Addressing Health-Related Social Needs to Improve Rural Health: An Annotated Bibliography

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Andrew F. Coburn, Ph.D., Research Professor Emeritus and
Senior Fellow, Maine Rural Health Research Center
Muskie School of Public Service
University of Southern Maine

Deborah A. Deatrick, MPH
Public Health Consultant

Karen Pearson, MLIS, MA
Policy Associate
University of Southern Maine

Maine Rural Health Action Network

New England Rural Health Association

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Feedback on this bibliography, recommendations for additional resources, and/or corrections (e.g., broken website links, etc.) are welcome and should be directed to admin@newenglandrha.org.

This report can be accessed from the New England Rural Health Association at https://nerha.memberclicks.net/me-rhan

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INTRODUCTION

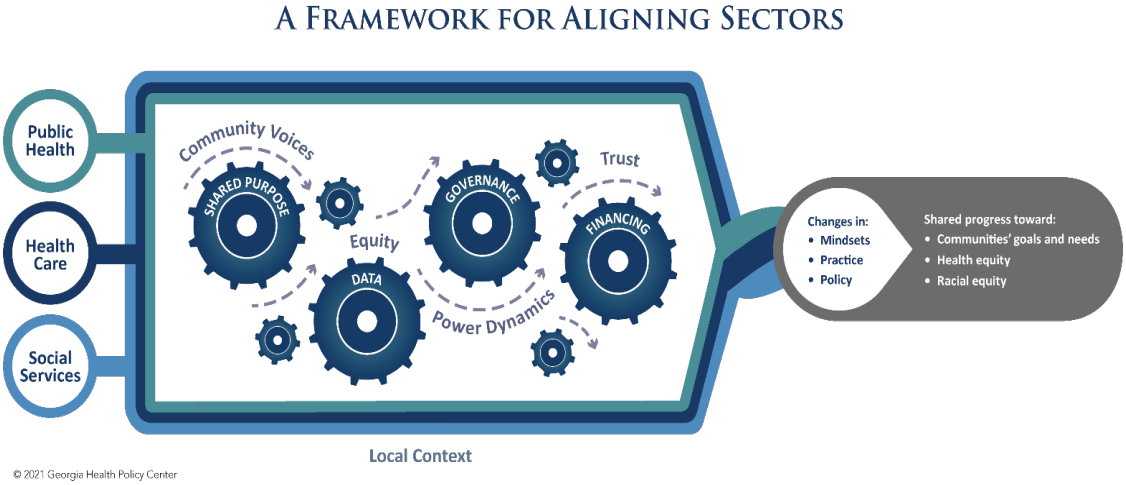
With growing evidence of the importance of Health-Related Social Needs to the health of patients, health care providers, policymakers, payers, and communities are searching for effective strategies to better address HRSNs.

In January 2022, we published a report, *Addressing Health-Related Social Needs to Improve Rural Health: Ideas to Action*, which identified strategies for building community and regional "systems of care" in rural states like Maine to better address the social needs of patients in the health system. The project was the product of the *Maine Rural Health Action Network's* discussions about strategies to accelerate rural health system transformation. The specific goal was to share information from the literature and from demonstrations and initiatives from around the country to inform the design of community-level rural health transformation initiatives in Maine. The report focused, in particular, on two key elements of reform: (1) the development and sustainability of community and regional partnerships among health care, public health, social service, and other community-based organizations, and (2) financing and payment models to incent and sustain systems of care to better address patients' health-related social needs (HRSNs) and advance equity. To identify promising strategies, we reviewed the recent literature, interviewed experts involved in state and local demonstrations, and spoke with leaders of MaineCare, Maine's Accountable Care Organizations (ACOs), private payers, and community organizations. We also talked with community and organizational leaders in three rural regions in Vermont, Western Idaho, and Oregon that have undertaken significant, collaborative health care and social service alignment initiatives.

This annotated bibliography provides a more detailed and expansive compendium of material and resources gathered in the course of our work. Often, local organizations do not have the capacity to look for and evaluate these resources. The goal is to inform organizational and community efforts to design and implement Health Related Social Needs (HRSNs) initiatives in Maine. The bibliography provides access to the most relevant background materials we collected in the course of our work on the report. Additionally, it includes materials and resources on topics not covered in the report and/or that have become available since our report was completed. This is by no means a comprehensive bibliography on the topics related to HRSNs. Since we began work on the original report in 2020, interest in and activity around the social determinants of health and HRSNs has grown significantly. Our aim was to provide a practical tool to help diverse rural communities and organizations access relevant information on new research, best practices, and policy analyses to better align health care with other community services to HRSNs.

Importantly, many of the items in this bibliography contain references to additional, relevant articles or documents.

The original report cited a framework (below) for aligning sectors to address HRSNs developed by the Georgia Health Policy Center's *Aligning Systems for Health* initiative funded by the Robert Wood Johnson Foundation. The framework was developed with input from funded communities and regions across the US and modified based on their real-world experience.



Using the framework as a guide, the bibliography was organized around the following topics or themes:

Frameworks: This category includes articles and materials that establish a framework for understanding HRSNs and the key elements of strategies to address them. Examples of HRSN programs and initiatives are discussed in several items in this category.

Case Examples*:* This section contains profiles or examples of state and/or community-based initiatives addressing the SDOH or HRSNs. These profiles are typically prepared by funders, such as the RWJF's Aligning Systems project, or policy organizations such as the National Academy for State Health Policy or the Center for Health Care Strategies.

Community Partnerships*:* Documents referenced in this section discuss strategies for effecting successful and sustainable partnerships among health care and other community organizations. Many review common challenges (and strategies to overcome them) in bringing organizations to the table and keeping them invested in building more aligned systems of care.

Financing*:* New financing and payment strategies and models are central to reforms targeting HRSNs. This section contains salient articles and documents on innovative strategies states and communities have employed to better use existing and new funding and community resources to align and expand HRSN-related services.

Data and Information Sharing*:* Although our original report discussed topics related to screening for HRSNs, the issues related to data and information sharing among health care and community organizations were not examined in depth. Given the central role of data and information sharing in aligning services across sectors, we included in this bibliography a limited number of items related to these issues.

Evaluation*:* Many HRSN initiatives are using investments and resources committed by health care, business, philanthropy, and other organizations who are interested in the potential return on investment (ROI) of these initiatives. The items in this section discuss approaches to and the challenges of evaluating HRSN initiatives.

It is important to note that these categories are not mutually exclusive; many of the items could have been, and in some cases were, placed in multiple categories. This is especially true of the items in the *Frameworks* and *Case Examples* sections which typically cover multiple topics.

FRAMEWORKS

This category includes articles and materials that establish a framework for understanding HRSNs and the key elements of strategies to address them. Examples of HRSN programs and initiatives are discussed in several of the items in this category.

