

# Build Effective, Actionable Partnerships Between Public Health and Healthcare Systems

SUPPORTING COMMUNITIES AND LOCAL PUBLIC HEALTH DEPARTMENTS DURING COVID-19 AND BEYOND —  
A ROADMAP FOR EQUITABLE AND TRANSFORMATIVE CHANGE



**Public Health Alliance**<sup>™</sup>  
OF SOUTHERN CALIFORNIA

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This document is one section of the [Supporting Communities and Local Public Health Departments During COVID-19 and Beyond - A Roadmap for Equitable and Transformative Change](#) report drafted by the Public Health Alliance of Southern California that includes policy, program, and resource recommendations to ensure that local public health departments are adequately prepared to support communities most vulnerable to the health and socioeconomic impacts of COVID-19 as well as future public health emergencies.



## RECOMMENDATIONS

- ▶ Build and Support Stronger Partnerships Between Healthcare, Public Health, and Communities
- ▶ Develop a Unified, Bidirectional Statewide Health Information Exchange
- ▶ Establish Effective, Efficient, Ethical, and Equitable Data Sharing Agreements
- ▶ Embed Equity into Healthcare System Emergency Response Structures
- ▶ Assess and Address Healthcare System Vulnerabilities for Future Emergencies
- ▶ Improve Oversight and Resilience of Long-Term Care Facilities
- ▶ Support and Expand Opportunities for Telehealth and Telemedicine
- ▶ Incentivize Pay for Value-Based Care versus Volume
- ▶ Leverage Resources Made Available through Medicaid Demonstration Waivers to Advance Health Equity
- ▶ Establish Collaboratively Funded Investment Mechanisms to Advance Equity and Prevention
- ▶ Ensure Existing Healthcare Funding Streams Include Investments in Prevention and Local Public Health Departments



## OVERVIEW

The COVID-19 emergency has necessitated rapid changes across the healthcare sector to meet the needs of patients and communities. The healthcare system, including health plans, hospitals, and clinics, quickly responded to address emerging needs, from mailed prescriptions and telemedicine appointments, to COVID-19 testing and distributing Personal Protective Equipment (PPE), to food distribution and providing internet access. Given the complex and evolving nature of the pandemic, with far-reaching impacts from acute disease incidence to sweeping economic and social impacts, this crisis required coordinated action across California's health system in the broadest sense, including local public health departments (LHDs), health plans, clinics, and more. This crisis made it abundantly clear that the siloed nature of healthcare and public health systems hindered the COVID-19 response and undermined shared goals of reducing health disparities and advancing health equity. In regions where healthcare, public health, and community partners had established relationships, all sectors were able to more effectively and equitably meet the needs of patients, providers, and communities. The COVID-19 emergency sharply elevated the urgency for an integrated, efficient, and coordinated continuum of care between public health and the healthcare system.

While the healthcare system pivoted quickly to support patients, providers, and communities throughout the crisis, it is clear that rapid and meaningful structural changes are needed to ensure the health system is equipped to elevate health equity and protect and support the health of residents, especially those most impacted by inequities. The healthcare system is poised to make lasting changes in data processes and infrastructure, provision of care to the most impacted communities, equity in emergency response operations, and coordinated oversight of ancillary healthcare facilities.

Furthermore, the stark inequities of the COVID-19 emergency, when combined with the clear disparities based on community conditions and structural racism, have contributed to a growing awareness and motivation within the healthcare system to engage in upstream social determinants of health policy, systems, and environmental work. Healthcare leaders described the rapid increase in social needs (e.g. food and housing support) among their patients and were surprised to learn how thin a financial and social margin many of their patients were living on. It is important to note that social needs and social determinants of health are fundamentally different and require drastically different strategies. Social needs are midstream factors such as a family's need for access to healthy food, which may be addressed by a regular food distribution program, while social determinants of

health are structural, systemic, and political factors, like lack of grocery stores in certain neighborhoods, and income inequality. The healthcare system has often been engaged in and supportive of social needs, but has generally not participated in upstream social determinants of health work. The COVID-19 pandemic however can be the catalyst for a shift. The expanded understanding and motivation to engage in the root causes of poor health outcomes and inequities will require meaningful, resourced partnership with the communities served by healthcare systems and public health partners. Hospitals and healthcare facilities have often functioned as anchor institutions in under-resourced communities, and now the healthcare system has an opportunity to further engage with, uplift, and be held accountable by their communities.

### SOCIAL DETERMINANTS AND SOCIAL NEEDS

**Figure 1.** Social Determinants and Social Needs

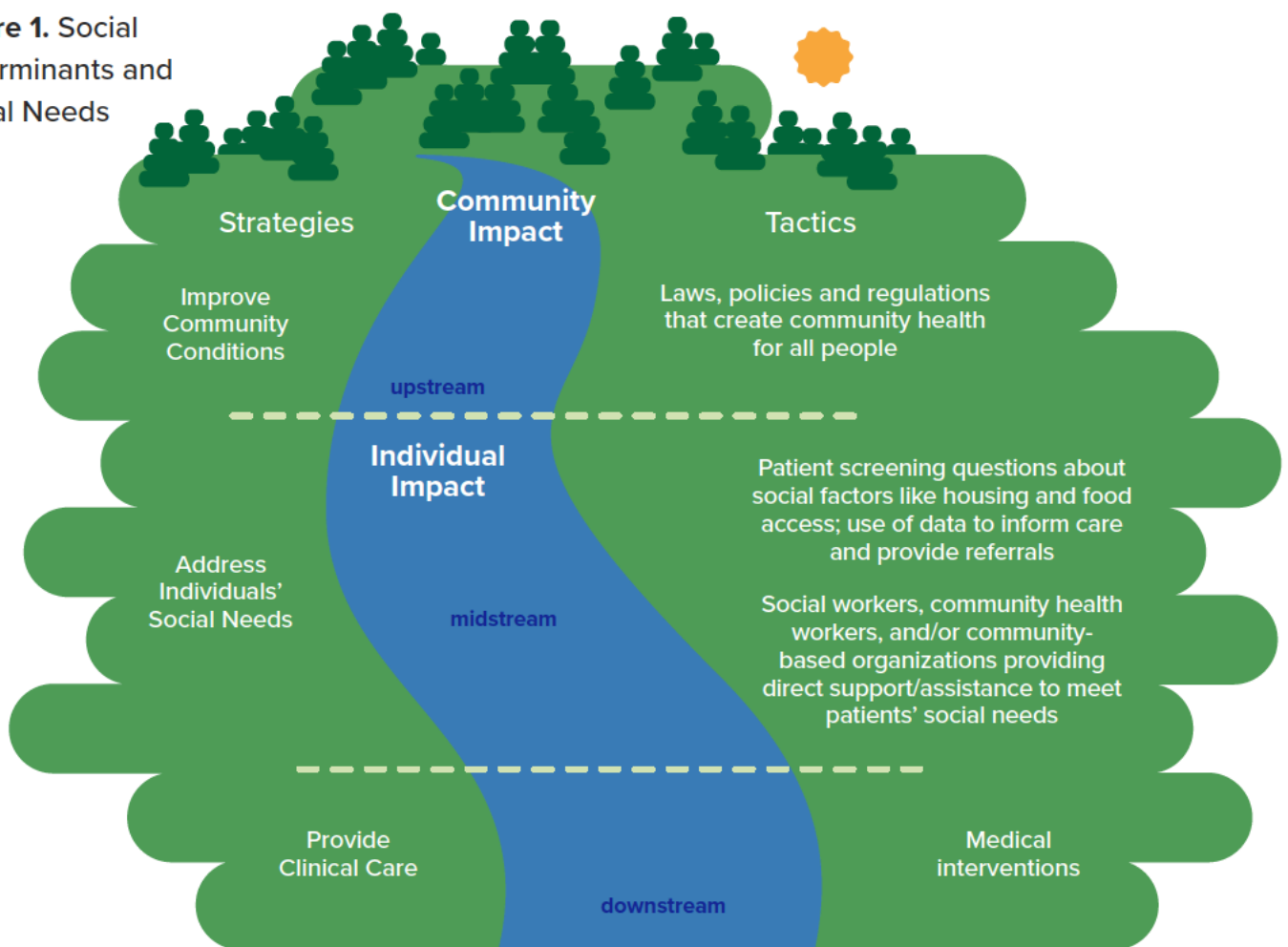


Figure adapted from <https://www.healthaffairs.org>

## CHALLENGES

1. Overall lack of coordination and communication between the public health and healthcare systems
2. Difficulties making organizational and operational changes to reflect different local public health orders
3. Challenges collecting, sharing, and using data between healthcare systems and public health
4. Inability to capture inequities using global, aggregated data analysis
5. Dramatic increase in social needs rapidly followed “stay at home” orders and business closures
6. Limited ability to address root causes of COVID-19 disproportionate impacts
7. COVID-19 revealed the serious vulnerability of long-term care facilities
8. Healthcare system is more prepared for short-term than long-term emergencies
9. Negative financial impact on the healthcare system

