Full Report

Comprehensive, Collaborative Health Systems Planning and Implementation in New Mexico:
Two Case Studies

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Cover Photograph

Hands Across America in New Mexico, circa 1986, by Joseph Sohm

I. Introduction

Since the establishment of Comprehensive Health Planning Agencies in 1966, community health planning has focused primarily on giving community members a voice in planning, delivering, and evaluating health-care services. However, emerging awareness of the influence of social, economic, physical, and political environments on health has prompted many communities to broaden their planning lens beyond health-care delivery systems.

Social Determinants of Health and Community Health Planning

Since the 1990s, health experts have increasingly recognized that health-care services cannot operate in a vacuum but must be linked to the environments in which people live, work, play, worship, learn, and recreate. Good health is not a matter of luck, but a direct result of the circumstances in which people are born, grow, age, and die. In turn, these environments and circumstances are shaped by broader systems and forces.

Recognition of the importance of social determinants of health has led to a fundamental rethinking of how communities plan for and develop effective health systems. Community health planning crosses not only disciplines but sectors, bringing to the table people with knowledge about the built environment, transportation, information systems, social services, food systems, housing, education, and more.

Thus, while health-care delivery systems remain critical components of community health, improving these systems is inadequate to create significant improvements in individual and community health. Effective community health planning has become a combination of community organizing, public health, clinical care, and social services. In other words, to be effective, community health planning must be *comprehensive*, *collaborative*, and *cross-sectoral*.

This model differs significantly from planning efforts that focused solely on coordinating or integrating clinical systems. We call this type of health planning "comprehensive, collaborative community health planning" (CCCHP). In this context the term "health" is used broadly to include physical, behavioral, oral, and environmental health, as well as various social determinants of health.

Changing Health Planning Environment

Increased awareness of the influence of social determinants of health is reflected in significant changes in policy, funding, practice, and regulation. In turn, these changes have affected how local communities in New Mexico plan for and implement interventions that support community health. These changes provide both opportunity and incentives for greater collaboration in health

planning to leverage resources, avoid duplication of effort, address community need, to improve health outcomes and to lower health care costs.

Needs Assessments

National and state standards require that community health needs assessments be used as the foundation for health planning. By analyzing a community's health needs, including clinical, social, and environmental, health planners can identify populations unable to obtain adequate services, elements impacting access to services, and gaps in the community's ability to meet local health needs. A needs assessment can lay the groundwork for implementing local solutions.

The state budget for health councils was cut entirely, from $2.8 million per year to zero; funding of $178,000 was allocated in fiscal year 2018.

Major health system players are required by law to address community health. For example:

- Since 2011, the Public Health Accreditation Board has required that public health departments conduct community health needs assessments every five years as part of the accreditation process.
- Federally Qualified Health Centers (FQHCs), along with affiliated organizations and Health Center Program look-alikes, are required to conduct a needs assessment at least once every three years.
- The Patient Protection and Affordable Care Act of 2010 (ACA) requires that nonprofit hospitals perform and report the results of a community health needs assessment conducted within the current or prior two tax years.

Needs assessments are also required by the state of New Mexico for health planning. Since 1991, community health needs assessments have been carried out by New Mexico's 33 county and six tribal health councils, which were established under the New Mexico Maternal and Child Care Health Plan Act. Councils are charged with developing maternal and child health plans that include needs assessments.

In 2010, the state budget for health councils was cut entirely, from $2.8 million per year to zero; funding of $178,000 was allocated in fiscal year 2018. However, most counties have not conducted community health needs assessments since 2015 and have little or no capacity to identify and address health priorities.[1]

1. As of March 6, 2019, legislation had been proposed in the New Mexico Senate to include $1 million in the 2020 fiscal year budget to support the work of county and tribal health councils.

Thus, three major health-care players are required by regulation to conduct community needs assessments, with minimal resources allocated to meeting this requirement. Almost all counties in New Mexico have at least one hospital, FQHC, and a health council, yet it is unclear whether these organizations are working together to complete the required needs assessments.

Accountable Health Communities

Emerging models of health-care delivery are designed to integrate clinical care with the means to assess and address social determinants of health. One of the most promising models, most pertinent to community health planning, is the Accountable Health Communities (AHC) model, which the Centers for Medicaid and Medicare Services (CMS) began testing in 2016.

The AHC model is based on the premise that enhancing clinical-community linkages can improve health outcomes and reduce costs. The AHC model has captured the interest of communities across the nation and in New Mexico about how best to identify individuals who face health-related social needs and connect them to appropriate community services. However, the impact of the AHC model in New Mexico communities is not clear.

New Mexico Healthcare Assistance Program

The passage of the ACA in 2010, which allowed the state to expand Medicaid to all residents making up to 138% of federal poverty level, created an unexpected source of funding for community health planning efforts in New Mexico. The New Mexico Indigent Hospital and County Health Care Act. The Act authorizes counties to pay health-care claims for the medically indigent by dedicating revenue from a second 1/8th increment to the gross receipts tax (GRT). This is an optional tax and all New Mexico counties, except DeBaca, Harding, and Socorro, have created county health-care assistance funds, which are not matched by federal dollars.

Each county makes independent decisions about how to manage their fund, including eligibility and covered services and administration. They commonly cover services that are not Medicaid-reimbursable such as preventive care clinics, detox and sobering centers, and county inmate health care.[2] The County Health Care Act limits how counties can use their health-care assistance funds, including prohibiting them from assisting residents with out-of-pocket costs. Counties are also required to contribute to the County-Supported Medicaid Fund and/or the Safety Net Care Pool. The County-Supported Medicaid Fund is a mandatory program in which counties provide funding to the state to support the state their share of Medicaid expenditures. Nineteen counties, including Santa Fe County, have elected to impose a separate 1/16th GRT increment for this purpose; the other counties transfer the equivalent amount from their existing community indigent fund.[2]

2. Program Evaluation Unit Legislative Finance Committee. Uncompensated care in New Mexico after the affordable care act. October 27, 2015.

Since the implementation of the ACA, the number of insured residents has increased, allowing counties to support both the Safety Net Care Pool (SNCP) and their own assistance programs in different ways than before ACA. This change has allowed counties to use their county health-care assistance funds more creatively.

Orgon Mountains, Doña Ana County, New Mexico

The Project

As new models emerge, the essential elements of successful health planning that addresses health systems and social determinants of health – and, critically, links them together to the benefit of individuals as well as families and communities – remain unclear. Little is known about how communities can engage in comprehensive, cross-sector collaboration that integrates health-care delivery systems with the social, economic, physical, and political environments in which people live.

This study was designed to address this gap in knowledge. We conducted two qualitative, exploratory, longitudinal case studies to address the question: How and why do some New Mexico community collaborative efforts to build a healthy community work better than others?

We sought to understand:

a) How processes, systems, methods and resources work in a way that makes assessment, planning and implementation more or less effective.

b) How and why organizations in different fields or sectors collaborate with one another to meet regulatory requirements and build a healthy community.

c) How and why those means of collaboration prove effective in building a healthy community.

Santa Fe County, New Mexico

II. Conceptual Framework

To address the question of effective health planning, we developed and tested a framework with two New Mexico communities that are engaging in CCCHP. To develop the framework, we first identified and reviewed more than 50 relevant studies and models in health planning, population health, and social determinants of health. Papers in the review included theoretical/conceptual literature and models on multi-sector community coalitions, health system models (including Accountable Health Communities), and community participatory health planning.

Of the models reviewed, we performed thematic comparisons of four widely used, evidence-based models for planning, and four for sustainability. The planning models were Mobilizing

for Action through Planning and Partnerships (MAPP); ReThink Health: The Pathway; Planned Approach To Community Health (PATCH); and PRECEDE/PROCEED. Sustainability models were Program Sustainability Assessment from Washington University in St. Louis; Sustainability Framework from the Georgia Health Policy Center; Collective Impact; and Community Coalition Action Theory, developed by Butterfoss and Kegler (2002).

