**CAPGI Progress Report** Collaborative Approach to Public Good Investments

[**https://capgi.**](https://capgi.)**urban.org August 2020**

We are pleased to report on the status of our Collaborative Approach to Public Good Investments (CAPGI) in Social Determinants of Health (SDoH). Our June 2019-May 2020 Feasibility Study is completed and both a full report {insert link} and a summary that was published as a *Health Affairs* blog post on August 13, 2020 describes how we assessed the readiness of the 10 communities which participated in our study, and what SDoH investment they are each focused on.

Covid-19 appropriately diverted the focus of health and social service provider organizations in the spring of 2020, and thereby slowed our progress everywhere, but on July 29th, the **Cleveland** coalition voted to move into implementation of a medically tailored meals program targeted at dually eligible older adults who are food insecure, socially isolated, and dealing with at least one common chronic condition (e.g., diabetes, hypertension, etc) who can benefit from careful nutritious choices. Our team is supporting them with a goal of January 1, 2020 implementation. The United Way of Greater Cleveland (UWGC) is serving as the trusted broker, and Ben Miladin, LISW-S, Director of Health, is the catalyst who has provided the requisite local leadership there. UWGC is also the backbone organization of CMMI’s Accountable Community for Health in Cleveland, wherein Ben plays a convening and leadership role as well.

Other sites are in various stages of re-focusing after the Covid-19 hiatus, and of course the pandemic is not over, but they all remain committed to trying to move toward implementation in the next 6-18 months. We are providing technical assistance to all our sites’ efforts with the support of a consortium of three of our original funders, the Episcopal Health Foundation, the Missouri Foundation for Health, and the Commonwealth Fund. Moving roughly west to east, like the prevailing winds, we briefly update each community’s status.

**Spokane**, Washington, led by Alison Poulson of [Better Health Together](http://www.betterhealthtogether.org/bhh) which will serve as trusted broker and is also a CMMI Accountable Community for Health (ACH) backbone, has a pilot project underway providing permanent supportive housing (PSH) to 50 residents. The pilot is financed by a contract from the Washington State Department of Commerce, which will end in July 2021. Alison’s original idea was to use CAPGI as a device to expand the scope and sustainably finance PSH in Spokane after the pilot is over. We have shared our business case templates (link) with Alison’s team, and they are using them in discussions with local stakeholders there, as the pilot progresses.

**Grand Junction**, Colorado, a place familiar to students of collaboration in US health care, is focused on providing supportive services to socially isolated older adults in voucher-supported housing. Either their long-standing and innovative health information exchange, the [Quality Health Network](https://qualityhealthnetwork.org/), or the highly respected [Mesa County Health Department](https://health.mesacounty.us/), will serve as the trusted broker. The QHN has spearheaded the construction of a closed-loop referral system called the [Community Resource Network](https://communityresourcenet.org/), which enables health and social service members of a patient-client’s care team to collaborate and improve lives more quickly and efficiently, through a real time patient record the patient-client can access from a mobile phone. Rocky Mountain HMO, now a part of United Health Care and the backbone of the CMMI ACH in Grand Junction, is also deeply involved. We have helped Grand Junction with considerations for intervention design and are ready to engage stakeholders with business case discussions when they are.

**Waco**, Texas has determined one of its major challenges is inappropriate arrests or policy-accompanied trips to hospital emergency departments by people who need behavioral health care more than incarceration or hospital care. [Prosper Waco](https://prosperwaco.org/) , a non-profit broad-based civic organization, led by a former mayor, is the trusted broker here, and the effort is being led by Suzii Paynter and Tiffiney Grey. A range of working groups is designing an intervention involving transportation and a range of behavioral health services to get people in crisis what they need quicker and more efficiently and safer for all concerned. We continue to support them as needed on data management and business case fronts.

**Kansas City**, Missouri-Kansas, has been focused on readmission reduction for years. Five major hospital systems partnered with a non-profit, the [Managed Services Network](https://www.marc.org/Community/Aging/Programs-and-Services/Managed-Services-Network-%28MSN%29.html) (MSN), to facilitate cooperation in readmission reduction efforts among other services, under the auspices of the [Mid-America Regional Council](https://www.marc.org/About-MARC/General-Information/What-is-MARC), and intergovernmental planning entity, which also houses the local area agency on aging, the [Department of Aging and Adult Services](https://www.marc.org/Community/Aging). The MSN has designed a pilot project to reduce readmissions associated with CHF, COPD, and other respiratory conditions. James Stowe, Director of Aging Services, is the leader of the effort and the MARC or the MSN will serve as the trusted broker within the CAPGI framework. We are just starting to engage stakeholders there.