### 1. Overall lack of coordination and communication between public health and healthcare Systems

Despite the dire need for a joint response, healthcare and public health leaders described challenges in coordinating and routinely communicating across sectors. Some healthcare leaders noted that they made efforts to engage with their respective LHDs, but due to the intensity of the response activities and public health’s limited staff capacity, they were often unable to coordinate. Healthcare leaders noted that due to high staff turnover both within the state and local public health departments, it was often unclear what the chain of command was and who was leading specific response activities. There was a similar challenge in identifying which local agencies were responsible for which activities and programs within a jurisdiction. It was often difficult for the healthcare sector to determine which local agency they should contact and coordinate with for specific needs, such as contact tracing or food

*“Coordinating the response would have been easier with stronger relationships with CDPH, we need to know where the conversations are happening, who is engaging where, and what is the chain of command” Healthcare interviewee*

distribution. One healthcare leader noted that “there were unclear channels, no one knew who was doing what, the City, the Sheriff’s Department, the County Health Department, Department of Health and Human Services...” Additionally, some healthcare leaders described that their clinic members were left out of important conversations regarding testing and vaccine allocation planning, while many of the local hospitals were continuously engaged. Among healthcare sector interviewees, there was general consensus that while some LHDs effectively communicated and coordinated, overall there was a lack of coordination that would have enabled a more effective and equitable response.



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## *Best Practices*

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Despite the challenges outlined above, according to healthcare leaders, the COVID-19 response strengthened relationships between LHDs and the healthcare system overall. Furthermore, healthcare systems with established relationships with LHDs and community-serving organizations were better positioned to support a coordinated response.

### **ESTABLISHED COMMUNICATION AND COORDINATION**

Early on in the COVID-19 emergency the **L.A. Care Health Plan** established a standing weekly meeting (eventually shifted to monthly) with the **Los Angeles County Department of Public Health** and **HealthNet** to facilitate regular communication and coordination between public health and the two health plans representing 30% of the LA County population. This early and ongoing coordination enabled effective collaboration to manage COVID-19 outbreaks in LA County skilled-nursing facilities, and with early vaccination strategy planning. Similarly, the **Inland Empire Health Plan** (IEHP) worked closely with San Bernardino and Riverside Health Departments to coordinate messaging and response. For example, IEHP collaborated with both LHDs to develop all of the COVID-19 related scripting for their nurse advice line to minimize contradictions and provide consistent messaging to the community. The **California Primary Care Association** described how a standing relationship with CDPH, through a grant and contract in place pre-COVID, helped facilitate communication, coordination, and an understanding of the protocols put in place to manage the pandemic.

### **CROSS-JURISDICTION COORDINATION**

Health plans and regional trade associations that provided coverage or representation across multiple counties and jurisdictions were able to help facilitate the sharing of best practices between LHDs. IEHP helped facilitate information sharing and collaboration in the Inland Empire region to coordinate COVID-19 response strategies. For example, IEHP was able to share information and facilitate dialogue between San Bernardino and Riverside Counties regarding Riverside County’s response to COVID-19 outbreaks in skilled nursing facilities. Ultimately, San Bernardino County enacted the same strategy as Riverside; partnering with the federal government to deploy the CDC strike team.

## 2. Difficulties making organizational and operational changes to reflect different local public health orders

Among healthcare systems and plans that provide coverage or services across multiple jurisdictions, interviewees described the ongoing challenge of making organizational and operational changes to reflect the different health orders in effect in different jurisdictions. Healthcare leaders described differing guidance related to testing and vaccine allocation as a major challenge, in some cases hindering their ability to respond as efficiently or effectively as they would have under uniform guidance. Others also described challenges understanding and coordinating guidance from different state-level agencies. Lack of uniformity in state and local level COVID-19 related guidance limited the healthcare systems ability to enact streamlined, uniform policies and practices across their networks and facilities.



### *Best Practices*

Throughout the COVID-19 response, regional trade organizations, professional associations, and other coalitions served a critical role in shaping coordinated responses across the healthcare system, including health plans, hospitals and clinics. They include the California Primary Care Association (CPCA), which represents more than 1,380 not-for-profit community health centers, and Regional Clinic Associations, including the Community Clinic Association of Los Angeles County (CCALAC). Representatives from both organizations described strategies to provide support, bi-directional communication, and joint advocacy to support providers and patients. CPCA described rapid advocacy for telemedicine coverage as the most critical policy to supporting the needs of patients and providers during the COVID-19 emergency; within three days of the statewide shelter in place order, there was approval for telehealth. Additionally, CPCA quickly shifted the technical assistance they provided to their members, including holding weekly information sessions on medical and policy related topics. Similarly, CCALAC began regularly convening their peer network, including Chief Medical Officers and Behavioral Health Leads, to facilitate bi-directional communication and coordinated response efforts. CCALAC acted as a conduit between state partners, including the CPCA and CDPH, and their clinic members. CCALAC provided templates, best practices, and compliance policies and procedures from the top down, and feedback and local needs from the bottom up. (For information on public health coordination see **“Ensure Greater Coordination, Collaboration, and Consideration of Equity Impacts When Issuing Health Orders and Guidance”**).

### 3. Challenges collecting, sharing, and using data between healthcare systems and public health

Throughout the COVID-19 emergency the healthcare system has described challenges collecting, sharing, and using data to coordinate with public health agencies at the local, state, and federal levels. The overarching challenges were the lack of consistency in indicators and data, as well as inadequate data and reporting infrastructure. There was not a set list of indicators collected by the healthcare and public health system, or an efficient way to transmit this information between collaborating entities. With limited cooperation, each LHD sets its own preferred format for, and method of receiving, reports. As a result, hospital systems were being required to produce multiple versions of the same report and transmit them in multiple ways, including via fax, secure email, or secure file transfer protocol (SFTP). Many healthcare leaders shared that they had inadequate access to data and that voluntary sharing protocols left a lot of gaps in necessary information. For example, LA Care Health Plan shared that they had inadequate access to death data, while the CPCA noted that primary care providers were unable to obtain COVID-19 testing data from [OPTUM](#), which [partnered with the State to expand COVID-19 testing capacity](#). Others described being able to get better and more consistent data from clinical laboratories like LabCorp and Quest than LHDs. One county echoed this from the perspective of the LHD, noting that “providers are to the point where they can export a lot of info from their EHRs [electronic health records], but LHDs have no way to get it into CalREDIE in a timely way.” As a statewide healthcare system, [Kaiser Permanente \(KP\)](#), described how inconsistent reporting requirements across counties, made it very difficult to efficiently share data across counties, both within the KP network and with LHDs.

### *Best Practices*

In Spring and early-Summer 2020, KP worked with the Public Health Alliance of Southern California to better understand gaps and barriers in data sharing between healthcare systems, health plans, and LHDs. The Public Health Alliance facilitated conversations between KP and LHD epidemiologists, and followed up via individual and small group interviews with LHD data staff. These discussions yielded valuable insights into the challenges introduced through inter-system data sharing, and identified opportunities for improvement.

