources for the project.

1. **Waco**

Trusted Broker: Prosper Waco (PW), a non-profit that functions like an civic uber-collaboration vehicle for the city and county (McLennan), with business, health care, government, and educational elite members, hired a very able project manager for the CAPGI work with EHF funding. With TA from us, they can play all Trusted Broker roles.

Intervention: Similar to Anne Arundel, they want to divert clients in mental health extremis from jail or ED (or both) to behavioral health crisis resources and also connect better with follow up interventions to avoid repeated calls. They have it designed to fill a gap in existing county and private resources. Their core idea is to use phone triage with the power to direct transportation to BH facilities and personnel rather than jail/ED. They have a savvy (recently retired) behavioral health leader and a creative FQHC CEO working with group including law enforcement and key managers from local psych hospitals to finalize the contours of the initiative. Their original idea was to create a new hotline phone number and staff it with BH professionals.

Range of Stakeholders Engaged: Good, although one hospital did not meet with us in a group because they don’t get along that well with one of the others. Also, only one health plan met with us and it was the plan of a major hospital system (Baylor Scott White), not the dominant plans in the area (Blue, United, self-insured TPAs). Since Texas is not an expansion state, MCOs are not as important for this target population as one might expect. At the same time, commercial insurers probably have more worker and family members who use the behavioral health crisis system now than they know about, so getting those plans involved will be key. Prosper Waco can probably open those doors, but COVID-19 prevented timely follow-up.

Credible vendors: It was not made explicit, but we assume the employees who would execute the intervention would work for country government in one agency or another.

Data management capacity: Each local stakeholder – hospital systems, health plans, law enforcement, the EMT service, the county mental health agency and the local FQHC system (11 branches under one CEO) – are all data savvy, understand BAAs, unique identifiers, etc. PW has the trust and internal capacity to become the data repository of necessary data flows, with TA from us to set it up.

Local philanthropy: EHF is supportive of Waco, and two local foundations are involved and active in the CAPGI work as well.

1. **Eastern Virginia**

Trusted Broker: The Richmond-based Virginia Center for Health Innovation (VCHI), a 501c3 with a 10 year history of leading and executing collaborative QI projects across Virginia, and with a Board that includes the major system and health plan CEOs in Virginia, is well positioned to play all TB roles in Virginia. The location of the proposed intervention could be statewide, but it might also be just in Eastern Virginia to start.

Intervention: Bay Aging, a very high functioning Area Agency on Aging, won a CMMI HCIA award and saved Medicare > $20m over 3 years with a home-visiting version of the Coleman care transitions model. They taught this method to other AAAs across Virginia and secured state funding to do it statewide (VAAA Cares) since the HCIA funding ended.

Range of Stakeholders Engaged: Major hospitals participated in the meeting, as did the CEOs of the three major health plans (Anthem, Optima (a plan of a major hospital system), and Aetna), after one on one conversations with Len and VCHI. The plans agreed to consider the business case, and Bay Area agreed to provide some detailed cost data. We wrote a memo and provided a business case template they both can use to assess these data and the essential “make or buy, and if buy, buy alone or collaboratively” decision each plan has to make. Bay Aging, like the plans, had to devote maximum energy dealing with COVID-19, so they have not been able to provide the plans the requisite data to go with our memo yet.

Credible vendors: Bay Area/VAAACares is a very credible vendor of in-home care transitions management.

Data management capacity: All the stakeholders and vendors are sophisticated data users and understand the BAAs necessary for VCHI to perform its essential functions, with our TA.

Local philanthropy: Numerous Virginia foundations are well known to VCHI and if the plans are willing to go forward, securing a local funding partner will likely not be a major problem.

COVID-19 INTERRUPTIONS

Soon after the Eastern Virginia site visit on March 2, George Mason University shut down all research-related travel, and shortly thereafter most of the nation adopted social distancing to the extent possible. By then health and social service providers had already turned to preparation and execution of protocols for delivering their essential services to vulnerable patients and clients under duress due to the increasingly severe pandemic. These organizations were simply not able to continue regular CAPGI planning meetings with coalitions and working groups. Consequently, we turned our last scheduled site visits into “virtual” visits with catalysts plus coalition members who could attend the virtual meeting or follow up later. In most cases, we were able to gather much of the same information we did from physical site visits, but without the personal contact or one-on-one meetings that would make follow-up questions and deeper dives easier. In all cases below, we report on what we were able to learn and note that many showed the same levels of continued interest in the CAPGI concept, despite the lack of in-person presentations.

