



## **Integrator Role and Functions in Population Health Improvement Initiatives**

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*Prepared by Nemours with input from national and community health experts, health providers, health plans and other partners*

The Affordable Care Act has spurred thinking and action about new approaches to the way we deliver and pay for health care, particularly within Medicare, Medicaid and the Children's Health Insurance Program (CHIP). Achieving the Three-Part Aim - better quality of care, better health for populations, and lower costs – has become a critical area of focus for reform. One approach to meeting the Three-Part Aim is to work to improve population health in a geographic area through seeding and funding integrators. Integrators work at a population-level, with health care, public health and other community partners, to promote prevention, improve health and well-being, improve quality and reduce health care costs, in a sustainable fashion.

### *Integrator Role in Population Health Improvement Initiatives*

An integrator is an entity that serves a convening role and works intentionally and systemically across various sectors to achieve improvements in health and well-being. The integrator role is not one-size-fits-all, but rather must be flexible to adapt in response to the needs of the community or population it serves.

An integrator may target a particular sub-population, or organize around a particular disease or condition. For example, an integrator may focus on a sub-population of children to integrate key developmental aspects that address long-term needs and promote a child's healthy development. This would require a long-term outlook and particular attention to the early years. Other integrators might focus on another phase in the life-course or a different disease or condition.

Integrators, or a system of integrators, may take various forms, depending on what resources currently exist in a given community and the strengths and needs of that community. An integrator need not perform all of the functions listed below at once and may not perform them in the order in which they are listed. Rather, over time the integrator may perform some, most or all of these functions either directly or by coordinating with other partners or integrators. Additionally, certain functions may be dominant in certain contexts and/or during certain times.

Any given community may have one or more integrators. In complex systems, it is unlikely that there will be a single integrator or that a single integrator will have enough specific ecosystem knowledge to truly be effective. There could be a system where local, natural communities are motivated to achieve Three-Part Aim related health goals and take on managing the resources available to them in some global, integrated manner, and where the larger systems they are part of have the same aim, impulse, and shared strategic vision. In these cases, there may be a system of nested integrators or multiple integrators that are focused on creating self-sustaining but interrelated local systems, where the capacity and impetus for integration is embedded in all

parts and levels of the system. This type of “bottom up” / top enabled approach engages communities, encourages the creativity of those who have firsthand knowledge of what is needed and what assets are available, and helps address community needs for entire populations in a geographic region.

A wide array of organizations could assume the integrator role, depending upon the goals of the initiative, the context of the community and its leadership, and the capabilities and resources of various stakeholders. Over time, there may be an evolution in the entity or entities serving the integrator role in an initiative. Ultimately, a successful integrator or system of integrators benefits the community or population by making the whole macro-system transparent to those who pay for it and those who use it, and by catalyzing and facilitating the integrated systems-work necessary to address the upstream social determinants of health.

### *System Level Functions in Population Health Improvement Initiatives*

#### **Leadership and Partner Engagement**

- 1. Engage partners from multiple sectors and/or connect with other integrators to achieve the Three-Part Aim, with an emphasis on integrating services and mobilizing interventions to address upstream determinants of health.** At a minimum, the health care and public health sectors, including mental/behavioral health, are engaged, as are other sectors such as child care, schools, business, and other community-based organizations.
- 2. Serve as a trusted leader in the community that accepts accountability for and strategically drives the integration functions.**
- 3. Facilitate agreement among multi-sector stakeholders on shared goals and metrics to improve the health outcomes of a population in a geographic area.** To fill this function, the integrator must be skilled at consensus-building over time in order to prioritize among competing issues and ensure continued long-term commitment to shared goals among partners.
- 4. Assess the community resources, including workforce capabilities, that are available to reach shared goal(s); determine what gaps need to be filled and what duplication needs to be reduced; and work with partners to make appropriate adjustments.** The integrator can either perform this assessment directly or facilitate a system whereby this function is performed by others.
  - a. Gather information on current programs, services and supports in the community.
  - b. Work to reconcile responsibility for population health using available resources and other strategies, such as making connections between community stakeholders. Negotiate responsibilities and modifications to current programs where overlap, duplication or gaps exist and expand programs or add new

programs where needed. These efforts lead to a more integrated, seamless system of care and supports that is easier to navigate and better serves the population.

- c. Collaborate with junior colleges and universities/colleges, vocational programs, local high schools, or other institutes to provide training for skills and new roles needed for local integration, such as navigators (described below) or local health teams to realize the aims of the integrated efforts.