### 4. Unable to capture inequities using global, aggregated data analysis

Disaggregating data is one of the best approaches to identifying health disparities. Failing to stratify data can hide inequities in COVID-19 health impacts. When data are not disaggregated by race/ethnicity, sexual orientation/gender identity (SOGI), and other demographics, healthcare and public health systems are unable to respond with targeted outreach and education, programs, and resources, further exacerbating inequities among disproportionately impacted communities. Some healthcare systems acknowledged that they do not typically analyze data disaggregated by race/ethnicity and other demographics, which would identify health inequities, but rather look at global outcomes. Another healthcare system reported that their response could have been more impactful if they had received and been able to act upon disaggregated data earlier on in the pandemic. As discussed in greater detail in the “Catalyze Transformative Shifts in Utilizing Data” chapter, LHDs on the receiving end of data reported by hospitals and healthcare



systems, frequently reported that important demographic characteristics, like race/ethnicity, were left blank or filled in with “other” or “unknown”. This suggests that, in addition to a change in data analysis practices, a shift in training at the provider level is required, emphasizing the importance of accurately capturing demographic measures.

The COVID-19 emergency made it clear that data collection, analysis and reporting methods need to modernize, and include a focus on disaggregated data.

## 5. Dramatic increase in social needs rapidly followed “stay at home” orders and business closures

It is well documented that the COVID-19 emergency and associated economic recession have had dire impacts on individuals, families, and communities, especially communities of color, low-wage workers, and those already experiencing inequities due race and/or place. Job and income loss, loss of insurance, and other economic impacts placed people in a position of reliance on emergency support systems that many had never relied on before. This increased demand taxed support systems and networks that were never intended

to meet the sustained needs caused by a national emergency, and generally had to operate with fewer donations and volunteers. Feeding America estimates that 45 million people (13.9%), including 15 million children (19.9%) experienced food insecurity in 2020, relative to 35 million people (10.9%), including 11 million children (14.6%) in 2019. Nearly 95% of the community survey respondents reported that healthy food access was a major concern for their communities, while 74% identified the overburdened emergency food system as a serious concern. Over 90% of community survey respondents indicated that inability to pay rent was also a major concern, along with threat of eviction (75% of respondents). While emergency support networks, community-based organizations (CBOs), and LHDs were on the frontlines of trying to meet these needs, healthcare systems and providers also witnessed the dramatic increase in social needs first hand. LA Care described the rapid increase in member use of their platform to search for reduced cost services, citing that the top searches were “food” followed by “housing.” CCALAC also described concerns about the digital divide, and acknowledged that while the rapid increase in telehealth is vitally important, there are still serious inequities in access to the internet and technology.

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## *Best Practices*

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Health plans and healthcare systems responded quickly to meet the growing social needs of their members and patients. Some provided direct supports to individuals and families, while others drastically increased their capacity to connect people to other organizations and resources to meet social needs. Kaiser Permanente established a help line for the specific purpose of connecting patients to social needs resources, while Blue Shield expanded upon their existing relationship with Unite Us to increase providers ability to connect patients to organizations providing social needs resources. Blue Shield also supported patients by waiving co-payments, co-insurance, and deductibles associated with COVID-19 treatment. A number of health plans, including LA Care and IEHP, directed outreach to patients, redirected grant dollars to support food distribution activities, partnered with food distribution organizations, and, in some cases, delivered meals to patients. LA Care operated several food distribution events out of their community resource centers, at which patients were also able to use the Internet to attend telehealth appointments and search for other resources.

## 6. Inability to address root causes of COVID-19 disproportionate impacts

Our healthcare system is not currently designed to address the social determinants of health. As described above, many health plans and healthcare systems are striving to more effectively address the social needs of their patients and communities, but very few have been able to actively engage in policy, systems, and environmental change related to the social determinants of health. The disproportionate impacts of the COVID-19 pandemic, including deaths, infections, and economic factors are driven by systemic inequities and structural racism, making it abundantly clear that the healthcare sector needs to be involved in upstream strategies. Health plans described that while they are responsible for paying for healthcare and addressing downstream health impacts, they are not involved in social determinants of health work, although they generally feel as if they should be. Healthcare leaders described the need for guidance from their LHDs and CBOs on engaging in upstream strategies to advance health equity.

## Best Practices

While many healthcare systems are still largely addressing social needs and have yet to expand their scope to focus on the social determinants of health, there are some early adopters who are paving the way. In November 2019, the [Healthcare Anchor Network](#), a group of 14 hospital and health systems, announced a collective \$700 million investment in place-based initiatives focused on the social determinants of health. The primary goal is to generate sustainable returns on investment while also deploying capital to address social determinants of health needs in their communities. Examples of place-based investments include affordable housing, grocery stores in food deserts, childcare centers, Federally Qualified Health Centers, and local business investments.

For more information see [Healthcare Anchor Network](#) and the Public Health Alliance of Southern California's [Innovative Community Investment Strategies](#) brief.

*“The healthcare system reimbursement model is inherently racist, it places all the power with the payer, not with the patient, in the safety-net system the payer decides what you need” Healthcare interviewee*

*“COVID impacts made it clear that equity and SDOH must be at the forefront of healthcare” Healthcare interviewee*

## 7. COVID-19 revealed the serious vulnerability of long-term care facilities

As of July 2022, over [one third of all US COVID-19 deaths](#), or 184,000, were linked to long-term care facilities, including residents and employees, with [over 10,236 COVID-19 deaths associated with skilled-nursing facilities in California](#). Numerous LHD, healthcare system, and health plan executives shared the challenges and missed opportunities to more effectively coordinate with and support long-term care facilities. One health plan reported that preventing and responding to outbreaks in SNFs was one of the most challenging efforts to coordinate given the numerous actors involved in oversight and regulation, sharing one specific point of confusion regarding who was responsible for paying for containment testing, the facility itself, the health plan, or the California Department of Public Health (CDPH).

Long-term care facilities (LTCFs), including skilled-nursing facilities (SNFs) and assisted-living facilities (ALFs), and their residents and staff are uniquely vulnerable to a respiratory illness like COVID-19: the residents are generally older, often with underlying health conditions; they live in congregate settings; and often receiving hands-on care from staff who are also caring for multiple patients. Due to low wages and part-time positions, many employees work at multiple facilities, complicating attempts to contain outbreaks in single facilities. Furthermore, there were [many intersecting factors that caused LTCFs to be very vulnerable to the pandemic](#), including:

- The national PPE shortage; and the focus on prioritizing PPE in hospitals over SNFs/ALFs when supplies were limited;
- Transfer of COVID infected patients from acute care settings into overcrowded unprepared SNFs;
- Inadequate infection prevention (IP) protocols from the federal government and lack of IP training for SNF and ALF staff;

- » Inexperienced and inadequately trained and supported staff.
- » Inconsistent containment testing for residents and employees.
- Inconsistent messaging and lack of clear communication to families and SNF/ALF visitors about infection prevention protocols;
- Direct care workforce shortage, resulting in even higher turnover in historically understaffed SNF facilities.
  - » Many SNF workers did not feel adequately protected (lack of PPE and IP protocols) and quit their jobs or sought higher paying, safer jobs in other industries.
  - » Many SNF workers quit because they lacked childcare during the pandemic.
- Lack of paid sick leave for workers forced many to come to work when ill and spread infection;
- Overcrowded SNFs with 2-3 residents per room sharing bathroom facilities;
- Aging SNF infrastructure with buildings lacking proper ventilation and other amenities for infection prevention;
- Long-Term Care Ombudsmen, who play a key role in protecting long term care facilities residents in California were prevented from entering facilities during the shut-down, leaving residents and families with little or no oversight or advocacy.

There are many agencies that share regulatory and oversight responsibilities for long term care facilities in California. The California Department of Public Health licenses and regulates Skilled Nursing Facilities. The California Department of Social Services licenses Residential Care and Assisted Living Facilities. Additionally, the [Long-Term Care Ombudsman Office](#) also provides an important role in oversight and protection of long-term care

residents, helping to mediate and initiate complaints and conflicts in both SNFs and ALFs. During the pandemic, there was a lack of coordination between the multiple oversight state agencies and local public health and social services departments, all issuing their own, sometimes conflicting guidance—leading to a great deal of confusion across facilities and family members.