Albertson, E. M., Chuang, E., O'Masta, B., Miake-Lye, I., Haley, L. A., & Pourat, N. (2022). Systematic Review of Care Coordination Interventions Linking Health and Social Services for High-Utilizing Patient Populations. *Population Health Management*, *25*(1), 73-85. https://doi.org/10.1089/pop.2021.0057

Recognizing that social factors influence patient health outcomes and utilization, health systems have developed interventions to address patients' social needs. Care coordination across the health care and social service sectors is a distinct and important strategy to address social determinants of health, but limited information exists about how care coordination operates in this context. To address this gap, the authors conducted a systematic review of peer-reviewed publications that document the coordination of health care and social services in the United States. After a structured elimination process, 25 publications of 19 programs were synthesized to identify patterns in care coordination implementation. Results indicate that patient needs assessment, in-person patient contact, and standardized care coordination protocols are common across programs that bridge health care and social services. Publications discussing these programs often provide limited detail on other key elements of care coordination, especially the nature of referrals and care coordinator caseload. Additional research is needed to document critical elements of program implementation and to evaluate program impacts.

Center for Health Care Strategies, Crumley, D., Mohr Peterson, J., & Ferguson-Mahan Latet, K. (2021, September 29, 2021). *Identifying and Addressing Health-Related Social Needs through Primary Care Innovation in Medicaid Managed Care* [webinar]. https://www.chcs.org/resource/identifying-and-addressing-health-related-social-needs-through-primary-care-innovation-in-medicaid-managed-care/

This webinar explored how state Medicaid agencies and health plans can partner with primary care teams to identify and address health-related social needs for the individuals and communities they serve. The 60-minute event focused on ways to strategically design managed care requirements and value-based payment models to advance work relating to health-related social needs.

Centers for Medicare & Medicaid Services. (2021). *A Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tool: Promising Practices and Key Insights*. CMS. https://innovation.cms.gov/media/document/ahcm-screeningtool-companion

This document describes the health-related social needs (HRSN) Screening Tool from the Accountable Health Communities (AHC) Model and share promising practices for universal screening. HRSNs are individual level, adverse social conditions that negatively impact a person's health or health care. HRSNs are distinguished from social determinants of health—the structural and contextual factors that shape everyone's lives for better or worse—and can be identified by the health care system and addressed in partnership with community resources. Identifying and addressing HRSNs can have many benefits, including improvements to individuals' health and reduced health care spending. The guide is intended for health care and social service providers who are increasingly adopting the practice of universal HRSN screening. Chapter 1 introduces the AHC Model and the AHC HRSN Screening Tool. Chapter 2 provides an

overview of the AHC HRSN Screening Tool and presents and describes the related screening tool questions for each domain, describes the scoring process and how to administer the tool outside the AHC Model. Promising practices for universal screening include: cultivate staff buy-in; tailor staffing models to site features; provide dedicated training on screening; use customized scripts to engage patients in screening; to maximize patient participation, consider the timing, location, and process for screening; anticipate population-specific needs; train staff to manage privacy and address safety concerns; institute continuous quality improvement; prepare staff to respond to common questions.

Centers for Medicare & Medicaid Services, & Center for Medicare and Medicaid Innovation. (2020). *Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool*. CMS.
https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf
This screening tool, used in the AHC Model, provides evidence as to whether systematically screening and addressing HRSN of Medicare and Medicaid beneficiaries has any effect on their total health care costs and health outcomes. Five core domains are addressed: Housing instability, food insecurity, transportation problems, utility help needs, and interpersonal safety. The final version also includes questions in eight supplemental domains of financial strain, employment, family/community support, education, physical activity, substance use, mental health, and disabilities.

Chappel, A., Cronin, K., Kulinksi, K., Whitman, A., DeLew, N., Hacker, K., Bierman, A. S., Meklir, S. W., Monarez, S. C., Johnson, K. A., Whelan, E.-M., Jacobs, D., & Sommers, B. D. (2022, November 29). *Improving Health and Well-Being Through Community Care Hubs*. Health Affairs Forefront web blog. Retrieved November 29 from https://www.healthaffairs.org/content/forefront/improving-health-and-well-being-through-community-care-hubs
The U.S. Department of Health and Human Services' strategic approach to addressing social determinants of health (SDOH) envisions a future in which all individuals, regardless of their social circumstances, have access to aligned health and social care systems that achieve equitable outcomes through high-quality, affordable, person-centered care. While identifying pathways to adequately fund social care is critical to achieving this vision, there is also a need for communities to develop sustainable partnerships among health care providers, the public health system, and community-based organizations (CBOs), and to develop the data and financing infrastructure needed to support these partnerships. Multistakeholder collaborations to address SDOH have flourished in recent years and have informed what is needed to develop a sustainable operating infrastructure between health care and CBOs to address health-related social needs. This infrastructure is increasingly provided by community care hubs (hubs)—community-focused entities supporting a network of CBOs providing services addressing health-related social needs—which centralize administrative functions and operational infrastructure. The authors discuss the role and functions of hubs, provide examples of these organizations, and explore policy opportunities to maximize their role.

Christens, B. D., & Inzeo, P. T. (2015). Widening the view: situating collective impact among frameworks for community-led change. *Community Development*, *46*(4), 420-435. https://doi.org/10.1080/15575330.2015.1061680
This article situates collective impact in relation to similar approaches, makes key distinctions between the collective impact framework and principles for grassroots community organizing, and draws on these distinctions to offer recommendations for enhancing collaborative practice to address community issues. The clarification of these distinctions provides possibilities for future innovations in community development practice, evaluation, and research. To tackle the root causes of the systemic issues that collective impact efforts seek to address will require learning from the community organizing approach to community engagement, analysis of power, and capacity for conflict.

Coburn, A. F., & Deatrick, D. A. (2021). *Addressing Health Related Social Needs to Improve Rural Health: Ideas to Action. Key Elements of a Rural, Community-Based Demonstration to Advance Whole-Person Care.* Maine Rural Health Action Network, New England Rural Health Association. https://mehaf.org/wp-content/uploads/Health-Related-Social-Needs-Final-Report.pdf
This report identifies strategies for building community and regional "systems of care" in rural Maine to better address the social needs of patients in the health system. The goal of the report was to identify strategies that fit Maine's policy and community context to inform the design of community-level rural health transformation initiatives, pilots, or demonstrations. The project focused on two key components of reform: (1) community partnerships and governance among health care, social service, and other community-based organizations, and (2) financing and payment models to incent and sustain systems of care to better address patients' health-related social needs (HRSNs) and promote equity. This report calls for a rural, community-based demonstration to test better ways of aligning funding and services to address health-related social need (HRSNs)--a subset of the Social Determinants of Health that have come to be recognized as major contributors to poor health outcomes among patients and excess costs in the health care system. The authors posit that despite the state's economic and demographic challenges (exacerbated by the pandemic), Maine is at a positive tipping point to move "upstream" to develop and test a regional approach to improve individual and community health that builds on and amplifies local energy, resources, and experience.

Croll, Z. (2019). *Sustainable Public-Private Strategies to Improve Population Health in Maine: Annotated Bibliography*. University of Southern Maine, Muskie School of Public Service. https://digitalcommons.usm.maine.edu/population_health/31
This annotated bibliography is organized into four major sections: Financing, Structure/Infrastructure, Policy Leadership, Accountability. Documents reviewed include peer-reviewed journal articles, book chapters, reports, and websites.