Core Elements

In our review, we identified six core elements and multiple common practices across models. Appendix A provides matrices of the thematic reviews. These six themes are as follows:

Partnerships/Collaboration/Engagement

All models emphasized the importance of bringing multiple partners to the table, working collaboratively, and engaging community leaders and residents. Research supports the concept that complex social issues are better addressed through collaborative efforts by multiple sectors than by organizations working independently. This is particularly true when communities want to improve population health by focusing on health determinants such as health care, health behaviors and social and physical environments.[3]

Entities such as the World Health Organization and the Centers for Disease Control and Prevention recognize the importance of including community engagement in strategies to build community capacity, promote health and sustain efforts.[4,5] Engaging members of disadvantaged communities in public health initiatives has also been suggested as a way to reduce health inequities. A meta-analysis of 131 studies on this topic found solid evidence that community engagement interventions have a positive impact on a range of health outcomes across various conditions.[6]

Leadership and Capacity

Leadership and capacity were also key themes across models. The sustainability of a collaborative effort or partnership depends not only on the leadership capacity within the local community but also on long-term training and technical assistance that contributes to build

3. David Kindig, George Isham, Population health improvement: a community health business model that engages partners in all sectors. Frontiers of Health Services Management Vol 30 Number 4 Summer 2014.
4. Minkler M. Introduction to Community Organizing and Community Building. Eds Minkler M.: 1-22. Rutgers, the State University of New Jersey. Second edition, 2005.
5. Centers for Disease Control and Prevention. http://www.cdc.gov/od/ocphp/nphpsp/EssentialPHServices.htm (Accessed on February 10, 2019.)
6. O'Mara-Eves, A., Brunton, G., Oliver, S., Kavanagh, J., Jamal, F., & Thomas, J. (2015). The effectiveness of community engagement in public health interventions for disadvantaged groups: a meta-analysis. BMC public health, 15, 129. doi:10.1186/s12889-015-1352-y

capacity of that community.[7] Strong leadership is necessary to ensure that efforts are meaningful and productive. For any collaborative effort to survive over time, leadership should eventually come from the coalition membership. Research on community coalitions show that leadership is the most often reported internal, or organizational, factor that helps a coalition create effective community and system changes.[8,9]

Leadership often stems from an individual person or organization or a group of individuals or organizations who mobilizes community members who share a vision, goal or concern. Butterfoss (2002) suggests that a good convener should possess the following characteristics:

- Strong links to and respect for the local community
- The respect of community organizations and key leaders or at least the perception that the agency is a neutral entity
- A deep understanding of community health issues, priority populations, and local politics
- Belief in collaboration and the patience and confidence to "trust the process" of community engagement and shared decision making
- Adoption within its own walls for positive health practices that support the activities of the coalition
- Ability to serve as an umbrella organization to provide private, not for profit status for the coalition
- "Deep pockets," or at minimum, a reserve of resources to support the basic administrative needs of the coalition
- Staff support through its employment and benefits structure
- Development, media and advocacy capabilities to positively promote the coalition and its work

Collaborative leadership appears more effective at transforming systems than single-leadership approaches. Commonly, collaborative leadership is built through the formation of a smaller committee composed of committed members who bring capacity to the group through their existing skills, knowledge, and influence. This smaller group is referred to as a steering, executive, or advisory committee, and members are oftentimes those who already hold visible leadership positions in the community, such as directors, managers, or elected officials.

Equally important in terms of leadership development are those who represent the authentic voices of the community. These are the community members with lived experience and those on

7. Butterfoss F. Coalitions and Partnerships in Community Health.
8. Roussos and Fawcett (2000)
9. Mizrahi and Rosenthal (2001)

the front lines, who can provide credibility and practicality to proposed strategies, processes, and actions. The literature emphasizes the importance of structuring the work to enable the broadest possible participation, especially for those who are most impacted by the work.[10,11]

Capacity refers to ensuring that leaders and potential leaders have the skills and knowledge to work effectively together, conduct all the management functions (operational, legal, financial, etc.) and advance system change.

Accountability: Strategy/Goals/Action

Collaborative efforts and coalitions are the result of a group of individuals or organizations coming together around a common goal, mission, vision, or issue. All models suggest that a formal mission, vision or purpose statement, developed collectively by partners, is essential to collaborative work. Such a statement allows group members to guide and align subsequent goals, actions, and outcomes. Strategic plans are most successful when accompanied by action or work plans developed to guide the implementation process and used to monitor progress.

Funding

All models discussed the importance of funding sources, processes, and stability. Health system planning, implementation and improvement requires committed resources that can be sustained over time. All models emphasized that funding is necessary not only for programs, but for the work of building and maintaining the collaborative group itself.

Communication

All models and studies emphasized the importance of clear, effective communication. Effective communication helps the group focus on a common mission, increase trust, share resources, understand individual and collective needs of all partners, and avoid and resolve conflict.[12] The quality of interactions is impacted by the frequency and intensity of interactions and benefits that members receive from such interactions. Positive relations among members are

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10. The Rippel Foundation 10 Essential Practices for Transforming Health and Well-Being through Regional Stewardship. ReThink Health. 2019.
11. Clark, N. M., Lachance, L., Doctor, L. J., Gilmore, L., Kelly, C., Krieger, J., Lara, M., Meurer, J., Friedman Milanovich, A., Nicholas, E., Rosenthal, M., Stoll, S. C., … Wilkin, M. (2010). Policy and system change and community coalitions: outcomes from allies against asthma. American journal of public health, 100(5), 904-12.

Lara, M., Cabana, M. D., Houle, C. R., Krieger, J. W., Lachance, L. L., Meurer, J. R., … Vega, I. (2006). Improving Quality of Care and Promoting Health Care System Change: The Role of Community-Based Coalitions. Health Promotion Practice, 7(2_suppl), 87S-95S. https://doi.org/10.1177/1524839906287064
12. Butterfoss F., Goodman R., and Wandersman A, Community coalitions for prevention and health promotion Health Education Research Theory and Practice Vol.8 no3 1993.

likely to create stronger group cohesion and a more productive environment or climate. Key features of communication in healthy, effective groups include openness, trust, honesty, and full participation (Butterfoss et al., 1993).

> Communication among members must be shared and accessible among all participants. This communication can take various forms, such as in-person meetings, email, newsletters, reports, access to shared files, and telephone.

In addition, communication beyond coalition members is essential to promoting the value of the work to key stakeholders, policymakers, and the community. Long-term investment and survival depends on community awareness of and support for the project's products, services and value to the community. It also helps build a positive image of the project, which, in turn, helps to recruit members and attract funders. Strategies to inform the public about collaborative efforts include in-person informational sessions, community conversations, special events, reports at public meetings, written reports, social media, websites, newspaper articles, op-eds, and informational materials (e.g. flyers, infographics, etc.).

Data and Evaluation

Almost all models studied emphasized the use of data to guide decision making during health system planning and implementation. Community health needs assessments often form the basis for identifying and prioritizing assets and needs. Data from these assessments are used to establish goals and objectives.

Indicators must be identified to define and measure current conditions and the desired change over time. Indicators may align with regional, state, and federal health initiatives, such as Healthy People 2020. Process data are used to monitor the progress and status of tasks. Data also provide credibility and help demonstrate value to funders, coalition members, and communities.

Most planning models encourage the use of measurable objectives for several reasons. First, it quantifies the desired change over a specified period of time. Typically, quantified measures are included in the goals, objectives, and/or actions described in a work/action plan or project management plan. Process measures are used to determine if the tasks or actions are being completed as planned, whereas outcome measures are used to determine if the project/initiative/intervention is having an effect on the targeted health outcomes.