Generally, LTCFs receive one routine inspection per year, in addition to complaint-based inspections. When the COVID pandemic hit, they paused the regular yearly inspections so regulators could focus on facilities with outbreaks. Additionally, LTC Ombudsman were prevented from entering facilities

at all and families were not allowed in to advocate for residents and issue complaints. Furthermore, in August 2020, CDPH provided [changes in guidance to skilled-nursing facility inspectors, instructing inspectors](#) to take a more cooperative and “consultative” approach with the facilities when they encountered violations. Some stakeholders vocalized concerns about this approach, indicating that this change in guidance could reduce accountability and requirements to address documented violations in a given time period. While this issue is still evolving at the time of publication, it presents an opportunity to increase transparent and independent oversight of long-term care facilities.

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## *Best Practices*

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The California Department of Public Health, in alignment with the Centers for Disease Control and Prevention (CDC) model, developed a skilled nursing facility strike team to help mitigate and contain COVID-19 in California facilities. CDPH provided resources for SNFs to help prevent, detect, and prepare for COVID-19, including [Assessment of California Skilled Nursing Facilities to Receive Patients with Confirmed COVID-19](#), and [Detection and Management of COVID-19 Cases in Skilled Nursing Facilities](#). In January 2021 CDPH issued an [All Facilities Letter](#) to notify all SNFs that they “can seek cost-sharing assistance and a state staffing contract to help increase staffing level,” given the major strain on SNF staffing levels. The CDC also developed specific guidance for nursing homes, [Interim Infection Prevention and Control Recommendations to Prevent and SARS-CoV-2 Spread in Nursing Homes](#), as well as a [Nursing Home Infection Preventionist Training Course](#).

The California Department of Aging worked with the Alzheimer’s Association to conduct [low-tech webinars](#) for caretakers, family, and friends through statewide calls in multiple languages to help educate families on safety, support, and resources related to the COVID-19 emergency. These webinars were conducted in multiple languages with community partners to increase accessibility.

County of Santa Clara Emergency Operations Center organized local resources to meet the projected staffing needs for skilled nursing facilities, distributing [a survey](#) for residents to document specific skills and match them with the needs of SNFs in the county. San Mateo County Health and the Health Plan of San Mateo designated three SNFs as [Centers of Excellence](#), based on “high standards of patient care and expertise with infection control,” tasked with providing care to COVID-19 positive patients requiring a higher level of care.

For additional nationwide best practices see The Centers for Medicare and Medicaid Services [Toolkit on State Actions to Mitigate COVID-19 Prevalence in Nursing Homes](#).

## 8. Healthcare system is more prepared for short-term than long-term emergencies

As the pandemic progressively worsened, it quickly became clear that the healthcare system was not prepared for an emergency the scope, magnitude or duration of the COVID-19 pandemic. Healthcare providers were donning makeshift PPE, hospitals were forced to move ventilators from one patient to another, and cities were establishing temporary morgues outside of hospitals. While the PPE supply chain eventually improved, private companies began producing hand sanitizer, and manufacturers refurbished and built more ventilators, the healthcare system will remain vulnerable to future emergencies without significant changes in emergency

preparedness and planning. Personal Protective Equipment supply has emerged as a critical issue throughout this emergency, triggering a nationwide shortage for healthcare providers and the general public. Some hospitals reported using a **typical year's supply of masks in less than 10 days**. One healthcare system described how emergency planning is often siloed in one branch or office of the healthcare system or facility, lacking a broader coordinated approach and planning process. Another health plan shared concerns related to regional emergencies, such as earthquakes, and the healthcare system's ability to respond in such an event given limited PPE supplies and a lack of coordinated cross-sector emergency planning.

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### *Best Practices*

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#### **RAPID ACQUISITION AND DISTRIBUTION OF PERSONAL PROTECTIVE EQUIPMENT**

Early in the pandemic response, health plans and healthcare systems acted quickly to support providers and facilities in acquiring and distributing PPE and other essential supplies. In many cases, health plans or regional trade associations were able to leverage existing relationships to quickly purchase and distribute supplies to provider networks. For example, IEHP spent over \$3 million in reserve funding to purchase PPE for providers in the Inland Empire. Kaiser Permanente established regional and national command centers to effectively acquire and distribute PPE and medical supplies, while also addressing regional variations in need and capacity. Local public health departments also played an important role in distributing PPE to providers and communities, often those who have been disproportionately impacted by COVID-19. The California Primary Care Association described Los Angeles County Department of Public Health's partnership with community clinics to distribute PPE as a successful model.

#### **IMPLEMENTED STRATEGIES TO REDUCE EXPOSURE RISK AND BURDEN ON HEALTH SYSTEMS**

Despite the immense challenges posed by the COVID-19 emergency, the healthcare sector was able to employ rapid, innovative strategies to reduce exposure risk of patients and providers, and reduce the burden on hospitals. The Inland Empire Health Plan implemented several strategies to further these efforts. They quickly shifted all prescriptions to 90-day by-mail to support and protect patients, while ensuring continuity of medication management. The Inland Empire Health Plan also implemented a strategy early on to keep less ill patients out of the hospital while reducing the burden on hospitals; IEHP secured 500 oxygen concentrators that could be sent home with and used by patients, who were also seen daily by a provider via a telemedicine appointment. The Inland Empire Health Plan also recognized the immense burden being placed on skilled nursing facilities (SNFs) to care for COVID-19 positive patients with limited staffing, supplies, and support. In response to this, the health plan paid SNFs an additional amount per day per COVID-19 positive patient. These are only a few of many examples of innovation employed by the healthcare system in response to the COVID-19 emergency.

## 9. Negative financial impact on the healthcare system

The healthcare system, including health plans, hospitals and clinics, and providers have been deeply impacted by the pandemic. While COVID-19 created an increased demand for specialized acute care, including providers and equipment in hospitals across the country, it also left many office-based small, rural, and safety-net providers with up to **60% reductions in visit volumes** and on the **brink of financial collapse**. This is extremely concerning both for providers and the communities they serve, who are often un- or under-insured and lower-income. The Community Clinic Association of Los Angeles County noted a rapid decrease in drop-in visits, preventive services, and elective surgeries. Furthermore, IEHP described how postponement of preventive visits and elective procedures put many non-capitated specialist providers (those who are reimbursed based on a fee-for-service structure) at serious financial risk, which impacts both the provider, the facility, and the surrounding community. Another factor that seriously impacted the healthcare system, safety-net providers, and clinics in particular, is the reality that many have had to absorb the costs of vaccines, while spending large sums on PPE for staff and patients. These factors placed major financial burdens on clinics that already operate on very thin margins, while serving many of the most disproportionately impacted communities.

### *Best Practices*

#### **RAPID ADVOCACY FOR TELEHEALTH TO SUPPORT PATIENT ACCESS AND HEALTHCARE SYSTEM RESILIENCE**

Quickly following the statewide stay-at-home in March 2020, health plans, regional trade associations, and other healthcare actors advocated for expanded access to and reimbursement for telehealth, telemedicine, and telephonic care. This shift enabled ongoing access for patients and reduced the financial impact on providers by curbing delay of services. The California Primary Care Association was able to get approval for telehealth within three days of the stay-at-home order, while the CCALAC deployed medical staff to shelters to help facilitate telephonic visits with providers among those experiencing housing insecurity or homelessness. LA Care rapidly expanded their “teledoc” service to meet the increased need for virtual appointments, and this model was adopted by other sister health plans.

#### **MAINTAIN AND SUPPORT CLINIC AND PROVIDER FINANCIAL HEALTH**

As described above, many providers faced negative financial impacts throughout the COVID-19 emergency due to postponement of care and fewer visits overall. This is particularly challenging for non-capitated providers. In order to support providers and the overall health of the community, especially in provider-poor areas, IEHP implemented a policy to bolster the financial health and resiliency of non-capitated providers. Inland Empire Health Plan paid these providers the average amount they would have received over the designated period. Similarly, Blue Shield described their ability to redistribute funds to providers, given the decrease in healthcare utilization, while receiving stable income from premium payments.