Crumley, D., Spencer, A., Ralls, M., & Howe, G. (2021). *Building a Medicaid Strategy to Address Health-Related Social Needs* [Tool]. Center for Health Care Strategies. https://www.chcs.org/media/Tool-Building-a-Medicaid-Strategy-to-Address-HRSNs_042921v3.pdf
State Medicaid agencies can use managed care and value-based payment initiatives to catalyze work relating to health-related social needs (HRSN) and drive better, more equitable health outcomes for Medicaid members. This resource, produced by the Center for Health Care Strategies with support from the Episcopal Health Foundation, is designed to guide state Medicaid agencies in developing a cohesive strategy to address HRSN. A robust HRSN strategy can help states achieve high-priority Medicaid goals — such as advancing health equity and

value-based care — and can be part of a broader state strategy to improve community-level social determinants of health. [Document summary]

Crumley, D., Spencer, A., Ralls, M., & Howe, G. (2021). *Building a Medicaid Strategy to Address Health-Related Social Needs: Environmental Scan*. Center for Health Care Strategies. https://www.chcs.org/media/Environmental-Scan-Building-a-Medicaid-Strategy-to-Address-HRSNs_042921.pdf

The Center for Health Care Strategies (CHCS), with support from the Episcopal Health Foundation (EHF), conducted an environmental scan to analyze best practices and state activities on health-related social needs (HRSN)-specific interventions; HRSN quality measures and screening tools; value-based payment arrangements involving HRSN; and Medicaid managed care contracting requirements and incentives related to HRSN. This scan highlights the available evidence on specific approaches, particularly in the Medicaid managed care context, as well as relevant resources and tools related to addressing HRSN. A companion tool, *Building a Medicaid Strategy to Address Health-Related Social Needs* (https://www.chcs.org/media/Tool-Building-a-Medicaid-Strategy-to-Address-HRSNs_042921v3.pdf), synthesizes the findings from these analyses and offers considerations for states that are developing a comprehensive strategy to address HRSN.

De Marchis, E. H., Brown, E., Aceves, B., Loomba, V., Molina, M., Cartier, Y., Wing, H., & Gottlieb, L. M. (2022). *State of the Science on Social Screening in Healthcare Settings*. Social Interventions Research & Evaluation Network (SIREN). https://sirenetwork.ucsf.edu/sites/default/files/2022-06/final%20SCREEN%20State-of-Science-Report%5B55%5D.pdf

To inform the intensifying national dialogue about social screening, SIREN researchers synthesize existing research on social screening in US health care settings. Findings are highlighted in five sections in the full report: 1. The prevalence of screening; 2. The psychometric and pragmatic validity of existing screening tools; 3. Patient and patient caregivers' perspectives on screening; 4. Health care providers' perspectives on screening; and 5. Screening implementation. For additional resources associated with this report, including an executive summary, slide decks, screening implementation guidelines and toolkits, podcases, and infographics, please visit: https://sirenetwork.ucsf.edu/tools-resources/resources/screen-report-state-science-social-screening-healthcare-settings

Department of Vermont Health Access. (2020). *Vermont Medicaid Next Generation ACO Program: St. Johnsbury's Experience with an Expanded Attribution Pilot Project*. Department of Vermont Health Access. https://dvha.vermont.gov/initiatives/payment-reform/vermont-medicaid-next-generation-aco-program

The goal of this document is to capture the details and experiences behind the implementation of the 2019 St. Johnsbury Vermont Medicaid Next Generation Expanded Attribution Pilot Project ("Pilot Project"). The anticipated audiences are health care, social service, and human services providers and leaders who are planning to implement similar expanded attribution programs in their local communities. The document highlights relevant experiences, tools, templates, operational frameworks, best practices, and lessons learned that came to life either leading up to or during the 2019 Pilot Project program year. Programs in other health service areas may vary from the St. Johnsbury Pilot Project as the expanded attribution approach is refined. The intent of sharing details of the St. Johnsbury experience is to help inform and support future design and implementation.

Elevate Health. (2021). *Elevate Health Brief*. Elevate Health. https://elevatehealth.org/media/elevate-health-at-a-glance
Elevate Health's mission is to build and drive community coalitions that transform health systems and advance whole-person health for all. They work with community partners, patients and providers to transform multisector systems of health and seek to increase savings, eliminate health gaps, and improve health equity for the residents throughout Pierce County, WA. [website description]

Fichtenberg C, Fraze TK. Two Questions Before Health Care Organizations Plunge into Addressing Social Risk Factors. online article. *NEJM Catalyst.* March 15, 2023. https://catalyst.nejm.org/doi/full/10.1056/CAT.22.0400
In this perspective piece as part of the NEJM Catalyst's theme issue on SDOH, the authors highlight that the focus on social risk screening and referrals assumes (1) that patients do not already know how to access resources; and (2) that resources to address patients' needs are readily available. However, there is little evidence to support these assumptions. In fact, many patients are already aware of resources, and the underfunded safety net in the United States does not fully provide the resources needed to address patients' needs. Furthermore, many patients are reluctant to seek help because of the shame and stigma associated with needing help in our society. In this context, screening and referring will provide limited benefits. The authors therefore recommend that health care organizations focus on better understanding the realities facing low-income patients and work with patients and social service experts to identify how health care organizations can best help to address patients' needs as well as the community conditions in which patients live. Ultimately, if the health care sector is genuine in its belief that improving health involves addressing social risk factors, it must invest in interventions that are commensurate with and responsive to the needs and challenges facing patients and communities.

Fraze, T. K., Beidler, L. B., & Savitz, L. A. (2022). "It's Not Just the Right Thing . . . It's a Survival Tactic": Disentangling Leaders' Motivations and Worries on Social Care. *Medical Care Research and Review*, *79*(5), 701-716. https://doi.org/10.1177/10775587211057673
Health care organizations face growing pressure to improve their patients' social conditions, such as housing, food, and economic insecurity. Little is known about the motivations and concerns of health care organizations when implementing activities aimed at improving patients' social conditions. The researchers used semi-structured interviews with 29 health care organizations to explore their motivations and tensions around social care. Administrators described an interwoven set of motivations for delivering social care: (a) doing the right thing for their patients, (b) improving health outcomes, and (c) making the business case. Administrators expressed tensions around the optimal role for health care in social care including uncertainty around (a) who should be responsible, (b) whether health care has the needed capacity/skills, and (c) sustainability of social care activities. Health care administrators could use guidance and support from policy makers on how to effectively prioritize social care activities, partner with other sectors, and build the needed workforce. [article Abstract]

Gale, J., Coburn, A., Pearson, K., Croll, Z., & Shaler, G. (2016). *Population Health Strategies of Critical Access Hospitals* (Briefing Paper #36). http://www.flexmonitoring.org/wp-content/uploads/2016/09/bp36.pdf
Hospitals and health systems, including those serving rural communities, are increasingly embracing population health strategies as they move toward accountable care models of health care delivery and financing and seek to re-focus their community benefit activities to improve

the overall health of their communities, demonstrating their accountability to local stakeholders. This paper details the population health strategies of a geographically diverse set of Critical Access Hospitals (CAHs) to identify key challenges, opportunities, and lessons that could inform the efforts of other CAHs and state Flex Programs. The paper provides examples of eight CAHs and communities that have made substantial commitments to population health and community health improvement. Key themes from the qualitative interviews of the selected CAHs highlight the collaborative nature and the high level of community involvement of the various initiatives.