Work plans are commonly augmented by a separate evaluation plan. Evaluation plans usually include the type of data is being collected (e.g. number of emergency room visits per person over

the previous 12 months); frequency of data collection (weekly, quarterly, annually); who collects the data; and how data are collected (methods such as intake forms, surveys, focus groups, etc.). Logic models are commonly used to identify short-, medium- and long-term outcomes and to help develop the evaluation plan.

Framework

We summarized these findings into a framework consisting of six core elements and actions. Table 1 provides an overview of the resulting conceptual framework.

"It is about the community collaborating in concrete ways to better serve the needs of everyone. Alinement, relationships and structures are hardwired a new way to get needs met. Especially for those who are most vulnerable and kicked out of services. It has ripple effect for all of us and the community. Resolve issues through collaboration, information sharing, and relationships to get better results."
- Anonymous study interviewee

Table 1: Core Elements of Comprehensive, Collaborative Health System Planning and Implementation

Core Element	Actions
Partnerships/ Collaboration/ Engagement	• Establish conditions for diverse stakeholders to work together across traditional boundaries to lead health-system planning, redesign, and high impact system improvements. • Create opportunities for meaningful engagement of the people most impacted and with lived experience. • Engage diverse and committed participants and incorporate practices of meaningful participation, feedback, input, support, and leadership.
Leadership and Capacity	• Incorporate voices of community members in project design and decision-making processes. • Ensure participants have or can develop the skills and knowledge to work effectively together, conduct management functions (operational, legal, financial, etc.), and advance system change.
Accountability: Strategy, Goals and Action	• Anchor work in a shared vision. • Develop strategies, goals, measurable objectives, and actions to guide processes and assure accountability.
Funding	• Gather and sustain adequate funding to anchor the community's capacity for health-system planning, implementation and continuous quality improvement and to sustain the system over time.
Communication	• Develop communication processes to ensure participants can access and receive information about all aspects of the health system, including planning, implementation, outcomes, funding, and capacity. • Centralize communication so stakeholders do not have to check numerous sources for information and can receive timely and meaningful information that is not duplicative.
Data, Measurement and Evaluation	• Provide stakeholders with data, models and tools to help them individually and collectively understand the complexity of the health system, set priorities for action, and measure progress and outcomes over time.

III. Methods

Identification of Case Study Participants

We asked CHI's statewide network of leadership team members to identify communities for inclusion in the study. Five community health planning groups were identified. Interviews and document reviews were used to determine if the community groups could demonstrate collaboration among various community partners and planning efforts that reached beyond clinical care.

Inclusion criteria were:

- Purpose, mission, and goals of the project
- Planning approach, model, and tools
- Population of focus (geographic, income, other)
- Collaboration and history with key participants
- Potential contribution of initiative to public health and health planning practice, research, and/or policy
- Staff time and resources to commit to study (e.g. interviews, meetings with CHI staff, etc.)
- Willingness to share relevant data, tools, and information.

Of the five communities, two met the criteria and were selected for the study.

Data Collection Activities

Data collection activities included site visits, in-person interviews, collection and review of documentation relevant to the project, and observation of network partner meetings. Table 2 provides an overview of data collection methods and how they were applied to specific research questions.

Table 2: Research Questions and Methods

Research Questions	Interviews	Observations	Secondary Data: Location Specific	Secondary Data: Models & Research
How and why do some New Mexico community collaborative efforts to build a healthy community work better than others?	X	X	X	X
How does their process, system, method and available resources work in a way that makes them more or less effective?	X	X	X	X
How and why do organizations in different fields in a community collaborate with one another to build a healthy community?	X	X	X	X
How and why do those means of collaboration prove effective in building a healthy community?	X	X	X	X

Site Visits with in-Person Interviews and Observation

Semi-structured interviews were conducted during site visits and were complemented by observations of partner meetings. The purpose of the interviews and observations was to:

1. Assess the purpose of the initiative from the perspective of its members;
2. Assess the elements motivating individual member engagement;
3. Gain a better understanding of the specific planning and implementation strategies used
4. Gather information about the local environment and processes with specific application to planning and implementation efforts.

In Santa Fe County, CHI observed two Santa Fe County Accountable Health Community (SFCAHC) Advisory Committee meetings in-person and two of the Navigator Network meetings in-person. CHI also conducted separate in-person interviews with two navigators and four Advisory Committee members. The interviewees were selected by the SFCAHC Project Manager. Each meeting observation lasted about two hours each and interviews were about one hour each. On-site observations and interviews with members of the SFCAHC project took place in the city of Santa Fe between September 2018 and January 2019.

In Doña Ana County, CHI staff attended one Advisory Council meeting, one full Wellness Institute meeting, and two Medication Assisted Training (MAT) workgroup meetings. All were held in Las Cruces. The six-member Advisory Council meets once per month and the full Wellness Institute meets twice per month. Interviews and observations took place between

October 2018 and January 2019. The meetings ranged from one to two hours in duration. A CHI staff person also interviewed three Wellness Institute committee members for about one hour each between December 2018 and January 2019.

All individuals interviewed from both the SFCAHC Advisory Committee and the Wellness Institute were asked a standardized set of open-ended questions. Questions were adapted slightly to be more appropriate for the navigator group in Santa Fe County.

Regular Meetings with Coordinators

CHI staff met monthly with the SFAHC Project Manager and the Interim Santa Fe County Health Care Assistance Program Manager between August 2018 and February 2019. The purpose of the meetings was to review the goals, objectives and status of activities for the CHI case study and to gain greater understanding of the SFCAHC project goals, progress, players, barriers and other topics not gleaned from the other sources. Additionally, the SFCAHC Project Manager arranged for CHI to meet with the SFCAHC project evaluators to gain a better understanding of the overall evaluation plan and for the SFCAHC evaluators to have an understanding of the CHI case study. That meeting took place in December 2018.

Regular contact was made between October 2018 and January 2019 with the Wellness Institute's Advisory Council members for the purpose of reviewing the case study goals, objectives and status of activities and to gain greater understanding of the Wellness Institute's goals, progress, players, barriers, and other topics not gleaned from the other sources.

Collection of Documentation

We solicited materials and data produced or directly collected by each site. Materials included:

1. Community health assessments
2. Strategic planning documents
3. Internal reports on planning or implementation activities
4. Tools used to plan, implement or evaluate the initiative
5. Meeting minutes
6. Newsletters
7. Data on process evaluation
8. Informational materials about the initiative targeting others outside of the core stakeholders.
9. Outcomes or annual reports from resulting from the initiative

Each site was asked about existing data on cost and/or outcomes. Since both initiatives are in the development stage, most data collected were process measures or qualitative measures, including survey results from Santa Fe County AHC navigators.

Data Analysis

All qualitative data from CHI in-person interviews, observations, and coordinator meetings were reviewed to identify patterns and themes in relationship to the framework's core elements. Other data provided by each site were reviewed to integrate qualitative or quantitative information from materials into the cases.

IV. Case Studies

Case 1: The Santa Fe County Accountable Health Community (SFCAHC)

The Accountable Health Community of Santa Fe County (SFCAHC) grew out of a combination of several elements, including a positive political climate, financial resources, identified health data-driven priorities, and leadership. The SFCAHC was officially launched in July 2017. Its purpose is to strengthen the network of community service organizations by improving communication, sharing information and resources, and working collaboratively to address the unmet social needs that influence health and well-being of Santa Fe County residents.