## RECOMMENDATIONS

### Build and support stronger partnerships between healthcare, public health, and communities

The COVID-19 emergency revealed the major challenges working across the silos of the healthcare, public health, and community-based systems, in some cases thwarting efforts to respond to community needs in an efficient and equitable way. Healthcare and public health must strive to break down these silos and work collaboratively on a routine basis to meet the needs of the communities they serve, especially those disproportionately impacted by inequities. As the public health system is striving to develop a more community-based, equity-centered workforce, as well as establishing funded partnerships with CBOs, the healthcare system has an opportunity to join these partnerships and begin developing trusted relationships with public health and community partners (see “[Build a Resilient Equity-Focused Public Health Workforce for the 21st Century](#)” for more information). In the wake of the COVID-19 emergency, the healthcare and public health systems are at a critical inflection point, in which they can make lasting systemic change to integrate community partners and priorities as the third pillar in a more expanded vision of a 21st century health system.

As the urgency to address both social needs and the social determinants of health grows, it is imperative to establish the structures and mechanisms to collaborate, hold one another accountable, and envision an equitable future together. To shape equitable, collaborative partnerships, it is critical that healthcare, public health, and communities co-create a common set of priorities across systems, guided by the following principles outlined in the [Aligning Systems with Communities to Advance Equity through Shared Measurement](#) brief.

1. Requires up-front investment in communities to develop and sustain community partners’ capacity
2. Is co-created by communities to center their values, needs, priorities, and actions
3. Creates accountability to communities for addressing root causes of inequities and repairing harm
4. Focuses on a holistic and comprehensive view of people and communities that highlights asset and historical context
5. Reflects shared values and intentional, long-term efforts to build and sustain trust

Following the guiding principles above, healthcare, public health, and communities can implement the following strategies to build robust partnerships.

- Exploration and acknowledgement of the historical and contemporary context of healthcare and public health in the community, including racism, power dynamics, past and ongoing collaborations, etc.
- Establish trust throughout ongoing collaboration, capacity building, and funding support through transparent, long-term contracts
- Prioritize the development of shared language across the three pillars to reduce sector-specific jargon
- Establish standing mechanisms and opportunities for information sharing and collaboration
  - » Establish ongoing executive level meetings, including public health and community partners to share power in setting priorities and making high-level decisions
  - » Include public health and communities in Health and Human Services and Medical commissions to break down silos
- Create ongoing opportunities for co-creation of priorities and future visioning to explore innovative initiatives and evolving goals
  - » See [Foresight – Designing and Future for Health](#) for guidance
  - » See ReThink Health’s [Portfolio Design for Healthier Regions](#) for more information
- Develop collaborative funding mechanisms for social determinants of health and equity, including Accountable Communities for Health and Wellness Trusts (see more in the following recommendations)

## Develop a unified, bidirectional statewide health information exchange

Public health practice – at the State and local levels – requires reporting from healthcare and hospital systems. Consistently sharing data between the healthcare and public health systems was a major challenge throughout the COVID-19 pandemic. Based on conversations with several California health plans and providers, and from discussions with LHDs held on California Conference of Local Public Health Data Managers and Epidemiologists calls, this has largely been a unidirectional relationship, often with ad-hoc data sharing protocols in place. From these conversations:

- LA Care shared that they participate in three different HIEs
- Community Clinic Association of Los Angeles County (CCALAC) noted that there weren’t enough hospitals participating in the HIEs for them to be efficient or effective
- California Primary Care Association (CPCA) argued that the public health and healthcare system needs a central HIE, not multiple systems like those currently in place for immunization registries

It is a challenge for both parties: hospitals and healthcare systems face an administrative burden in reporting outside of their existing electronic health records systems, and LHDs may get delayed and/or incomplete data. These data are crucial to support direction and refinement of public health programs and resources.

Blue Shield of California summed it up succinctly: the pandemic has supplied “our ACA moment” to rethink our data systems and develop a unified HIE with a mandate for its use. The State can support this new system that is bi-directional, interoperable, and sustainable, to build better data relationships and continuum of care between local public health departments, hospitals, and healthcare systems. The National Academy of Medicine, in its Health Data



Sharing to Support Better Outcomes report, details what this might look like, and recommends setting policies that “establish ground rules and standards across networks, as well as support the development of technologies and systems that promote, rather than impede, data sharing.” In short, development of data standards, core datasets, support for Meaningful Use, and data sharing protocols that allow for streamlined reporting between systems are core components of a unified HIE. These protocols need to build in clear guidance and development of electronic messaging standards, specifically for laboratories and other reporting entities in healthcare and hospital systems to ensure timely, accurate data collection and interoperability with existing State and LHD data systems. See more information in the 2009 California Health and Human Services [Health Information Exchange Strategic Plan](#).

## Establish effective, efficient, ethical and equitable data sharing agreements

In order to improve individual, community, and population health, the healthcare and public health sectors must establish effective, efficient, ethical, and equitable data sharing agreements. The COVID-19 pandemic has demonstrated the urgent need for data sharing in order to measure and act upon health outcomes, particularly in cases of glaring inequities. COVID-19 has made it clear that health data sharing is no longer just a moral imperative, but a vital component and strategy in overcoming the crisis. Furthermore, incorporating measures of community conditions into clinical data will offer an opportunity to address health inequities where they begin.

While the healthcare and public health sectors are often uplifted as the primary actors in data sharing agreements, it is also critical to include community partners, especially those that represent and serve communities disproportionately impacted by inequities. All participants in the healthcare, public health, and community systems would benefit from

cross-institutional and cross-sector data sharing. Strategies to modernize data sharing agreements and protocols are outlined below.

- Engage with patients, individuals, and communities in the development of a trusted, privacy and civil rights protected data sharing system.
- Integrate social determinants of health measures in clinical data, such as access to housing, healthy food, employment, and transportation. While these can provide important context on patient populations, they are critical towards addressing the upstream, root causes that contribute to health disparities.
- Ensure government policies support data exchange across networks and support development of technologies and systems that support data sharing, such as Center for Medicare and Medicaid Services Interoperability and Patients Access.
  - » Develop a compensation strategy for asynchronous care, which refers to telehealth services where there is no continuous real-time interaction between the patient and provider, and electronic communication. During the pandemic, insurers and federal agencies relaxed regulations around virtual care reimbursement codes for bidirectional communication among providers, staff overseeing clinical data systems, and patients.
- Create reimbursement codes for bidirectional communication among providers, staff overseeing data systems, and patients.
- Shift the risk/benefit calculus from risk aversion for sharing data to emphasizing risks associated with not sharing data (i.e., misdiagnosis, late diagnosis, repeat test, poor care coordination, medical errors, etc.).
  - » Assess and share the enumerated financial, human and organizational integrity cost of not sharing data across systems and sectors.

- For more information see the National Academy of Medicine’s [Health Data Sharing to Support Better Outcomes: Building a Foundation of Stakeholder Trust](#) report.

## Embed equity into healthcare system emergency response structures

In order to respond effectively and equitably to local, regional, and nationwide emergencies, the healthcare system, including health plans, hospitals, clinics, and other entities must authentically embed equity into all emergency preparedness planning and response structures. Throughout the COVID-19 emergency, inequities were greatly exacerbated unless there were ongoing robust strategies to prevent these outcomes. There are a number of strategies that the healthcare system can implement to embed equity into emergency planning and response structures. Firstly, it is essential that CBO partners and community representatives be included in all planning and response activities to ensure the needs and priorities of the community are being elevated and addressed. Similarly, the healthcare system should provide funding and support to local CBOs who play a critical role in emergency response activities for patients and community, from PPE distribution to operating testing and vaccination sites. Secondly, all health plans, hospitals, and clinics can establish and appoint a health equity lead, or rotating health equity position, to advance health equity strategies throughout planning and response activities. Health equity leads can provide guidance on equity in data collection, analysis and sharing, communications and outreach, and changes in programs or care provision.