Gaskins, A. S. P., Steinitz, R., & Hacke, R. (2020). *Investing in Community Health: A Toolkit for Hospitals*. Center for Community Investment and Catholic Health Association. https://centerforcommunityinvestment.org/community-health-toolkit
This toolkit is designed to help health care organizations look at their resources in a different light, expand their efforts to support their communities, and maximize their impact on community health by harnessing the power of their investment capital. In addition, it delves into several key topics: distinguishing between financial contributions and investment strategies, understanding the value of investment strategies for addressing the social determinants of health, and mobilizing investment capital to improve community health. [website description]

Georgia Health Policy Center. (2022). *Assessment for Advancing Community Transformation (AACT) Action Planning: Prioritizing Areas for Community Transformation*. Georgia Health Policy Center. https://ghpc.gsu.edu/the-assessment-for-advancing-community-transformation-tool/
AACT is community-driven and -directed and no outside support is needed to use the tool or interpret results. The AACT consists of six Key Themes, with topics including collaboration, communication, advance equity, plan for action, measure to improve, and sustainability; 22 Subthemes providing drilldown questions on main topic areas; four Stages: A continuum to describe current status of efforts from 'not yet started' to 'sustaining' for each of the 22 questions, and one Community Score in which Community members independently score then meet in deliberate conversation to agree on one score for each of the 22 items and an overall score, establish a baseline, and prioritize action steps. The validated AACT tool brings people together to get a deeper understanding and agreement on where the group is in its work together. It is not about getting a high score—there may be some places where a group is further along and other areas where efforts are just beginning. The AACT is not designed to compare or rank communities. It is intended to help communities determine where attention can be focused to accelerate community transformation. This tool was jointly developed by 100 Million Healthier Lives/Institute for Healthcare Improvement, County Health Rankings & Roadmaps, and Georgia Health Policy Center, with support from the Robert Wood Johnson Foundation. [website description]

Gutierrez, M., Belanger, K., Clark, V., Friedman, J., Redfern, J. F., Weber, B., Fluharty, C., & Richgels, J. (2010). *Rethinking Rural Human Service Delivery in Challenging Times: The Case for Service Integration*. RUPRI Rural Human Services Panel. https://rupri.org/wp-content/uploads/ServiceIntegration_Feb2010.pdf
In rural communities, rising rates of poverty and unemployment, coupled with the unique risk factors inherent in rural life, have created an unprecedented need for human services. By organizing resources and integrating human services into regionally-based, client-centered systems, geographic population centers, to which rural people already spend significant time traveling to address other daily needs, could also become the location in which they access the most essential of human services. Creation of regional hubs for service integration and

coordination also provide greater opportunity for attracting philanthropic support, increase organizational capacity and oversight, and increase the efficiency of management infrastructure. As a starting point, it is essential to understand the infrastructure and workforce capacity needs for a typical regional service integration system. Finding appropriate frameworks for regional service integration is also critical given the diversity of rural human services administration throughout rural America. In addition, local leadership remains a vitally important component to achieving this transformational change. Anchor organizations must be committed to this model and local leadership, through these intermediaries, must be identified. This model offers national and local foundations an avenue to partner with local, state and federal government agencies to support needed research, evaluation, technical assistance, and policy and practice analysis for rural communities. Establishing a rural human services framework, modeled after the rural health services research, policy, and practice infrastructure is essential, along with rural access to broadband and technology for linking service providers and bringing needed services to where people live regardless of their remoteness.

HealthBegins. (2019). *Levels of HRSN & SDOH Integration Framework*. HealthBegins. https://2hdp0l1trjr524kvdq3mg5sa-wpengine.netdna-ssl.com/wp-content/uploads/2020/07/levels_of_hrsn_and_sdh_integration_framework.pdf
A practical framework to help health care and social service partners address health-related social needs and social determinants of health, it adapts a taxonomy developed in 2013 by SAMHSA-HRSA Center for Integrated Health Solutions to describe levels of behavioral health integration in primary care. The goal of this framework is to provide health care, social service, and public health stakeholders with clarity, increase the precision of their communication, and accelerate practice and system redesign related to HRSN and SDOH integration. This practical six level framework begins with coordination and moves through increasing levels of collaboration and integration. Even if outcomes improve as levels of integration increase, it is not practical to believe that every health care and social service partner will be able to implement increasing levels of integration due to external pressures, organizational capacity, financing, and/or differing values. By implication, the numbering of levels suggests that the higher the level of integration, the more potential for positive impact on health for defined populations and, more broadly, whole communities. [from the Executive Summary]

Hester, J. A., Stange, P. V., Seeff, L. C., Davis, J. B., & Craft, C. A. (2015). *Toward sustainable improvements in population health: Overview of community integration structures and emerging innovations in financing* (CDC Health Policy Series No. 2). Centers for Disease Control and Prevention. https://stacks.cdc.gov/view/cdc/27844
This report explores opportunities to establish effective, more sustainable community-focused delivery and payment models to improve population health. Specifically: evolving community-level population health delivery models, key functions, opportunities, and challenges of a community integrator, concept of a balanced portfolio as a crucial component in developing a sustainable financial model, and emerging financing vehicles that could be used for specific population health interventions.

Johnson, K., Ogbue, C., Verlander, K., & Barolin, N. (2022, August 8). *Lessons From Five Years of the CMS Accountable Health Communities Model*. Health Affairs. Retrieved August 8 from https://www.healthaffairs.org/content/forefront/lessons-five-years-cms-accountable-health-communities-model
The Accountable Health Communities (AHC) Model was the Centers for Medicare and Medicaid Services' (CMS') first model test focused on evaluating HRSN screening, referral, and navigation.

It was built on emerging interventions in Accountable Care Organizations (ACOs), Medicaid Managed Care, Medicaid health homes, and home and community-based services programs. Early evidence from the AHC Model is promising, and there are many lessons to share to continue addressing HRSNs and social determinants of health for Medicare and Medicaid beneficiaries. In this article, the authors review key evaluation findings to date and promising practices that providers and payers can implement to address HRSNs in their patient populations and communities. They also describe emerging themes for how AHC Model participants, called bridge organizations, plan to scale and sustain the model interventions and how lessons learned are being embedded across CMS.