Partnerships and Collaboration

The SFCAHC Advisory Committee was convened by Santa Fe County Community Services Department as a partnership between senior leaders from community organizations contracted to provide navigation services, representatives from the Santa Fe County Health Policy and Planning Commission, with additional partners including representatives from the hospitals, community health centers, philanthropy, and other interested members of the community. As of 2018, more than 20 individuals and organizations consistently attended quarterly meetings of the SFCAHC Advisory Committee.

During the first quarter of the SFCAHC project, the Navigator Network consisted primarily of the seven entities contracted by the county to provide navigation services. After the third quarter, the group grew to 12 organizations. Between one and eight navigators per organization attend meetings. The county and navigators would like to open the group to anyone who is interested and can benefit from the SFCAHC project and peer learning opportunities at some point in the future.

The importance of engaging SFCAHC frontline staff and service recipients was articulated numerous times at meetings and during interviews. The Navigator Network is a cornerstone of

the SFCAHC project. At regular monthly meetings the navigators are consulted and provide feedback on core components of the project such as the screening tool, data collection, how emergency flexible funding can or cannot be used, and other issues. During navigator interviews, participants stressed that they felt listened to and that their feedback made a difference in how the program evolved. "The County listens to navigators to get our input about what works and what doesn't," said one navigator.

"The AHC represents a model of inter-agency cooperation, networking and co-learning that goes beyond competition and limited exchange of communication."

Source: Annual reports provided by the original cohort of Santa Fe navigation contractors, quoted in Santa Fe County, Accountable Health Community, FY2018 Data Report

The SFAHC project has taken several steps to engage community members. First, Santa Fe County contracted with a videographer to work on a story telling feature with three individuals who used SFAHC services. Second, the County hired a consultant and community organizer to work with the Advisory Committee and Navigator Network to define what community engagement should look like for the project and the best means to engage community. Both consultants met two times with both the Advisory and Navigator group members. One recommendation that resulted from these efforts is to form a Community Advisory Group to include individuals who received SFCAHC services. Each navigator will recommend one to two candidates to be invited by the SFCAHC Project Manager to submit an application to join the Community Advisory Group, which will be launched sometime in 2019.

Leadership and Capacity

Santa Fe County Government is the lead organization for the SFCAHC project. It provides the primary source of funding and has hired a full-time project manager to lead the project.

Two primary committees form the backbone of the project: 1) a Navigator Network consisting of navigators from each of the contracted organizations and Santa Fe County programs (senior services, housing, detention) that provide coordination and navigation services directly to individuals; and 2) an Advisory Committee consisting of more than 20 individuals representing government, community organizations, health-care service providers, philanthropy, and the public. The Navigators' Network meets monthly and the Advisory Committee meets quarterly. Ad hoc committees address navigation, information and technology (IT), sustainability, and evaluation have also been formed and meet as needed.

A project manager was hired in December 2016 and seven community organizations were contracted to provide the initial navigation services to low income and uninsured residents of Santa Fe County. The project manager handles most day-to-day operations. However, due to the complexity of the project and the financial investment by the County, she consults with individuals up the County's chain of command on legal, financial, strategic, evaluation, and other matters that impact the project. She and other leaders from the County depend on the knowledge and skills of both the Advisory Committee and the Navigation Network members to provide input on design, implementation, and evaluation of the project.

An IT consultant was hired to help to provide an IT assessment and provide technical assistance with IT implementation.

Accountability: Strategy, Goals, and Action

In 2013 the Santa Fe County Health Policy and Planning Commission (HPPC), which serves as the county's health council, partnered with the Community Services Department and CHRISTUS St. Vincent Regional Medical Center to conduct a community health profile. The assessment findings and recommendations were presented to the HPPC commissioners and resulted in the Santa Fe County Health Action Plan 2015-2017.

The group identified six health priorities:

1) Increase enrollment of residents in health insurance
2) Reduce suicides
3) Reduce alcohol abuse
4) Reduce drug abuse
5) Reduce low birth weight
6) Increase consumption of healthy food.

The plan also noted the need to address overarching issues that affect health, including poverty, income disparities, access to care, and the need for greater coordination of services across agencies and between health-care providers and community resources.[13]

To support implementation of the SFCAHC initiative, the Santa Fe County Community Services Department (CSD) contracted with a third party to conduct an analysis of the County's population and needs along with identifying key gaps in existing services available to meet those

13. Santa Fe County Community Services Department and Santa Fe County Health Policy and Planning Commission FY2015-17 Santa Fe County Health Action Plan. April 8, 2014.

needs. One major conclusion from the 2017 *Santa Fe County Health Services Gap Analysis* was:

> … CSD can provide leadership and can work with community providers, funders, and advocates to help set goals, create momentum, and point the way. Providers, along with government entities and advocates, can work to collaborate effectively, maximize resources, and advocate collectively to accomplish commonly agreed upon changes in funding and policy. Together, the County and community players need to agree on the priorities for action. This need for leadership and alignment is the overriding theme from all the input in this project.[14]

With input from navigators, Advisory Committee members and other stakeholders, a vision and goals for the project were developed. The vision is: By 2020, all County residents regardless of income have access to high-quality health care and are linked to the resources they need for health and well-being. The project goals include:

- Residents and providers collectively identify problems and co-create solutions.
- Navigators link residents to resources within a cohesive provider network.
- Social, economic, and physical environmental resources are available to all residents.
- Information systems are coordinated. Data are collected, monitored, and evaluated to improve services and population health while reducing health-care costs.

When the SFCAHC was launched in 2017, a detailed action plan was developed detailing specific milestones, tasks, lead persons responsible, target dates, and status. The plan is reviewed and updated regularly by the Project Manager and County. The action plan identifies benchmarks, and the status of those benchmarks is updated in the SFCAHC Project Management Annual Report prepared by the project manager.

Member input was directly tied to actions, and group leaders sought member feedback to inform the design, implementation, and evaluation of the project. For example:

- During planning for the community engagement component of the AHC, both groups were asked their perceptions about what SFCAHC is or is not, how SFCAHC is accountable to the community, what is community as it relates to the SFCAHC project, who is or is not being engaged, to what end or purpose do we engage community,

14. Hyde & Associates. Leadership and Alignment, Santa Fe County Community Services Department – Health Services Gap Analysis. October 10, 2017.

and how to engage the community. Information from these discussions led to a recommendation to form a community group comprised of individuals who received SFCAHC services.

- During a meeting with project evaluators to discuss how best to measure the project's two main outcomes—decreased time spent in emergency rooms and in the detention center—navigators helped to shape content and delivery of evaluation questions. Based on feedback from the navigators, evaluators changed the question wording to be more appropriate for the clients, clarified the frequency of data collection, added questions to existing screening tools, and tied question results to the navigator quarterly reports.

Strategy and actions also evolved out of on-the-ground experience. For instance, after the SFCAHC project was officially launched in 2017, clients were routinely screened for five factors that can affect health: transportation, food, personal safety, utilities, and housing. Within the first quarter, 83 individuals screened positive for 352 social needs. Although 174 identified needs were addressed during that time period, navigators identified barriers to addressing needs. These needs were prioritized when, at the navigators' request, county officials agreed to dedicate emergency flexible funding to meeting them.

Another main strategy is to build advocacy capacity for the project. To do this, the County hired a consultant who specializes in community organizing and engagement. She facilitated discussions with both the advocacy and navigator group members. As a result of the discussions it is proposed that in 2019 a Community Advisory Committee will be formed, consisting of individuals who received SFCAHC services, and navigators will receive advocacy training.