1. **Milwaukee**

Trusted Broker: Milwaukee Health Care Partnership, a 501c3 coalition of safety net providers and local government, with jointly funded staff, is the natural convener if not TB, and they led local discussions in fall and winter about CAPGI applications in Milwaukee. However, before COVID-19 hit, they asked to postpone our scheduled site visit in mid-March “because their board did not want the Partnership alone” to be the “sponsor” of our visit. They thought they could easily find a co-sponsor, but that did not occur quickly. I connected the CAPGI lead there to Ben Miladin in Cleveland’s United Way, and he spoke with his Milwaukee counterpart, but by then COVID had arrived and so no virtual visit ever took place.

Intervention: according to the CCC, either food or housing; they wanted our help to decide.

Range of Stakeholders Engaged: Good, some local MCO participate in partnership working groups.

Credible vendors: yes.

Data management capacity: with TA, seemed likely to be adequate.

Local philanthropy: engagement indicated in the CCC.

1. **Hartford**

Trusted Broker: Wellville has an outpost there, and that organization plus the local United Way seems well positioned to play the TB roles.

Intervention: Connecticut Childrens’ Medical Center (CCMC) has published RCTs of a parent-mentoring program that achieved net savings through reduced childhood asthma exacerbations. They want to add components like an electronic monitoring device and home assessment/improvements also targeted at childhood asthma. They have developed NIH and PCORI proposals to add these components, for which CAPGI would be a complement or sustainability mechanism.

Range of Stakeholders Engaged: CCMC, their affiliated pediatric group, their clinically integrated network (ACO), the dominant commercial insurer (Anthem), and the state Medicaid office are all involved in discussions with the United Way/Wellville, and we shared our business case template with them as well. Discussion and modifications are ongoing.

Credible vendors: Were identified by CCMC already.

Data management capacity: Very sophisticated AMC, health plan, state Medicaid office. with TA United Way could be the TB manager.

Local philanthropy: Good relations between the United Way and local philanthropies, which have long focused on North Hartford, the target area of this intervention.

1. **Grand Junction**

Trusted Broker: Either the local, very high functioning HIE, Quality Health Network, or the highly respected local health department could be the TB.

Intervention: They offered 3 and might be willing to do them all if sufficient TA funding could be secured. The most completely developed is case management for socially isolated older adults, extended to section 8 housing from a similar program currently in place in public housing units. Case manager teams would come from local housing authority and MA health plan. #2 is family coaches to support single mothers to prevent child maltreatment. #3 is housing stability through pet friendly rental housing, through risk mitigation for landlords.

Range of Stakeholders Engaged: excellent, including dominant local health plan.

Credible vendors: in all cases, interventions would be staffed by employees of local trusted organizations.

Data management capacity: QHN has built a closed-loop referral information system which connects health data with social service data for complex case management and data analytics.

Local philanthropy: Local philanthropy is aware and supportive, but small, so the big question is the commitment of the Colorado Health Foundation, which has funded projects in Grand Junction in the past, and has taken on a SDOH focus in recent years, but has made no commitment to this project to date.

1. **Kansas City**

Trusted Broker: 5 large hospital systems created the 501c3 Managed Services Network, to help them coordinate efforts at reducing readmissions for Medicare patients. They have a pilot underway that is funded by the Blue of KC. The MSN, which operates within a very high functioning Area Agency on Aging, and under the auspices of the Mid America Regional Council (with local CEO membership), would be the TB. This was one of the first sites to express interest in our model when the paper came out.

Intervention: expand the scope of the readmission reduction pilot to more patients. It is focused on assessing and addressing the upstream needs of patients with CHF, COPD and other respiratory conditions.

Range of Stakeholders Engaged: Very good. The local Blue is paying for the pilot. Data from that could help recruit other payers to the effort, but the Blue alone, along with the hospitals, may suffice.

Credible vendors: The local AAA employs the nurses and social workers who do the work.

Data management capacity: Very savvy local organizations will have shared exactly the types of data necessary for the CAPGI project in the pilot.

Local philanthropy: engagement indicated in the CCC.

1. **Spokane**

Trusted Broker: Better Health Together, the backbone of the CMMI AHC, is well positioned to be the TB in Spokane.

Intervention: Permanent supportive housing for the chronically homeless. They have a pilot underway for 50 clients, funded by state Dept. of Commerce. Pilot will end July 2021. They want CAPGI to be ready to expand it by then.

Range of Stakeholders Engaged: very good. They have been meeting with plans, hospitals, housing folks, law enforcement, etc. They are now using our business case templates.

Credible vendors: Pilot underway already, so yes.

Data management capacity: BHT has savvy data folks pilot will deliver all data types we would need.

Local philanthropy: They are engaged with BHT, have been for 3 years.