Kenney, G. M., Waidmann, T., Skopec, L., & Allen, E. H. (2019). *What Would it Take to Reduce Inequities in Healthy Life Expectancy?* (Catalyst Brief). Urban Institute. https://next50.urban.org/sites/default/files/2019-9/Next50%20Health%20Catalyst%20Brief_0.pdf
The authors identify strategies and priorities for the health care sector to help people address their health-related social needs and in turn narrow inequities in health and healthy life expectancy. Health care sector action, investment and innovation strategies include: systematically assess health-related social needs, establish community resource networks and platforms, incentivize investments in nonmedical services with health-sector payoffs, establish sustainable mechanisms for the operation and financing of programs addressing health-related social needs that yield cross-sector payoffs, and align organizational policies and activities to reduce social needs. Priorities for building knowledge changemakers need include: identify high-value targets among health-related social needs, build an actionable evidence base of proven interventions that resolve health-related social needs, and assess strategies for integrating health, social services, and other systems.

Kohli, J., & De Baisi, A. (2017). *Supporting Healthy Communities: How Rethinking the Funding Approach can Break Down Silos and Promote Health and Health Equity*. Deloitte Center for Government Insights. https://www2.deloitte.com/content/dam/insights/us/articles/3608_supporting-healthy-communities/DUP_supporting-healthy-communities.pdf
The authors discuss the Healthy Communities Funding Hub model which proposes a place-based hub where many of the barriers to community-based health improvement effort can be addressed, bridging a gap in many communities which lack an infrastructure for sustainably funding multisector partnerships to improve health. The framework of the model brings together funding from federal, state, local, and philanthropic sources across the many sectors that affect health. Each hub would serve as a trusted intermediary and formal financial manager, equipped with the necessary financial capacities to coordinate health improvement funds, and be a single point of financial accountability to stakeholders. The report provides examples, key factors to consider, and areas for further exploration.

Landers, G. M., Minyard, K. J., Lanford, D., & Heishman, H. (2020). A Theory of Change for Aligning Health Care, Public Health, and Social Services in the Time of COVID-19. *American Journal of Public Health*, *110*(S2), S178-s180. https://doi.org/10.2105/ajph.2020.305821
This article describes the core elements of the Robert Wood Johnson-funded initiative, *Aligning Systems for Health*.

National Academies of Sciences, Engineering, and Medicine. (2021). *Models for Population Health Improvement by Health Care Systems and Partners: Tensions and Promise on the Path Upstream: Proceedings of a Workshop*. National Academies Press. http://nap.edu/26059
The workshop explored the growing attention on population health, from health care delivery and health insurance organizations to the social determinants of health and their individual-level manifestation as health-related social needs, such as patients' needs. The workshop showcased collaborative population health improvement efforts, each of which included one or more health systems. This publication summarizes the presentations and discussions from the workshop. [website description]

National Academies of Sciences, Engineering, and Medicine. (2021). *Population Health in Rural America in 2020: Proceedings of a Workshop*. National Academies Press. https://nap.nationalacademies.org/catalog/25989/population-health-in-rural-america-in-2020-proceedings-of-a
Rural America is economically, socially, culturally, geographically, and demographically diverse. This multidimensional diversity presents complex challenges and unique opportunities related to delivering health care and improving health outcomes and health equity in rural communities. To explore issues related to population health in rural America, the Roundtable on Population Health Improvement of the Board on Population Health and Public Health convened a public virtual workshop, "Population Health in Rural America in 2020" on June 24-25, 2020. The workshop planning committee was composed of rural health experts representing public health, health care, and tribal health. Presentations and discussions focused on rural America in context, rural health vital signs, rural health care in action, assessment, and implementation strategies for improving the health and health equity in rural populations, and rural health policy. This Proceedings of a Workshop summarizes the presentations and discussions from the workshop. [website description]

NEJM Catalyst Innovations in Care Delivery, *Volume 4, Issue 4, April 2023.* https://catalyst.nejm.org/toc/catalyst/4/4
This special double issue of NEJM Catalyst Innovations in Care Delivery shows how health care organizations are actively addressing the social determinants of health and health-related social needs. This special theme issue highlights important ongoing work on both the barriers to addressing these challenging topics and strategies for overcoming them.

North Carolina Department of Health and Human Services. (2019). *North Carolina's Healthy Opportunities Pilots: A Review of Proposed Design for Interested Stakeholders*. North Carolina Department of Health and Human Services. https://www.ncdhhs.gov/media/11697/download
This paper describes the preliminary program design for the Healthy Opportunities Pilots for interested stakeholders, including human service organizations (e.g., community-based organizations and social service agencies), health care providers, care management entities, advocates and others. The Healthy Opportunities Pilots present an unprecedented opportunity to test the impact of providing selected evidence-based interventions to Medicaid enrollees and to establish and evaluate a systematic approach to integrating the provision of evidence-based non-medical services into the delivery of health care. For more information, visit the Health Opportunities Pilots website at: https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/healthy-opportunities-pilots

Northeast Kingdom Collaborative Trisector Task Force. (2018). *From Strength to Strength: Advancing Economic Development through the Intersection of the Creative, Recreational and Food Sectors in the Northeast Kingdom* (The Action Plan of the Trisector Task Force). Northeast Kingdom Collaborative. https://drive.google.com/file/d/1l_sdQCyWKtI4QGh7fd0WIn4veRp1A2Ge/view
The Task Force framework looks at using collective action to promote economic and community development by leveraging representation in the creative, recreational and food sectors. It represents a blueprint for how conversation among nonprofit and private groups to align their work can result in the development of projects capable of transforming communities. The Task Force focused on five initiatives: 1. Coordinate and expand marketing the region; 2. Sustain and grow high-quality place-based events; 3. Enhance economic growth through rural community hubs; 4. Expand access to trisector experience for kids; 5. Increase broadband connectivity. FMI: https://www.nekcollaborative.org/reports

Oostra, R., Zuckerman, D., & Parker, K. (2018). *Embracing an Anchor Mission: ProMedica's All-In Strategy*. ProMedica & The Democracy Collaborative. https://democracycollaborative.org/publications/embracing-an-anchor-mission-promedicas-all-in-strategy
This report offers an in-depth look at how the Toledo, Ohio based health system aligned its institutional operations and clinical practice to better tackle the social determinants of health. From an innovative hospital-owned grocery store in a food desert to investments in preserving affordable housing, this exploration of ProMedica's decade-long journey to understand how their resources as a health care anchor could be used for the well-being of the communities they serve is a useful guide for hospitals and health systems embarking on similar shifts. ProMedica's Anchor Mission is embedded in an overall strategy related to addressing the social determinants of health as a whole. ProMedica takes a multi-tiered approach to measuring the success and significance of their Anchor Mission approach to tackling the social determinants of health. Their dashboard measures key indicators in ten overarching areas of focus for social determinants including: economic and community development, education and job creation, thriving, inclusive business and equitable employment, personal finances, social determinant screening, hunger, housing, infant mortality, arts and culture development, and SDOH research.