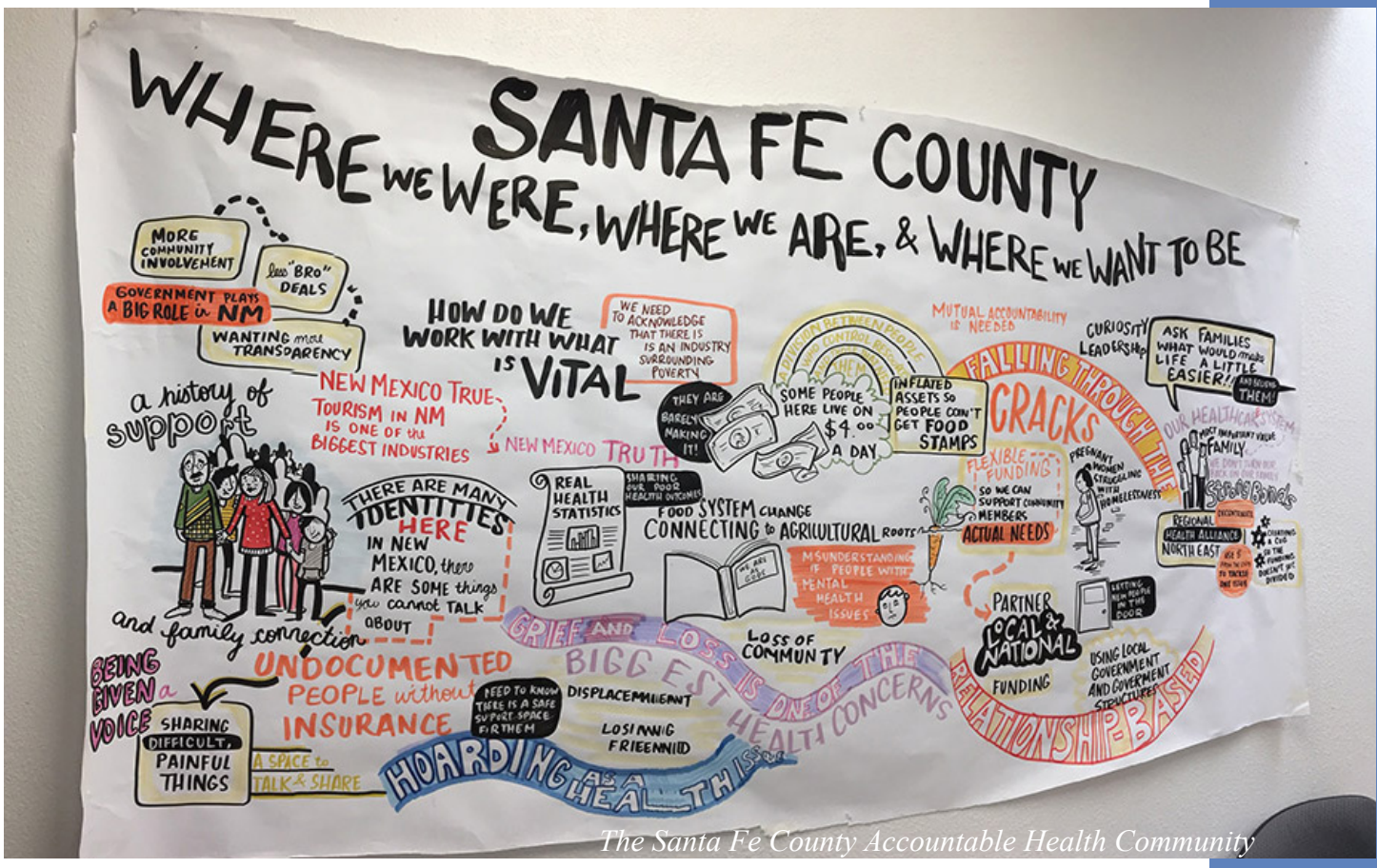
Funding

In February 2016, CMS released a funding opportunity for groups interested in building accountable health communities. The CMS vision, as articulated in the RFP, echoed much of the vision that Santa Fe County and its partners had described in their Health Action Plan. A regional group, of which SF County was a member, applied for CMS funding but the proposal wasn't accepted. However, the vision articulated in the RFP prompted Santa Fe County to develop a three-year plan detailing how the AHC model might be implemented locally and pursued the idea of creating an AHC in the county.

In 2017, this plan was presented to the Santa Fe County Board of County Commissioners, who authorized $3.3 million in surplus indigent funds to implement the plan over a three-year period. In addition, recognition of the need to address non-clinical barriers to health led the county to establish an emergency fund to help navigators pay for one-time emergencies relating to un-met social determinants of health such as the cost of transportation, fees to access legal and identification documents, security deposits for housing, childcare, baby supplies, hygiene

products, and other needs. The County worked with its financial and legal teams to allow a portion of indigent funds to be dedicated to a flexible fund that navigators can use to help clients address these social determinants of health.

Santa Fe County also utilized the state statutory health care exemption, which allows for an exemption to the State Procurement Code for the purposes of "creating a network of health care providers or jointly operating a common health service" that is likely to "reduce health care costs, improve quality of care or improve access to care." (2006 New Mexico Statutes Section 13-1-98.1 Hospital and health care exemption, Section (B)). With a determination that this health care exemption could apply to Santa Fe County's implementation of an Accountable Health Community, they were able to contract directly with community services organizations.



The Santa Fe County Accountable Health Community

As the SFCAHC project evolves, the need and desire to expand navigation and other services is becoming more apparent. Sustainable funding sources that mix local, state, and federal funding for ongoing elements of the SFCAHC will be vital for continuity. Development of sustainable funding mechanisms was identified as a high priority for year two. Thus, the county is exploring options to diversify SFCAHC funding, including how to leverage partner resources, grants, billing insurance for navigation services, and fees for organizations that use the navigation software.

Communication

The SFCAHC Project Manager is the central point of contact for all communication. Both the Navigator and Advisory Committee members know that if there is a question or they need information that she is the person to contact. The Project Manager is responsible for scheduling both the monthly navigator meetings and quarterly Advisory Committee meetings, as well as distributing agendas and materials (including minutes from previous meetings) prior to the meetings. Additionally, she writes and disseminates quarterly newsletters and annual reports to members of both groups and a larger stakeholder group. Newsletters, annual reports and other relevant data, such as the needs and gaps assessment are easily accessible via the SFCAHC project page on the County's website. All other documents are kept on file by the Project Manager and/or the county.

Communication during SFCAHC Advisory and Navigator group meetings was also forthright and open. Participants were invited to provide feedback on diverse issues such as evaluation measures and data collection methods, community engagement, and a shared navigation database.

Discussions were rich and participants were forthcoming about their concerns around these topics. For example, the focus of one Advisory Committee meeting was a demonstration of software that was to be used by all navigators employed by or contracted with the County to document navigation services. Client files could be accessed by other navigators, depending on each navigators' authorized level of access. Several concerns were voiced about preserving patient privacy, especially in cases where the patient has a behavioral health diagnosis. Members also questioned the proposed use of a standard patient consent form allowing information to be shared among all members of the network and voiced concerns about potential duplication of efforts if a provider had its own electronic medical record system. The Project Manager and County staff took careful note of these concerns, and a subcommittee was formed to take a deeper look into the concerns and to provide solutions.

The SFCAHC invested significantly in promoting the SFCAHC project and in community engagement. For instance, SFCAHC is in the process of producing "The Story Telling Project." This project shares the stories of three individuals who have experienced services from the SFCAHC. Print materials, photos and short videos will tell their experiences and connects their stories to the broader message of what SFCAHC is (and is not) and how it can promote change that will benefit all Santa Fe County residents. A name, tagline and messaging have been developed by the story tellers, navigators and a focus group of other people who have been enrolled in the AHC.

Data and Evaluation

SFCAHC members use and track multiple data points, as described in their evaluation plan. For instance, the group has set a clear objective for a reduction in emergency department visits over the three-year project period (2017 to 2020).