During the COVID-19 pandemic [Mass General Brigham](#) healthcare system, including Brigham and Women’s Hospital (BWH), integrated equity strategies and priorities into their incident command system. The Mass General Brigham COVID-19 response included system-level and hospital-level incident command (IC) teams. The BWH IC team included six equity working groups convened

to focus on: “1) data and monitoring COVID equity issues, connected to existing quality and safety infrastructure; 2) access, social determinants of health, and disability; 3) employee equity issues; 4) public policy and advocacy; 5) internal communication; and 6) community health and the local community the hospital serves.” (See [Figure 2](#)) BWH systematically integrated equity leaders into their IC structure to ensure that COVID-19 response actions did not inadvertently exacerbate inequities that were already playing out in communities. Additionally, BWH implemented [strategies to mitigate disproportionately burdening employees of color](#) “with additional, but uncompensated requests related to diversity, equity, and inclusion efforts.” This exemplifies a strong model for integrating equity into emergency response structures.

See [“Embed Equity Throughout Local Health Department Emergency Planning, Response & Recovery Processes.”](#)

## Assess and address healthcare system vulnerabilities for future emergencies

The COVID-19 emergency revealed the vulnerabilities in the healthcare system, specifically related to workforce, PPE and supplies, medical equipment, and hospital capacity. While the healthcare system has quickly adapted and rolled out stop gaps and short-term solutions to address these vulnerabilities, it is critical that that system as a whole, in partnership with regulatory state and federal agencies, as well as public health partners, take action to increase the resiliency of the system to future emergencies. As the intensity and frequency of climate change-related emergencies increase, and the potential for regional emergencies such as earthquakes persist, there are a number of strategies the healthcare system can undertake.

In alignment with state and federal partners, healthcare systems need to conduct a robust assessment of the supply chain challenges during

the COVID-19 emergency, including PPE, supplies, and medical equipment, as well as proposed changes to accommodate future regional or nation-wide emergencies that may tax the supply chain. This assessment and future planning must include community clinics and CBOs that were critical partners in the COVID-19 response, including distributing PPE, testing, and vaccination. Community health partners should be included in planning for future emergency allocation and distribution to facilitate a smooth and efficient response to future emergencies. Assessment and planning activities need to include a specific focus on hospitals and clinics in communities disproportionately impacted by inequities, that have been plagued by a lack of investment in healthcare facilities and other health promoting supports and resources. Additionally, it is critical that healthcare system and hospital emergency planning coordinate closely with public health emergency preparedness to support a coordinated and integrated emergency response and recovery strategy. Healthcare systems can coordinate with LHDs to proactively identify inequities and prioritize needs, as well as identify care access vulnerabilities, such as trauma deserts.

## Improve oversight and resilience of long-term care facilities

The pandemic elucidated the vulnerabilities of long-term care facilities, in which healthcare is provided outside of the typical healthcare sphere, such as skilled nursing facilities. As has been widely documented, facilities providing care outside of the hospital and clinic setting were hit particularly hard by the COVID-19 pandemic; **over 10,000 lives were lost in California alone**, as of July 2022. As described in the Challenges above, skilled-nursing facilities and other long-term care facilities faced severe staffing shortages, and inadequate access to PPE and infection prevention protocols. While CDPH conducts annual inspections of each facility, the efficiency and efficacy of emergency oversight and rapid intervention during public health emergencies could be improved. Critical insights and improvements could be achieved by establishing a Long-Term Care Facility Task Force. Essential participants would include: regulatory agencies, health plans, local public health departments, LTC Ombudsman, worker representatives, and patient advocates. The Task Force can engage in the following activities:



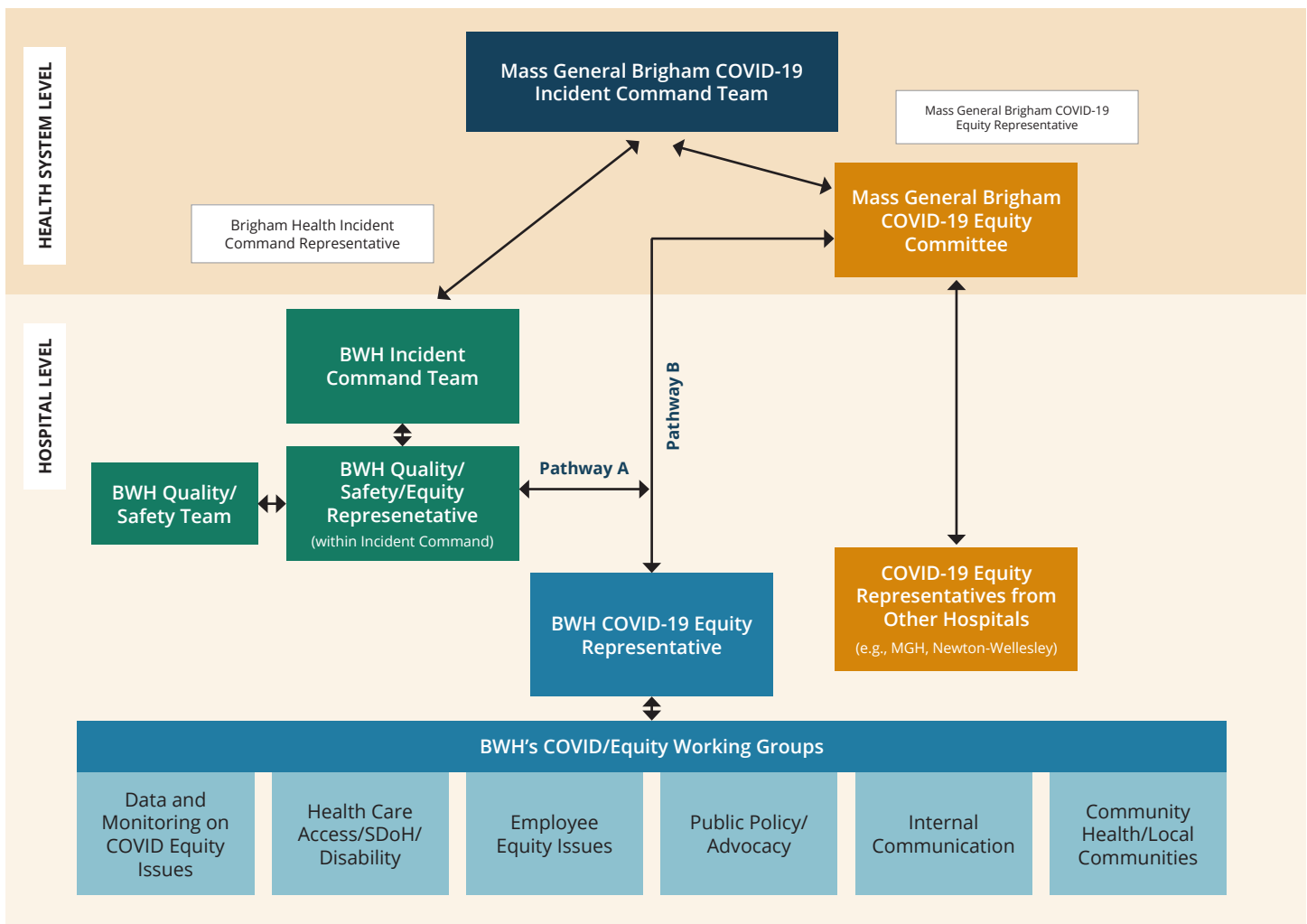


Figure 2: Mass General Brigham Incident Command Structure

- Evaluate the shortcomings and underlying policies that contributed to the devastating impacts of COVID-19 in these facilities, including internal practices related to testing and hygiene, communications, coordination, and data collection and reporting.
- Improve emergency oversight and regulatory powers and protocols for the relevant agencies in preparation for future emergencies, to ensure rapid, coordinated, and effective support and response activities
- Increase coordination and collaboration across agencies that hold regulatory and oversight responsibilities to ensure that messaging and protocols are consistent across types of LTCFs.
- Issue recommendations for facility owners and operators, and other stakeholders to address the short, medium and long-term recovery needs and opportunities to build resilience in long-term care facilities, such as:
  - » Develop coordinated emergency response plans in partnership with relevant public and private partners. Plans need to include elements such as: infection control protocols, contingency plans for extreme heat and power shutoffs, communications plans for residents and resident families, etc.
  - » Increase standing PPE supply, and identify supply chain in event of different emergencies (e.g., masks for respiratory

disease versus mask for wildfire smoke).