### **Spread, Scale and Sustainability**

- 5. Work at the systems level to make policy and practice changes in both the public and private sectors that impact populations and/or support partners or connect with other integrators in making these changes to scale up what works so that the entire population can benefit.** This role is different from directly providing services and supports, which is usually a role filled by various partners in an initiative. In some cases, however, an integrator may house and/or support discreet services.
- 6. Serve as a source for spreading what works at both the policy/systems level and at the practice level to reach sufficient scale.**
  - a. Promote innovation by helping the organizations in different systems make connections they didn't see when working in their traditional silos. Using various modes of communication, an integrator often disseminates evidence and best practices to the various partners or other integrators working in an initiative and actively enhances and spreads this knowledge so the shared outcome(s) can be achieved.
  - b. Take responsibility for ensuring that system improvement and active learning are happening in all aspects of the system.
  - c. Get the evidence-based policy and practice changes to the right institution or individual and increase the breadth of the policy or practice change to reach a larger population.
  - d. Provide training and technical assistance to ease implementation. When appropriate and feasible, integrators often create learning collaboratives to disseminate and continuously improve training resources.
- 7. Sustain change by impacting policies and practices in collaboration with institutions and community partners at the local, community and state levels.** For change to be sustained, new infrastructure may be needed or existing infrastructure and governance may need to evolve to reduce reliance on specific leaders or administrations. For example, stronger regulations, enhanced training, and new payment or funding streams are all methods for scaling and sustaining what works over the long term.

**8. Pursue financial sustainability via various methods, including leveraging existing and new sources of funding, developing innovative uses of current sources, and testing payment reforms that promote value and incentivize disease prevention and healthy development.**

- a. Investigate opportunities to employ multiple funding streams (e.g., Medicaid, public health and population health promotion programs, such as Community Transformation Grants, and others) to demonstrate how strategies such as connecting and utilizing different funding streams targeted to one purpose, program or initiative, reallocating, or pooling funding streams can advance the Three-Part Aim and assist in diffusing what works.
- b. Develop innovative financing and payment systems to optimize population health and contain costs.
- c. Explore points of leverage such as community benefit, civic goals and/or cross-sector savings.

**Continuous Learning and Improvement to Promote Population-Level Solutions**

**9. Gather, analyze, monitor, integrate and learn from data at the individual and population level. Apply this knowledge to improve care and the patient experience at the individual level, improve systems at the population level, evaluate progress, and ensure that resources are targeted most efficiently, based on actual needs of communities and groups of patients.**

- a. Aggregate individual level data from multi-sector service providers and population data from community, state and national sources.
- b. Establish a repository of information for the population-based prevention initiatives.
- c. Conduct environmental scans, surveys or community needs assessments to systematically determine and evaluate the needs of groups of patients or types of communities (e.g. rural community without much access to public transportation vs. urban community in an industrialized area) to inform resource allocation within an initiative.
- d. Provide data to the multi-sector partners or integrators in an initiative to support continuous learning and improvement and help chart the course toward achieving their shared health outcome goal(s). Create a dashboard to highlight data on improvement goals and intervention outcomes.
- e. Integrate and share accessible data across the systems serving the population, bridging the gaps that often result when work occurs in traditional silos.

- f. Collaborate with local research organizations to provide ongoing evaluation of efforts.

**10. Identify and connect with system navigators (those roles intended to help individuals coordinate, access and manage multiple services and supports) so the integrator can harvest and aggregate data from individual cases and use the data to promote population-level solutions.** The connection between families and services often happens via those serving a case management function (navigator, case manager, care coordinator, social worker, educator, community health worker, and/or community health team) who can identify issues, accomplishments and challenges that families have in common and assist patients and families in navigating the health care system, managing chronic disease, adhering to treatment, and connecting to relevant community and population-based services. These system navigators have access to and can provide additional data about the individual experience of care. The integrator applies this knowledge, by working with navigators either directly or through a partner organization, to improve policies and practices where people, live, learn, work, play, and worship.

**11. Develop a system of ongoing and intentional communication and feedback at multiple levels including with affected sectors, systems and communities.**

*Examples of Integrators*

Some examples of integrators might include:

<ul style="list-style-type: none"> <li>• Group or staff model HMOs (Kaiser Permanente, Group Health of Puget Sound)</li> </ul>	<ul style="list-style-type: none"> <li>• Community clinic</li> </ul>	<ul style="list-style-type: none"> <li>• Integrated health system (e.g., Nemours, Geisinger)</li> </ul>
<ul style="list-style-type: none"> <li>• Public Trusts (e.g., the Children’s Board of Hillsborough and Tampa Counties)</li> </ul>	<ul style="list-style-type: none"> <li>• Hospital district</li> </ul>	<ul style="list-style-type: none"> <li>• Accountable Care Organization</li> </ul>
<ul style="list-style-type: none"> <li>• Other quasi –governmental agencies (Public benefit organization, etc.)</li> </ul>	<ul style="list-style-type: none"> <li>• Public Health Department</li> </ul>	<ul style="list-style-type: none"> <li>• Community-based non-profit (including faith-based)</li> </ul>
<ul style="list-style-type: none"> <li>• Coalition</li> </ul>	<ul style="list-style-type: none"> <li>• University</li> </ul>	<ul style="list-style-type: none"> <li>• Independent/free-standing institute</li> </ul>