In 2013 a *Community Health Profile* was completed, sponsored jointly by the HPPC, Santa Fe County Community Services Department and CHRISTUS St. Vincent Regional Medical Center. The *Profile* identified overarching issues such as poverty, disparities by ethnicity, a growing aging population, an insufficient healthcare workforce, more prevention services and the need for greater coordination of services across agencies. Additionally, the *Profile* identified six high priority health goals for the county for 2015-2017: increased health insurance enrollment; reduced alcohol abuse, drug abuse, low birth rates, and suicides; and increased consumption of healthful food. The overarching issues and health goals were incorporated into the initial SFAHC project plan that was approved by the Board of County Commission and received three years of funding (FY2017-FY2020).

In addition, the County contracted with a third party to conduct a health services gap analysis, which was issued in October 2017.[15] The report covered demographics and population details of Santa Fe County residents; individual health care risks and challenges faced by county residents; and systemic and provider issues impacting access to health services and the well-being of county residents. For the report, an analysis of various local, state, and federal data sources was conducted and additional data was gathered via eight public town halls, 22 key informant interviews, five provider specific focus groups, and a survey of local service providers.

The report's conclusion further justified the SFCAHC project: "Creating a broad-based level of community, political, financial, and policy support for identified health priorities will help to create additional funding and activities to meet these needs. Working together, providing leadership, and aligning efforts and services will help to make Santa Fe County residents healthier and the community a safe and healthy place to live." The recommendations from the health system gaps analysis also helped to inform the project logic model and strategic plan and strengthen stakeholder buy-in.

The SFCAHC logic model was used to develop action plans and to establish quantitative and qualitative measures for the project. Various process measures were identified, and reporting tools and methods were developed and deployed.

15. Hyde & Associates, Leadership and Alignment: Santa Fe County Community Services Department – Health Services Gap Analysis. October 17, 2017.

The Project Manager is responsible for data collection, analysis and reporting. She produces an annual data report that includes measures such as the number of individuals served, number and type of social determinants identified and addressed, amount and purpose of flexible emergency funds used, number and type of navigator trainings, etc. Qualitative data are also included in the reports, including descriptions of progress made on various planning, implementation, evaluation or capacity building objectives, along with storytelling about how certain individuals benefited from the SFCAHC project.

The County is contracting with a third party to conduct an evaluation of SFCAHC outcomes with a focus on reductions in jail time and emergency room visits. Finally, with input from the Advisory Committee and Navigator Network, the County is purchasing a web-based software platform to track navigation services. The software will be used to track screening results for social determinants of health and all services provided by network members to address those issues, along with referrals to organizations outside of the network. These data will be used to target areas for quality improvement and utilization management.

Case 2: The Wellness Institute of Doña Ana County

In 2013, the director of the Southern New Mexico Family Residency Program sat down to brainstorm about coordinating patient care with the director of La Clinica de Familia, a federally qualified health center serving Las Cruces and southern Doña Ana County. That brainstorming session would eventually lead to a meeting of Doña Ana County residents involved in health-care – practitioners, directors, and others who wanted to streamline health-care delivery systems. The group initially focused on fixing the links in health-care delivery systems, changing policies and processes so that patients would receive a continuum of care. But as they worked together, they realized that to truly improve health and health care in the county, they had to embed that care in the community itself. They realized that they were not seeking health, but wellness for all Doña Ana County residents.

In this way, the Doña Ana Health Collaborative evolved over time to become the Wellness Institute of Doña Ana County. The group took on the role of county health council in 2017. The Wellness Institute continues to work to streamline referral processes, reduce duplication of services, align financial incentives to encourage high-value health care, and fill gaps in service. It has also taken on the challenge of addressing social needs, not only for individuals in a way that is integrated into clinical care, but at a population level.

Partnerships and Engagement

Membership in the Wellness Institute is open, and participants represent a variety of sectors including health-care providers, county government, payers, public health professionals,

researchers, educators, and others. Most members are managers or directors within their organizations, although an increasing number of front-line workers and student interns began to attend meetings in 2018. Attendance at the Wellness Institute's bi-monthly meetings varies from 10 to more than 30 people; the majority of attendees are from the City of Las Cruces.

Recycled roadrunner overlooks Las Cruces. Photo credit Marisol Diaz

Membership in the Wellness Institute has developed organically over time. One member described it this way: "The Wellness Institute has never recruited members, *per se*. People and organizations hear through word of mouth. There's no pressure to recruit membership. Everyone comes and is accountable for their own engagement and participation. There are eight people from founding organizations who rotate in and out who take on core, shared leadership – the Wellness Advisors. This has led to a strong, trusting relationship with each other, which has been helpful in getting things done."

While attendance at twice-monthly meetings varies, a core group of participants serve as Wellness Advisors and include the Doña Ana County Health and Human Services Department, the Southern New Mexico Family Residency Program, La Clinica de Familia Health Center, New Mexico State University, the Community Foundation of Southern New Mexico, the Southwest Center for Health Innovation, and Western Sky Community Care (a Medicaid MCO).

Leadership and Capacity

The Wellness Institute uses a shared leadership approach and its initiatives take place through various organizations that contribute staff time, cash, or in-kind resources at different levels over time. In 2018, it formed an Advisory Council to set strategic direction and goals. The Advisory Council is comprised of six people in leadership positions within county government, health-care institutions, higher education, and philanthropy.

The Wellness Institute depends on the combined knowledge and skills of Advisory Council leaders to move identified goals and objectives forward and calls upon its membership to contribute as needed. Management functions are shared among Advisory Council members.

Wellness Institute projects and programs are generally carried out by work groups, with appropriate member organizations taking the lead on each project.

Accountability: Strategy, Goals, and Actions

Since the inception of the Wellness Institute in 2013, members have recognized the need for structure and planning. Soon after the group began meeting (then as the Doña Ana County Health Collaborative), they engaged a consultant to examine models of other community health collaboratives and make recommendations regarding a future structure. Subsequently, through a careful collaborative process, the group developed a working mission statement and identified elements from several models that they wanted to implement.

In December 2015, 20 members of the Wellness Institute convened for a full-day strategic planning session. They developed the following vision, mission, and goals:

- Vision: Improve the health of Doña Ana County by creating a central collaborative where major stakeholders in the health care community innovatively work together to decrease waste and redundancy and synergize activities based on data obtained and disseminated to academic and community outlets.
- Mission: The collaborative is an innovative community-centered model for health care delivery that integrates social, behavioral, and physical approaches to care.

Strategic Goals: By 2019, the Wellness Institute will:

1. Create a sustainable infrastructure for the work of the Wellness Institute: The Institute will establish an autonomous, well-recognized, and sustainable organization to carry out its mission.

2. Train and support a new generation of health and healthcare professionals:

    2.1. Doña Ana County healthcare professionals and educators will develop a new culture that revolutionizes the teaching of the health-care workforce with a focus on prevention and wellness through integrated practices.

    2.2. Doña Ana County will become recognized as an innovator and leader in interprofessional education for all health-related professions.

3. Bring providers, payers, researchers, government and community organizations together to develop community-wide approaches to health care.

    3.1. The Institute will lead in establishing coordinated systems of care that involve all sectors of the community.

    3.2. Priority areas are health literacy, behavioral health, and diabetes.

In 2017, the Wellness Institute and partner organizations held a Health in All Policies training followed by the Live Well Summit (cohosted by the City of Las Cruces). The Health in All Policies model remains a fundamental philosophy for the Institute; however, specific goals for adoption of the approach have not been set.

In 2019, the Wellness Institute will focus on establishing structure, building community capacity to administer Medication Assisted Treatment (MAT), and bringing together groups across the county that are working to address the opioid crisis. In addition, it will continue to support the development of the New Mexico Primary Care Training Consortium to train primary care and psychiatry residents.