- ◇ Develop and provide training to managers and staff on proper PPE use, including use of different protective masks and other equipment.
- » Require facilities to collect, track, and analyze health outcomes data and establish data sharing agreements with local public health departments.
  - ◇ Data analyses should be stratified by race/ethnicity to help identify disparities within facilities.
  - ◇ Use predictive analytics to predict outbreaks and identify vulnerable facilities.
- » Increase Cost Transparency in Long-Term Care. Assess sufficiency of Medicare and Medicaid nursing home rates to cover direct care and administrative costs, including: expenditure allocations between direct care, administrative costs and other expenses, related party transactions, nursing home resident acuity levels, potential to apply acuity adjustment to rates, and rate implications for adjusted patient ratios and staffing needs.
  - ◇ Evaluate data on associations between health and safety outcomes and financial structure of facilities. See California Health Care Foundation’s 2020 Edition – Long-Term and End-of-Life Care in California for more information.
- » Advocate for increased wages for staff, including hazard pay and paid sick leave, wage enhancements, and minimum staff ratios to support a more robust and consistent workforce.
- » Strengthen paid training and certification requirements and opportunities, including

annual in-service education requirements to build skills and scopes of practice.

- ◇ Assess quality and adequacy of current workforce training and scopes of work (e.g. Certified Nursing Assistant (CNA) training).
- ◇ Ensure all staff are trained in health equity principles and culturally sensitive care.
- Assess opportunities to improve facility design and distribution of patients to minimize risk of infectious disease spread. For more information see the California Health Care Foundation’s COVID-19 in California’s Nursing Homes: Factors Association with Cases and Deaths Report.
- LTCF Architectural Reform: Provide incentives and reduce regulatory barriers to renovation of older structures; require single occupancy rooms, better ventilation, and other improvements in facilities that will help with infection prevention, emergency evacuation, digital divide, and climate change.

## Support and expand opportunities for telehealth and telemedicine

Early on in the COVID-19 emergency, health plans and healthcare systems rapidly advocated for the covered expansion of telehealth and telemedicine to support continuity of care, preventive services, and COVID-related needs. Healthcare, public health, and community advocates agree that this coverage should be supported and expanded beyond the pandemic as a critical health and equity strategy in the healthcare system. Healthcare and public health described a significant decrease in “no-show” appointments for telehealth visits. Expansion of telehealth and telemedicine is an important healthcare equity strategy in that it creates expanded options for care for populations that do not have

access to a vehicle or transit, or are unable to take time off of work for appointments. The Urban Indian Health Consortium described the expansion of telehealth as not only an effective means for reaching the American Indian and Alaska Native communities throughout the COVID-19 emergency, but also as a much needed ongoing care option. There are a number of important components to effectively advance this recommendation.

- Advocate for payment systems at the federal and state level that allow for the continuation and expansion of these services.
- Collaborate with health equity and community advocates, organizations, and leaders to assess the needs and priorities of communities. This should include an assessment of internet and technology access, preferences for telehealth models, etc.
- Partner with community organizations and trusted leaders to identify community spaces, or health plan association resources centers (e.g. LA Care) to support easier community access to the internet and technology for telehealth visits.
- Fund universal broadband access, especially in rural and low-income areas.

## Incentivize pay for value-based care versus volume

The predominant volume-based payment system does not align with healthcare system goals to reduce health disparities and advance health equity, in fact, it can exacerbate existing inequities. Throughout the interviews with healthcare system and health plan leaders, interviewees emphasized the imperative to align healthcare payment systems with burgeoning healthcare goals to address structural racism and systemic inequities. Shifting the healthcare payment model to a value-based or pay-for-performance model will place the emphasis on long-term health outcomes, especially for communities disproportionately impacted by health inequities. While most Medi-Cal payments to

providers are not based on fee-for-service they are also not explicitly tied to quality improvement or reducing health disparities. Therefore, it is critical that efforts to reform healthcare at the State and Federal levels consider making payment explicitly tied to health outcomes and reducing disparities. Furthermore, these changes should also include incentives to reach and successfully treat patients and communities most impacted by inequitable health outcomes. Furthermore, the necessary shift to prioritizing quality or health outcomes versus volume underscores the importance of robust data sharing agreements and a statewide health information exchange.

See California Pan-Ethnic Health Network's guide on [Centering Equity in Health Care Delivery and Payment Reform](#) for more information.

## Leverage resources made available through Medicaid demonstration waivers to advance health equity

Medi-Cal managed care plans can leverage Medicaid Demonstration and Emergency Waiver flexibilities to more effectively and routinely partner with LHDs and CBO partners to advance health equity. The federal Department of Health and Human Services (HHS) allows states to apply for waivers to test new approaches that are not permissible under current Medicaid law. [Section 1115](#) of the Social Security Act (SSA) gives HHS the authority to approve state-specific policy approaches to better serve Medicaid populations. These waivers typically last for five years. [Section 1915\(b\)](#) of the SSA allows states to implement voluntary managed care programs and use cost savings to provide additional services to beneficiaries. California's 2015-2020 [waivers](#) included several programs focused on the social determinants of health including a Whole Person Care Pilot, Global Payment Program, and Public Hospital Redesign and Incentives in Medi-Cal (PRIME). In October 2019, the California Department of Health Care Services (DHCS) released its proposal to re-apply

for these waivers. Entitled California Advancing and Innovating Medi-Cal (CalAIM), the proposal builds upon the successes of several programs covered by the expiring Medicaid demonstration waivers (both Section 1115 and 1915(b)). These include the Whole Person Care and Coordinated Care Initiatives. The proposal also integrates key components of the new administration's priorities including homelessness, behavioral healthcare access, children with complex medical conditions, justice-involved populations, and a growing aging population. Due to the COVID-19 pandemic, California was granted a one-year extension of its 2015-2020 waivers so they are now set to expire on December 31, 2021. Most components of CalAIM, if approved, are now set to take effect on Jan. 1, 2022, with a phased-in approach for various other components.

There are a number of strategies that should be implemented in order to leverage these opportunities to include public health. For example, stronger incentives need to be included in these waivers for Medi-Cal managed care plans to contract with LHDs to provide basic healthcare services and to advise on the development of population health management plans, enhanced care management, and in lieu of services. Additionally, clearer guidance should be included in State and federal healthcare policies on how LHDs can access healthcare funding to support LHD priorities, as well as opportunities in which health plans can fund LHD programs or activities.

Another important strategy is to [leverage emergency waiver](#) (Centers for Medicare and Medicaid Services Section 1135) flexibilities granted during a public health emergency to more effectively address the needs of disproportionately impacted communities and advance equity in emergency response. For example:

- **Utilize Non-Traditional Facilities to Provide Services** – the 1135 waiver grants approval to allow services to be rendered at unlicensed facilities to increase response capacity (e.g. tents, mobile clinics, isolation centers,



shelters, etc.). This is an important strategy to increase capacity in areas that are resource poor, especially during events when communities may have decreased access to transportation to access services.

- **Mobilize and Redeploy Community Providers to Provide Care** – the 1135 waiver allows providers who are not currently licensed as Medicaid providers to be temporarily enrolled to provide care with little to no screening. This is a critical strategy to expand the workforce during an emergency, with particular emphasis on redeploying community providers to areas most disproportionately impacted by the emergency.
- **Facilitate Redirection of Providers to Emergency Needs** – under the 1135 waiver providers that are furloughed or not working can be redirected to address emergency needs, such as COVID-19 case surges.