Raday, S., Krodel, N., & Chan, A. (2018). *Human Services Organizations: Partnering for Better Community Health. Actionable advice from the Healthy Outcomes Initiative*. Nonprofit Finance Fund. https://nff.org/report/human-services-organizations-partnering-better-community-health
This report explores how collaboration between human services organizations and health systems can help people experience better health outcomes. The report and comprehensive resources capture knowledge and insights from the Healthy Outcomes Initiative, a multi-year project supported by The Kresge Foundation, and are intended for those new to human services and health collaborations as well as pioneering practitioners. [website description]

Ruggles, L. (2020). Frameworks for Community Impact - Community Case Study. *Front Public Health*, *8*, 197. https://doi.org/10.3389/fpubh.2020.00197
The Affordable Care Act of 2008 placed specific community health needs assessment and community benefit reporting requirements on US not-for-profit hospitals. The requirements are straightforward, but come with no expectation for synergy between the needs assessment and the community benefit spending, no direction on how to design systems to improve community health, and with surprisingly little accountability for improving health outcomes. With the help of diverse community partners, one Critical Access Hospital in rural Vermont has successfully linked the needs assessment with community benefit dollars to address upstream contributors

of health. In 2014, the Northeastern Vermont Regional Hospital led the creation of *NEK Prosper: Caledonia and Southern Essex Accountable Health Community* with a mission to tackle poverty as the ultimate root cause of poor health in the region. This article outlines how a hospital community health needs assessment ignited a change in how community partners worked together, aligned organizational strategies, and overcame industry jargon barriers to create regional system change to improve health. And how that same hospital has used community benefit dollars to accelerate action at the community level.

Taylor, L. A., & Byhoff, E. (2021). Money Moves the Mare: The Response of Community-Based Organizations to Health Care's Embrace of Social Determinants. *Milbank Quarterly*, *99*(1), 171-208. https://doi.org/10.1111/1468-0009.12491
Recent health policies incentivize health care providers to collaborate with community-based organizations (CBOs), such as food pantries and homeless shelters, to address patients' social determinants of health (SDOH). The perspectives of health care leaders on these policy changes have been studied, but the perspectives of CBO managers have not. In order to understand how CBOs in Massachusetts are perceiving and responding to new Medicaid policies that encourage collaboration between health care organizations and CBOs, researchers interviewed 46 people in leadership positions at CBOs in Massachusetts. They found that Massachusetts CBOs perceive health systems as potential sources of revenue, due in part to an ongoing Medicaid redesign that encourages the integration of health and social services. However, this perception is driving CBOs to appear more like health care organizations, and the impacts of these changes on welfare remain unknown.

Thomas-Henkel, C., & Schulman, M. (2017). *Screening for Social Determinants of Health in Populations with Complex Needs: Implementation Considerations*. Center for Health Care Strategies. https://www.chcs.org/media/SDOH-Complex-Care-Screening-Brief-102617.pdf
This brief examines how organizations participating in Transforming Complex Care (TCC), a multi-site national initiative funded by the Robert Wood Johnson Foundation, are assessing and addressing SDOH for populations with complex needs. It reviews key considerations for organizations seeking to use SDOH data to improve patient care, including: selecting and implementing SDOH assessment tools; collecting patient-level information related to SDOH; (3) creating workflows to track and address patient needs; and (4) identifying social service resources and tracking referrals.

Wodchis, W. P., Shaw, J., Sinha, S., Bhattacharyya, O., Shahid, S., & Anderson, G. (2020). Innovative Policy Supports for Integrated Health And Social Care Programs In High-Income Countries. *Health Affairs*, *39*(4), 697-703. https://doi.org/10.1377/hlthaff.2019.01587
As high-income countries face the challenge of providing better and more efficient integrated health and social care to high-needs and high-cost populations, they may require innovative policy supports at both the national and local levels. The authors categorized policy supports into four areas: governance and partnerships; workforce and staffing; financing and payment; and data sharing and use. Their structured survey of 30 integrated health and social care programs in high-income countries in 2018 found that most programs had policy supports in two or more areas, with supports for governance/partnerships and for workforce and staffing being the most common. Financing and payment and data sharing and use were less common. Local partnerships empowered integration across sectors, and new staff roles that spanned health and social care embedded this integration in care delivery. National policies—including bundled financing and investment in data—enabled integration and cross-sector accountability.

CASE EXAMPLES

This section contains profiles or examples of state and/or community-based initiatives addressing the SDOH or HRSNs. These profiles are typically published by funders, such as the RWJF's Aligning Systems project, or policy organizations such as the National Academy for State Health Policy or the Center for Healthcare Strategies.

Aligning Systems for Health. (2019). *Aligning in Action: Yamhill Community Care Organization*. Georgia Health Policy Center.
https://www.alignforhealth.org/resource/aligning-in-action-yamhill-community-care-organization/
This case study explores Yamhill Community Care Organization's (YCCO) best practices for effectively aligning systems to meaningfully impact health inequities in Yamhill County, Oregon. The case study examines how communities that describe their work as aligning systems are doing it around four core components of a theory of change that the Robert Wood Johnson Foundation and Georgia Health Policy Center are testing: purpose, governance, data, and sustainable financing mechanisms. YCCO coordinates care for enrollees in the Oregon Health Plan (Medicaid) in Yamhill County. Founded in 2012, the YCCO aligns its organizational goals with multi-sector, community, and government partners using a collective impact framework to address social problems. [website description]

Aligning Systems for Health. (2020). *Aligning in Action: Western Idaho Community Health Collaborative*. Georgia Health Policy Center.
https://ghpc.gsu.edu/download/aligning-in-action-western-idaho-community-health-collaborative/
This case study examines how payers, foundations, health systems, and public health came together in early 2019 to form a 10-county collaborative and align each other's strategies and investments in a coordinated effort. The resulting Western Idaho Community Health Collaborative (WICHC) represents just under half of the state's population. WICHC is a 21-member collaborative that represents the subject matter expertise across the different sectors working within community health — dental, behavioral health, nursing, physicians, public health, hospitals, transportation, local government, and community-based organizations. [website description]

Ariadne Labs. (2021). *Right Care, Right Place, Right Time in Maine*. Ariadne Labs.
https://www.ariadnelabs.org/resources/downloads/right-care-right-place-right-time-in-maine-report/
Focused on Washington County, Maine, this study is a joint research initiative developed by personnel at Ariadne Labs, Boston, Massachusetts and the Schmidt Institute, Bangor, Maine with funding provided by the Maine Health Access Foundation. The research team conducted forty-six interviews with frontline medical, dental, nursing, EMS, behavioral health, long term care, tribal health, patient and community groups, inclusive of seventy-nine individuals. The study had four objectives to identify systemic constraints (local and distant) that affect the ability of Washington County residents to access and utilize health and social services: (1) identify the existing clinical service strengths in Washington County among hospitals, Federally Qualified Health Centers (FQHC), nursing homes, emergency medical service (EMS) providers, behavioral health services, public health entities, community organizations, and any tertiary medical center that receives transfers/overflow/diversion from one or more of the rural

hospitals; (2) identify local gaps in health care services and gaps in services elsewhere in the state that affect local capacity and the impact of those gaps on the quality and safety of care for community members; (3) identify the priorities and preferences of providers for sustaining or restoring essential health care in their communities; (4) identify community coalitions capable of organizing and leading change/innovation in the provision of health care services in partnership with the Maine Department of Health and Human Services.