Communication

A council coordinator acts as the central point of contact for all communication. She schedules both the monthly Advisory Council meetings and full Wellness Institute meetings, documents the decisions/actions during the meetings, follows up after meetings as needed, and coordinates events hosted by the Institute.

Meetings are not publicized, and participation is generally through word of mouth. However, the Wellness Institute is currently developing an annual State of Health report, which will be used to introduce community leaders from across sectors—including elected representatives, schools, higher education, and the business community—to the influence they have on health through their community leadership roles.

Funding

Wellness Institute activities are funded through a combination of leveraged and shared resources by core partners. The City of Las Cruces collaborated with the Wellness Institute to leverage funding and resources and co-sponsored the Live Well Summit in 2016. The Wellness Institute serves as the county health council and uses the dedicated $4,000 per year for capacity building. It invested in developing an organizational plan in 2018; in 2019, it is working to develop a State of Health in Doña Ana County report.

Las Cruces, New Mexico

Doña Ana County government donates staff time of the council coordinator. La Clinica de Familia, a community health center with clinics located throughout the county, provides meeting space. By leveraging member resources, the Wellness Institute has built its infrastructure and programs with little direct financial support beyond health council funding. Contributions to the work have come from the Paso del Norte Health Foundation, the Domenici Institute at New Mexico University, and other member and non-member organizations. The Community Foundation of Southern New Mexico began acting as fiscal agent for the Institute in 2018, and the group is currently assessing potential funding opportunities.

Data and Evaluation

The Wellness Institute uses a combination of data from multiple sources, including the county medical indigent program, detention center, and other local organizations. The Wellness Institute also has primary data from the local ambulance company, hospital emergency departments, and some utilization data from La Clinica de Familia (a community health center) community health needs assessment. The New Mexico Indicator Based Information System (IBIS) is an important resource for county-level data on morbidity, mortality, and other indicators.

In addition, Wellness Institute members collect and share data from their collaborative programs, including *Nuestra Vida*, a community-wide diabetes prevention and management program and *Stepping Up*, an initiative to reduce incarceration of people who are living with mental illness. Clinical data are supplemented by information about social needs, including food insecurity, violence in the home, transportation, and legal issues.

Managed care organizations are important providers of data for the Wellness Institute. Originally, Molina was a member and regularly shared system use data; currently, another MCO, Western Sky Community Care, is analyzing and sharing data. This information has helped members and member organizations identify what type of services community members in Doña Ana County access and where they access those services. It has also provided a set of standard quality measures that can be used for comparative analyses.

V. Comprehensive, Collaborative Community Health Planning: Does the Framework Hold?

This paper provides two illustrative case studies of comprehensive, community-based health planning in New Mexico communities. It assesses the elements that contribute to positive community collaboration and identifies ways that these two communities have successfully built their capacity to impact population health outcomes. We used these case studies to test and update the framework we developed based on a review of related research.

Partnerships, Collaboration, and Engagement

Our findings confirmed the importance of committed, engaged partners who work collaboratively toward a shared mission and vision and support and guide the work. Coalition members at both sites include representatives from county government, major health-care providers such as hospitals and community health centers, community foundations, and various community organizations that serve the populations of interest (people who are low income, high utilizers, uninsured, homeless, etc.).

County governments are a major player for both the SFCAHC and Wellness Institute. The Community Services Department at Santa Fe County is leading the SFCAHC work, and the Director of Health and Human Services Department of Doña Ana County is a major contributor to the Wellness Institute efforts. Our findings suggest that support and leadership of county government is essential for successful CCCHP. Informed elected and appointed officials helped, in part, to prioritize cash and in-kind resources, and leadership capacity was evident.

For SFCAHC, the early involvement of the Health Policy and Planning Commission and the Santa Fe County Commissioners was critical to garnering support and funding. In Doña Ana County, Wellness Institute members involved elected officials in a training about how local government can influence the health system, which contributed to their support for the Live Well Summit in 2016. The City of Las Cruces and Doña Ana County worked together to leverage city and county dollars and produced a background report in 2016.

Both cases demonstrated the influence that local government can have on both planning and implementation of community health initiatives. Elected and government officials should be included in planning efforts as early as possible. They should be given information about the impact of health systems on community well-being, the influence of social determinants on health, and models of community health planning.

"What is required is a coordinated effort across determinants between the public and private sectors, as well as financial resources and incentives to make it work."

Source: Kindig DA. A Pay-for-Population Health Performance System. JAMA. 2006;296(21):2611–2613. doi:10.1001/jama.296.21.2611

Both sites began their planning efforts with strategic partners. For the SFCAHC project, initial members of the Advisory Committee and Navigator Network came from organizations contracted to provide navigation services. Membership for both groups expanded over time to include other organizations from the community that support the project mission. The Wellness Institute has a core group of dedicated regular members and others who attend more sporadically.

Health-care delivery systems remain essential partners in community health planning, however, the engagement of prominent health-care organizations in the counties has been challenging. Both initiatives have strong support from the federally qualified health centers/community health centers that serve each county. In Doña Ana County, only one of two community health centers is actively engaged. The second one was invited but has not participated.

"What impressed me the most is right from the beginning I knew it was going to be different.

We had all the players in one room communicating together…[it was a] whole new dynamic. Everyone was more engaged, more ownership, and more committed. We are a team with shared accountability."

- Anonymous study interviewee

Santa Fe County's long-time hospital has been only marginally involved in the SFCAHC project. The county's newest hospital, which opened in the fall of 2018, has shown sustained interest by sending a representative to attend Advisory Committee meetings and ad hoc committees when time permits, and hosted a navigation meeting in December 2018 at the new hospital site to introduce hospital care coordinators to navigators. Likewise, in Doña Ana County one hospital (Memorial Medical Center) has participated sporadically, while the other (Mountain View Regional Medical Center) has not participated at all.

The difficulty engaging health systems suggests that traditional health-care delivery systems may resist the comprehensive, collaborative, cross-sectoral planning that is required to address social determinants of health, despite regulatory and community pressures to do so. This suggests that activities to support partnership and engagement should include educating clinicians and health-care administrators in the CCCHP model.

Geographic barriers also creates barriers to participation and were not addressed in the original framework. Although both initiatives are county-wide, few representatives regularly attend the coalition meetings from outside the county seats of Santa Fe and Las Cruces.

Representation from municipal governments is mixed. SFCAHC involvement by the City of Santa Fe has been limited but is likely to change since the former SFCAHC Health Care Assistance Program Manager has taken a position with the City of Santa Fe's Health and Human Services department.

Most of the SFCAHC Advisory Committee and the Wellness Institute members are managers or directors within their organizations. This can be advantageous when trying to address system and policy issues that need the support and approval of senior management to move efforts forward.

However, it is equally important to have input from frontline staff and service recipients to better understand what is working and what is not working and to receive that information in a timely manner throughout the planning, implementation, and evaluation phases of the project.

"Developing regional stewardship often follows a crooked path. Sometimes, there may be big boosts in momentum, as progress occurs in some areas faster than others. Leaders may also slip back into old routines, and then must either rededicate and recalibrate their work or risk falling off the path completely. Every step presents opportunities to galvanize movement into the next phase."

Source: Rethink Health: A Pathway for Transforming Health and Well-Being through Regional Stewardship. The Rippel Foundation, 2019.

Participants at both sites acknowledge the importance of community engagement. However, who "community" is and the end goal for engaging community is oftentimes not defined during the planning and implementation process. The SFCAHC project is consciously addressing these questions with input from the advisory and navigator group members. Ultimately, they hope to have support from all community residents and are working on a strategic communications plan to target specific groups with appropriate messaging. In contrast, the Wellness Institute is focusing on reaching out to community leaders and decision makers, including elected officials and business, philanthropic, health care, and education leaders.