## Establish collaboratively funded investment mechanisms to advance equity and prevention

The healthcare and public health systems can work collaboratively with private and public entities to fund investment mechanisms that center community priorities and advance equity. In order to establish and advance collaboratively funded investment mechanisms, all partners, including healthcare, public health, community development, and CBOs must actively work across silos and include one another in planning activities, and the identification of shared priorities and opportunities. There are several hospital systems around the U.S. that have embraced innovative financing and are working closely with a multi-sector group of partners to invest in their communities. CommonSpirit Health, Trinity Health, and Kaiser Permanente are making community investments in social determinants of health such as affordable housing and food access across California and several other States on the West Coast, while hospitals in the Industrial Midwest and East Coast are leveraging their role as anchor institutions to make community investments in a variety of areas. There are a number of guiding recommendations and robust models that healthcare systems can look to in beginning or advancing these efforts.

The National Alliance to Impact the Social Determinants of Health’s [Opportunities to Advance SDOH Efforts Through Pooled Funding](#) has identified six recommendations to advance collaboratively funded approaches to advance health equity.

1. Accelerate efforts to enable existing federal health funding to be used in shared interventions addressing social needs and social determinants of health (SDOH).
2. Allow the use of existing federal program funding to support the development of “backbone” organizations that can be trusted partners in pooling funding and administering initiatives.
3. Coordinate efforts across federal departments to collectively address SDOH, including through pooled funding arrangements, waivers, and additional program flexibilities.
4. Encourage participation by Foundations, states, the private sector, and others in collective initiatives, pooling funding with federal programs to accelerate health, social, and economic gains.
5. Safeguards and “guardrails” should be clearly established to ensure that public funds used in pooled arrangements meet the needs of those they are intended to serve and provide effective stewardship of public funds.
6. Evaluate progress and expand evidence available to guide additional pooled funding initiatives.

There are many established and emerging innovative investment strategies outlined in the Public Health Alliance of Southern California’s [Innovative Community Investment Strategies](#) report, several of which are outlined below.

### ACCOUNTABLE COMMUNITIES FOR HEALTH MODELS

The California Accountable Communities for Health Initiative (CACHI) sites in California have been actively engaged in exploring innovative financing strategies for several years and have a head start on other efforts. CACHI financing strategies include a variety of innovative investment strategies, which are guided by the overarching CACHI structure of multisector collaboration, community engagement, and governance. The [National Academy of Medicine](#) published a comprehensive literature review of the effectiveness of strategies in addressing population health challenges, and a chapter in the latest [Practical Playbook](#) describes the lessons learned from the CACHI sites after 2 years of implementation. The Funders Forum for Accountable Health has also published an [inventory](#) of Accountable Communities for Health (ACH) sites around the country, and [10 case studies](#) of ACH models of varying types.



## COMMUNITY HEALTH AND WELLNESS TRUSTS

Three states (Minnesota, Massachusetts, Oklahoma), two counties (Imperial County, California and Pierce County, Washington.) and one city (East San Jose, California) have implemented structured funds to address the social determinants of health in their communities. Often called “Wellness Trusts” or “Public Health Trust Funds,” these models raise revenue from specified sources. Those dollars are then directed into a dedicated trust fund that supports community health needs. In the CACHI Initiative, establishing a “wellness trust” is a core component of each cohort’s workplan. Each of the 15 sites are actively exploring ways to establish one. One site, Imperial County, had a wellness trust predating the CACHI initiative by several years. The Imperial County wellness trust has been successful in gaining support from the local health plan, businesses, and community-based organizations. A Satewide California Wellness Trust/Health Equity Fund Program concept proposal was proposed by the [California Alliance for Prevention Funding through a formal budget request](#) and [AB 1038](#) (2021), which included a Health Equity and Racial Justice Fund as one component. In Pierce County, Washington, a wellness fund called the [OnePierce Community Resiliency Fund](#) evolved out of another community investment strategy— an Accountable Community for Health established through a Medicaid Section 1115 Demonstration Waiver. A common concern raised about wellness trusts is whether steering limited resources to a dedicated trust fund is a good use of funding for all partners involved. Many communities have other structured funds or invest their resources to address the social determinants of health in other ways. Restructuring current systems can be difficult. Finding the right revenue source can also be challenging, as creating a fund often involves raising taxes or mandating fees from participating organizations. To address these issues, the Hospital Association of Southern California (HASC) has created a set of [Guiding Principles for the Establishment of Public Health Trust Funds](#) to guide implementing of any dedicated

trust fund in Southern California where hospitals and health systems are encouraged to participate.

## Ensure existing healthcare funding streams include investments in prevention and local public health departments

### LEVERAGE HEALTHCARE EXPENDITURES TO IMPROVE PUBLIC HEALTH

We spend an [estimated \\$3.6 trillion annually on healthcare](#), but less than 3% of that is spent on public health and prevention. As a result, there is a significant opportunity to leverage healthcare resources to improve public health infrastructure. It is important that the healthcare sector expand their investments in prevention and public health including resources for LHDs through their existing funding streams. This is especially important because LHDs provide many basic healthcare services covered by Medi-Cal and Medicare, often with little to no reimbursement. Many LHDs do not have the billing infrastructure set up to properly account and be reimbursed for all the services they provide under Medi-Cal. They also lack the capacity to track all the state and federal policy changes that impact their work, including the complex Medicaid waiver processes. There needs to be greater collaboration between the healthcare and public health sector, and incentive mechanisms need to be put in place to ensure this happens in a meaningful way. For example, California has the opportunity to utilize its Medicaid demonstration waivers to include stronger incentives for Medi-Cal managed care plans to contract with LHDs to provide basic healthcare services and to advise on the development of population health management plans, enhanced care management and in lieu of services. State and federal healthcare policies could provide clearer guidance on how LHDs can access healthcare funding for their needs, including Intergovernmental Transfers (IGT), and how they can get health plans in particular to pay for their specific needs.

## FUND PUBLIC HEALTH THROUGH STATE-LEVEL COST CONTAINMENT MEASURES

A small fraction of healthcare cost containment savings redirected to public health could drastically improve public health infrastructure and bolster the healthcare and public health system continuum.

The proposed [Office of Health Care Affordability \(OHCA\)](#) within the Office of Statewide Health Planning and Development (OSHPD), would advise and advance a number of activities to contain the cost of healthcare and support affordability for consumers and purchasers. It is important that public health, and LHD leaders in particular, are included in the OHCA Advisory Council and actively engaged to support ongoing systems change. The OHCA activities include the following:

1. Increase public transparency on total healthcare spending in the State
2. Set an overall statewide cost target and specific targets for different sectors of the healthcare industry
3. Enforce compliance with the cost target
4. Promote and measure quality and equity through performance reporting
5. Set a statewide goal for adoption of alternative payment models and develop standards for use by payers and providers during contracting
6. Measure and promote sustained systemwide investment in primary care and behavioral health
7. Monitor and address healthcare workforce stability
8. Increase public transparency on healthcare consolidation, market power, and other market failures

Especially in light of the COVID-19 emergency and the broad understanding of the chronic underfunding and understaffing of LHDs, these activities must include investments in LHDs in the same manner they propose investing in primary care and behavioral health. Furthermore, LHDs must be meaningfully engaged throughout these processes to strengthen partnerships and build capacity across sectors to more effectively support prevention and social determinants of health work. Public health programs are the equivalent of population-level preventive care, and with adequate investment, can have even farther reaching impacts, especially for communities facing health inequities. According to [Trust for America's Health](#), investing \$10 per person per year in community prevention programs could yield more than \$16 billion in healthcare savings within five years. State-level cost containment savings could be used to fund wellness trusts, as discussed above. The [Massachusetts Prevention & Wellness Trust Fund](#) supported “clinical-community partnerships focused on childhood asthma, falls among older adults, hypertension, and tobacco use” from 2014-2018 with demonstrated cost savings and health outcome improvements.

There are a number of existing and emerging strategies to ensure the existing healthcare funding streams include investments in prevention and LHDs. Bridging the gap between healthcare and public health will facilitate the expansion of the continuum of care and enable both sectors to more effectively advance shared health equity priorities.