Bhatt, J., Nadler, J., Hewson, A., Chang, C., & Varia, H. (2022). *Advancing Health Equity Through Community-Based Ecosystems*. Deloitte Insights. https://www2.deloitte.com/us/en/insights/industry/health-care/community-health-healthcare-ecosystem.html

Stronger partnerships can help health systems address drivers of health and create a world in which everyone thrives. The authors conducted this study to understand how health care systems improve health equity by strengthening existing ecosystems and increasing connections, tools, and shared goals among the partners. To gather these insights, they interviewed 15 C-suite–level experts in areas such as health equity, diversity, equity, and inclusion from health systems, CBOs, departments of health, foundations, and technology companies and conducted an extensive literature review. These ecosystem models have different names: public-private partnerships, collective impact, stewardship, or aligned action. Regardless of the model, keys to successful ecosystems often include: establishing relationships with the right partners in the community and ensuring community voices are heard, creating a governance model and developing shared goals, leveraging new technology platforms when possible, and using existing key performance indicators (KPI) to understand progress. Every ecosystem will be unique to its geographic area and its participants. While sustaining ecosystems is not without challenges, partnerships that evolve into ecosystems can have a greater impact on the drivers of health and the health of their communities. [From the Executive Summary]

Center for Health Care Strategies, Crumley, D., Mohr Peterson, J., & Ferguson-Mahan Latet, K. (2021, September 29, 2021). *Identifying and Addressing Health-Related Social Needs through Primary Care Innovation in Medicaid Managed Care* [webinar]. https://www.chcs.org/resource/identifying-and-addressing-health-related-social-needs-through-primary-care-innovation-in-medicaid-managed-care/

This webinar explored how state Medicaid agencies and health plans can partner with primary care teams to identify and address health-related social needs for the individuals and communities they serve. The 60-minute event focused on ways to strategically design managed care requirements and value-based payment models to advance work relating to health-related social needs.

Centers for Medicare & Medicaid Services. (2021). *Aligning Provider and Payer Activities to Address Social Determinants of Health: Spotlight on Allina Health*. CMS. https://innovation.cms.gov/media/document/ahcm-casestudy-allina

Allina Health, a not-for-profit health care system operating in Minnesota and western Wisconsin, is a participant in the Accountable Health Communities (AHC) Model. This spotlight describes Allina Health's partnership with Blue Cross and Blue Shield of Minnesota to build on work accomplished under the model to develop their SDOH 2.0 strategy.

Centers for Medicare & Medicaid Services. (2021). *Building Strong Community Partnerships to Address Social Needs: A Case Study in Effective Advisory Board Collaboration From The Accountable Health Communities Model*. CMS. https://innovation.cms.gov/media/document/ahcm-casestudy-healthnet

Health Net of West Michigan is a nonprofit organization in Kent County, Michigan, that aims to create a "community where everyone has a fair and just opportunity to be as healthy as possible." As an Alignment Track bridge organization participating in the Accountable Health Communities (AHC) Model, Health Net established an advisory board made up of community partners across sectors who strive to create equitable systems change. Health Net's advisory board focuses on addressing social determinants of health at the community and systems levels, involving community advisors and executive-level representatives from community entities, coalitions, and local government.

Centers for Medicare & Medicaid Services. (2022). *Making the Business Case for Addressing Health-Related Social Needs: Spotlight on Reading Hospital*. CMS. https://innovation.cms.gov/media/document/ahc-reading-hosp-spotlight

Reading Hospital is the flagship hospital of Tower Health in Reading, Pennsylvania. The hospital's Community Wellness department created the Community Connections Program (CCP) to implement the Accountable Health Communities (AHC) Model, through which Reading conducts screening, referral, and community service navigation for Medicare and Medicaid patients' health-related social needs (HRSNs) at 29 clinical delivery sites. This spotlight describes how Reading's CCP staff secured internal funding to sustain HRSN screening, referral, and navigation activities beyond their participation in the AHC Model.

Chuang, E., Pourat, N., Haley, L. A., O'Masta, B., Albertson, E., & Lu, C. (2020). Integrating Health And Human Services In California's Whole Person Care Medicaid 1115 Waiver Demonstration. *Health Affairs*, *39*(4), 639-648. https://doi.org/10.1377/hlthaff.2019.01617

This study provides an overview of early progress in and strategies used to implement California's Whole Person Care (WPC) Pilot Program, a $3 billion Medicaid Section 1115(a) waiver demonstration project focused on improving the integrated delivery of health, behavioral health, and social services for Medicaid beneficiaries who use acute and costly services in multiple service sectors. WPC pilots reported significant progress in developing partnerships, data-sharing infrastructure, and services needed to coordinate care for identified patient populations. The authors also identified major barriers to WPC implementation, such as difficulty identifying and engaging eligible beneficiaries and the lack of affordable housing. The findings offer insights to leaders and policy makers interested in testing new approaches for improving the health and well-being of medically and socially complex patients.

Department of Vermont Health Access. (2020). *Vermont Medicaid Next Generation ACO Program: St. Johnsbury's Experience with an Expanded Attribution Pilot Project*. Department of Vermont Health Access. https://dvha.vermont.gov/initiatives/payment-reform/vermont-medicaid-next-generation-aco-program

This goal of this document is to capture the details and experiences behind the implementation of the 2019 St. Johnsbury Vermont Medicaid Next Generation (VMNG) Expanded Attribution Pilot Project ("Pilot Project"). The document highlights relevant experiences, tools, templates, operational frameworks, best practices, and lessons learned that came to life either leading up to or during the 2019 Pilot Project program year. The intent of sharing details of the St. Johnsbury experience is to help inform and support future design and implementation.

Elevate Health. (2021). *Elevate Health Brief*. Elevate Health. https://elevatehealth.org/media/elevate-health-at-a-glance
Elevate Health's mission is to build and drive community coalitions that transform health systems and advance whole-person health for all. They work with community partners, patients and providers to transform multisector systems of health and seek to increase savings, eliminate health gaps, and improve health equity for the residents throughout Pierce County, WA. [website description]

Gale, J., Coburn, A., Pearson, K., Croll, Z., & Shaler, G. (2016). *Population Health Strategies of Critical Access Hospitals* (Briefing Paper #36). http://www.flexmonitoring.org/wp-content/uploads/2016/09/bp36.pdf
Hospitals and health systems, including those serving rural communities, are increasingly embracing population health strategies as they move toward accountable care models of health care delivery and financing and seek to re-focus their community benefit activities to improve the overall health of their communities, demonstrating their accountability to local stakeholders. This paper details the population health strategies of a geographically diverse set of Critical Access Hospitals (CAHs) to identify key challenges, opportunities, and lessons that could inform the efforts of other CAHs and state Flex Programs. This paper provides examples of eight CAHs and communities that have made substantial commitments to population health and community health improvement. Key themes that emerged from the qualitative interviews of the selected CAHs highlight the collaborative nature and the high level of community involvement of the various initiatives.