**Springfield,** Missouri, has long been dedicated to making sure all children get a good start at life chances, having been a pioneer in the [Parents as Teachers](https://www.sps.org/ParentsAsTeachers) movement. Today, with Clay Goddard, Director of the excellent [Springfield-Greene County Health Department](https://www.springfieldmo.gov/2853/Health) playing a leading role, they have come to focus on birth to age two and are very close to deciding to implement [Family Connects](https://familyconnects.org/family-connects-model/), a well-tested program that improves new parents’ capacities to manage and teach infants and toddlers to help them stay healthy and ready for pre-school. As do Waco, Grand Junction and Anne Arundel County Maryland, Springfield nurtures an elaborate interconnected set of advisory groups that bring civic, philanthropic, business, government, health care, public health and community perspectives to bear on almost every initiative and make health and social service collaboration seem easier and natural. In September Family Connects will complete a feasibility study that will inform the final intervention design, and then we’ll be ready to engage with local stakeholders.

The **District of Columbia** effort is spearheaded by Kara Blankner, executive director of the Jane Bancroft Robinson Foundation (JBRF) which is dedicated to reducing racial disparities in breast cancer mortality. The trusted broker roles here will be shared among the JBRF which will convene community members and stakeholders, [Quantified Ventures](https://www.quantifiedventures.com/), which will handle the bidding and set prices, the [DC Primary Care Association](http://www.dcpca.org/) (an umbrella non-profit data analytics shop for local FQHCs) will manage data flows and, the [Institute for Public Health Innovation](https://www.institutephi.org/), which will manage the contracts with the vendors. JBRF is leading a city-wide effort to rethink and redesign breast cancer navigation in DC and one outcome of that process, scheduled to be completed in November, will be the specific upstream intervention the group wants to implement and test. This fall we will re-engage with local stakeholders including the major hospital systems with cancer treatment centers, breast cancer-focused FQHCs, and local health plans.

**Anne Arundel County** Maryland has a similar primary problem definition as Waco, and they already have a smaller scale version of a model they hope to expand using CAPGI: crisis response teams which pair specially trained policemen with social workers as a unit to respond, and de-escalate behavioral crises if possible, to avoid arrests and long waits in ERs for psychiatric consults, and get people to the behavioral health services they need directly and in real time. Anne Arundel, like every county in Maryland, has a Local Management Board, in their case its called the [Partnership for Children, Youth, and Families](https://www.aacounty.org/boards-and-commissions/partnership-for-children-youth-families/) which serves as an uber-convener for multi-sector collaboration on many fronts. The Partnership, under the leadership of Pam Brown, will function as the trusted broker with the strong and multi-dimensional support of the County Executive, Steuart Pittman. We remain ready to engage stakeholders there when they are. Maryland presents a uniquely interesting set of stakeholder incentives for an intervention that will likely reduce acute health care utilization (and law enforcement activity), since mental health is carved out of Medicaid MCOs and hospitals are on a global budget.

**Eastern Virginia** is home (in Urbanna) to an outstanding area agency on aging, [Bay Aging](https://bayaging.org/), which showed its mettle in reducing readmissions with a home visiting program by winning an Health Care Innovation Award from CMMI and then saving Medicare over $20 million (by the evaluator’s reckoning) on a small number of patients. The [Virginia Center for Health Innovation](https://www.vahealthinnovation.org/) would be the trusted broker if enough health plans agree they would be better off on net collaborating using CAPGI and contracting with Bay Aging than doing what they are doing now on their own (typically using RNs to call patients post-discharge). In early August we wrote a detailed memo to frame a set of factual questions to help them make that determination, which only the plans can do with their own data. We all agreed when we met this is a classic “make or buy” decision. We await their decisions to engage further.

**Hartford Connecticut** has a number of collaborative assets: (1) Gina Federico is an effective Director of the [North Hartford Triple Aim Collaborative](https://www.wellville.net/north-hartford-wellville-community/), which is a major project of the United Way of Central and Northeastern Connecticut; (2) the Triple Aim Collaborative is partially funded by [Wellville](https://www.wellville.net/wellville-5/), the five site experiment in fostering local collaborations, which enables Rick Brush to help make health and social sector collaboration a success in Hartford; (3) Connecticut Children’s Medical Center, a leading children’s hospital with extensive research experience specifically focused on asthma management and abatement; (4) a history of focusing on child well- being, from their CMMI State Innovation Model grant to current Medicaid payment policies. The United Way would be the trusted broker, and the intervention the collaborative is planning involves CCMC teaching parents how to better manage their children’s asthma to improve health and lower costs. We have reviewed business case templates with stakeholders there and expect to hear back from them soon about next steps.