Leadership & Capacity

Leadership was approached differently in each case study but was perceived as critical in both initiatives. Wellness Institute membership is comprised mostly of people with strategic and management experience, while the SFCAHC has developed structures to train and give voice to navigators and community members. These findings support the inclusion of leadership and capacity as essential elements of the framework for successful CCCHP.

> *"Yes, it's [the project is] worthwhile. It is different in that although you have high level players there is effort to bring voice of front line and clients. Not superimposing strategies on a broken system. They image an ideal system and bring in administration to make it work. Reimagining, creativity and responsiveness that I don't' see in other systems."*
>
> *- Anonymous study interviewee*

The SFCAHC project is under the leadership of the County and staffed by a full-time project manager. This position allows for efficient communication and resources to attend to multiple strategies being implemented simultaneously. The Wellness Institute shares leadership responsibilities among dedicated Advisory Council members, making it critical that Advisory Council members have the capacity necessary to carry out the Wellness Institute's overall vision as well as each of the unique projects and strategies. The goals and objectives of the Wellness Institute have been rolled out more slowly with a focus on one primary activity at a time.

In both cases, community capacity building was significant. The SFCAHC project invested in improving the system and individual capacity of the navigators. Each month the navigators met to learn through outside resources and their peers about resources and tools to help them assist their clients in addressing social determinants of health—especially those areas included in the screening tool (housing, food, personal safety, transportation, and utilities).

The Wellness Coalition focuses on building the capacity of local providers and improving access to services. Areas of focus include diabetes and mental health and/or substance use disorders. In addition to the *Nuestra Vida* diabetes prevention, education, and management program, it is investing resources to build local capacity to improve access to and the quality of Medication Assisted Treatment (MAT), opioid prevention and harm reduction projects, and has led the creation of a *Stepping Up* jail diversion and treatment program.

Neither location requires a formal commitment to be included as "a member" of the initiative, such as a Memorandum of Understanding or Coalition Involvement Agreement; nor do they operate under formal bylaws or decision-making guidelines. However, the SFCAHC project currently uses a more formal approach for decision making than does the Wellness Institute.

Accountability: Strategy, Goals, and Action

Both SFCAHC and Wellness Institute members established a shared vision, mission, and values early in the organization's development. Each group defined project goals and objectives, as well as the strategies to achieve them.

- SFCAHC has adopted structured planning and implementation processes, in line with significant public funding and government accountability for the project.
- The Wellness Institute, as an independent, unincorporated coalition, has adopted a dynamic approach to meeting its goals and priorities. Each project is part of a broader effort to create community resilience and simultaneously addresses stated goals and builds community capacity to support wellness holistically. With the establishment of the Wellness Institute's Advisory Council, the group began to set strategic direction more clearly; however, a commitment to create dynamic responses to community needs remains inherent in the group's structure and approach.

Funding

Each site had different, but successful approaches to funding. As with any health system change, funding resources can significantly impact the timing and success of work. The use of indigent funds by Santa Fe County stands an example of creative use of an existing resource. This source of funding is currently recurring, and about half of New Mexico counties reported surplus indigent funds. The use of indigent funds by the County for the flexible emergency spending account also showed creativity and collaboration. Several navigators and advisory group members mentioned the emergency flexible fund as a cost effective and impactful way to assist clients with social determinants of health so they can address basic needs and refocus their attention to addressing their health issues.

The Wellness Institute, on the other hand, shares and leverages resources from both public and private sources to support targeted goals and activities. This approach has helped to build a sense of ownership from partner organizations, as they are investing not only time and expertise but dollars. Additional funding will be required, however, for the group to undertake tasks that require additional capacity.

Communication

In both cases, a single point of contact is responsible for internal communications about meeting logistics, information, and other activities. However, the SFCAHC has engaged in open communication with the general public, widely publicizing its services and activities.

Santa Fe, New Mexico

The Wellness Institute has had limited public communication, relying mostly on word of mouth or events such as a Health in All Policies workshop and the Wellness Summit. Communication efforts focus on community decision makers. An initial "state of health in Doña Ana County" report will be disseminated to the community in late April 2019; business and community leaders will be invited to the unveiling of the report. Wellness Institute meetings tend to be technical in nature, often focusing on potential uses of value-based payment models, best practices in interventions for specific conditions, coordination between health-care systems, training of health-care and public health professionals, and concerns.

Data, Measurement, and Evaluation

Both initiatives use data from multiple sources, including member organizations, and have established core measures of success. Process, short-term, and long-term indicators are incorporated into planning document.

Of particular interest in this case study was how community health assessments were conducted or used. We found little to no collaboration among entities required to conduct community health needs assessments. In general, community needs assessments previously generated by health-care organizations were not a major source of information for health system planning.

In 2012, Santa Fe County hospital and health council did collaborate to conduct a community health needs assessment. However, in 2019 one of the local hospitals is scheduled to perform a required two-year community health needs assessment and has not communicated about the assessment with the SFCAHC project. Likewise, in Doña Ana County, the Wellness Institute has not communicated about any plans to collaborate with the nonprofit hospitals or two local community health centers on upcoming community needs assessments.

VI. Updating the CCCHP Framework

Our findings in these two case studies support the six elements of the initial CCCHP framework. However, the lived experiences of these two communities with different needs, resources, and people suggest additional activities and considerations for use of the framework.

We caution that we conducted only two case studies, both in areas with relatively large populations in comparison to the remainder of New Mexico. Our findings may not be applicable to rural and frontier areas or populations with other characteristics. Because both CCCHP projects were in relatively early stages of implementation, we were not able to document health outcomes. Further empirical research is needed to test and further develop the framework.

Despite these limitations, our examination of two CCCHP initiatives allows us to propose that our CCCHP framework can provide a useful guide for community health planners.

Table 3 shows the updated framework. Additional activities and considerations are shown in italics.

Comprehensive Collaborative Health Planning Framework

Core Element	Description
Partnerships, Collaboration, and Engagement	• Establish conditions for diverse stakeholders to work together across traditional boundaries to lead health-system planning, redesign, and high impact system improvements. • Create opportunities for meaningful engagement of the people most impacted and with lived experience. • Engage diverse and committed participants and incorporate practices of meaningful participation, feedback, input, support, and leadership. • *Involve county government* • *Recognize and address geographic challenges to full community participation* • *Take specific steps to build community engagement* • *Be patient.*
Leadership and Capacity	• Incorporate voices of community members in project design and decision-making processes. • Ensure participants have or can develop the skills and knowledge to work effectively together, conduct management functions (operational, legal, financial, etc.), and advance system change. • *Build community capacity by providing information and training to elected officials and other community leaders who are not members of the coalition.*
Accountability: Strategy, Goals, and Action	• Anchor work in a shared vision. • Develop strategies, goals, measurable objectives, and actions to guide processes and assure accountability. • *Create mechanisms to respond to changing community needs.*
Funding	• Gather and sustain adequate funding to anchor the community's capacity for health-system planning, implementation and continuous quality improvement and to sustain the system over time. • *Use creative strategies to leverage existing funding and other resources, including donated staff time.*
Communication	• Develop communication processes to ensure participants can access and receive information about all aspects of the health system, including planning, implementation, outcomes, funding, and capacity. • Centralize communication so stakeholders do not have to check numerous sources for information and can receive timely and meaningful information that is not duplicative. • *Develop plans and mechanisms for communication with the community at large, including elected officials and business leaders.*
Data, Measurement, and Evaluation	• Provide stakeholders with data, models and tools to help them individually and collectively understand the complexity and interactions of the health system, set priorities for action, and measure progress and outcomes over time. • *Share resources to meet regulatory requirements for data, such as community health needs assessments.*