Georgia Health Policy Center. (2018). *Local Financing Innovations: Caledonia-So. Essex Accountable Health Community*. GHPC. https://scholarworks.gsu.edu/ghpc_briefs/225
This brief is one is a series of innovations highlighting creative health system change. These innovations address upstream drivers of health, do not solely rely upon grants, involve multisector partners, and maintain a long-term focus, rather than fixing an immediate community need. The mission of the Caledonia-So. Essex Accountable Health Community is to improve the health and well-being of the people of Caledonia and southern Essex counties by integrating efforts and services, with the goal of reducing poverty in the region. The five identified outcomes they are striving to achieve include fostering a well-housed, well-nourished, physically healthy, mentally healthy, and financially secure population.

Health Research & Educational Trust. (2017). *Hospital-community partnerships to build a Culture of Health: A compendium of case studies*. HRET. https://www.aha.org/system/files/hpoe/Reports-HPOE/2017/hospital-community-partnerships-case-study-compendium.pdf
This report features descriptions of various community initiatives to build a Culture of Health. Collaboration is an essential feature of developing, implementing and sustaining effective strategies and programs to achieve a Culture of Health. Key takeaways from the compendium include the following observations: (1) partnerships share valuable assets including financial and human resources, tools, and expertise; (2) hospital-community partnerships are necessary to develop non-clinical interventions to address community health issues; (3) identifying partners and assets and action planning may be simplified through structured activities; (4) drivers of success include aligned goals, transparent and ongoing communication, and strong leadership; (5) successful partnerships leverage their strengths and identify weaknesses; (6) evaluation and celebration of progress can strengthen partnerships and accelerate momentum; and (7) sustainable partnerships integrate innovative strategies and practical tools in existing practices.

Johnson, K., Ogbue, C., Verlander, K., & Barolin, N. (2022, August 8). *Lessons From Five Years of the CMS Accountable Health Communities Model*. Health Affairs. Retrieved August 8 from https://www.healthaffairs.org/content/forefront/lessons-five-years-cms-accountable-health-communities-model

The Accountable Health Communities (AHC) Model was the Centers for Medicare and Medicaid Services' (CMS') first model test focused on evaluating HRSN screening, referral, and navigation. It was built on emerging interventions in Accountable Care Organizations (ACOs), Medicaid Managed Care, Medicaid health homes, and home and community-based services programs. Early evidence from the AHC Model is promising, and there are many lessons to share to continue addressing HRSNs and social determinants of health for Medicare and Medicaid beneficiaries. In this article, the authors review key evaluation findings to date and promising practices that providers and payers can implement to address HRSNs in their patient populations and communities. They also describe emerging themes for how AHC Model participants, called bridge organizations, plan to scale and sustain the model interventions and how lessons learned are being embedded across CMS.

Kaye, N. (2021). *Massachusetts Fosters Partnerships Between Medicaid Accountable Care and Community-Based Organizations to Improve Health Outcomes*. National Academy for State Health Policy. https://www.nashp.org/massachusetts-fosters-partnerships-between-medicaid-accountable-care-and-community-organizations-to-improve-health-outcomes/

Since 2018, three Massachusetts state agencies have incentivized Medicaid accountable care organizations (ACOs) to forge partnerships with community-based organizations and social service agencies. These partnerships have improved the quality of care, with enhanced care coordination and social services support, for thousands of Medicaid enrollees. In the past year, the state has leveraged these partnerships to respond to the COV ID-19 pandemic. This report explores how they did it. [website description]

Kaye, N. (2021). *Oregon's Community Care Organization 2.0 Fosters Community Partnerships to Address Social Determinants of Health*. National Academy for State Health Policy. https://www.nashp.org/oregons-community-care-organization-2-0-fosters-community-partnerships-to-address-social-determinants-of-health/

Since 2012, Oregon has fostered partnerships between its Medicaid accountable care organizations (Coordinated Care Organizations or CCOs) and community-based organizations (CBOs). These CCO/CBO partnerships have helped reduce health inequities by addressing both individual CCO members' social needs and community social determinants of health (SDOH). This report explores how Oregon built on the achievements and lessons learned from the first phase to more effectively foster partnerships that focus on state and local population health priorities. Key takeaways include:

- Success in efforts to foster CCO/CBO partnerships that address SDOH.
- Strengthening and refining CCO policies over time to more effectively foster CCO/CBO partnerships.
- The most effective CCO/CBO partnerships had clear expectations and roles for both partners, which in turn created actions linked to measurable outcomes.
- Supporting both partners was critical to success. Oregon's Transformation Center helped CCOs, and to an extent CBOs, to implement the new policies.
- The state's public health agency is a critical partner in Oregon Medicaid's efforts to foster CCO/CBO partnerships. The state health department also provided support by convening partners and providing data that informed planning.

Michigan State Innovation Model project. (2017). *Jackson Community Health Innovation Region. Building Capacity to Transform Care: Year One Highlights*. Michigan Department of Health and Human Services. https://www.michigan.gov/-/media/Project/Websites/mdhhs/Folder3/Folder44/Folder2/Folder144/Folder1/Folder244/Jackson_Bright_Spots_final.pdf?rev=dd342a598a0f4eeca646f0c548adac4c
Jackson's Community Health Improvement Region (CHIR) is a partnership of health and human service agencies addressing health, education and financial stability across Jackson County, Michigan. The CHIR functions as a distributed network with multiple collective impact collaboratives or 'strands' (Health Improvement Organization, Financial Stability Network, and Cradle to Career Education Network) working together to leverage shared infrastructure that supports a systems change approach to community well-being. Henry Ford Allegiance Health serves as the backbone organization for health improvement efforts, providing leadership and facilitating the development of a common agenda, shared measurement, mutually-reinforcing activities, and continuous communication.

Naeem, J., Salazar-Contreras, E., Sundaram, V., Wainwright, L., Kosel, K., & Miff, S. (2022). The Dallas Accountable Health Community: Its Impact on Health-Related Social Needs, Care, and Costs. *NEJM Catalyst*, *3*(9), CAT.22.0149. https://doi.org/10.1056/CAT.22.0149
Leaders at the Parkland Center for Clinical Innovation describe the challenges and successes associated with their 5-year involvement in a federally supported study of care delivery efforts to address health-related social needs through community collaboration and patient navigation. The program resulted in lower utilization, a decrease in health care expenditures, and a positive ROI.

National Academies of Sciences, Engineering, and Medicine. (2021). *Models for Population Health Improvement by Health Care Systems and Partners: Tensions and Promise on the Path Upstream: Proceedings of a Workshop*. National Academies Press. http://nap.edu/26059
The workshop explored the growing attention on population health, from health care delivery and health insurance organizations to the social determinants of health and their individual-level manifestation as health-related social needs. The workshop showcased collaborative population health improvement efforts, each of which included one or more health systems. This publication summarizes the presentations and discussions from the workshop. [website description]

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This special double issue of NEJM Catalyst Innovations in Care Delivery shows how health care organizations are actively addressing the social determinants of health and health-related social needs. This special theme issue highlights important ongoing work on both the barriers to addressing these challenging topics and strategies for overcoming them.

New York State. (2018). *North Country Innovation Pilot (NCIP)*. New York State. https://northcountryinitiative.org/
The North Country Innovation Pilot (NCIP) is a unique partnership of providers poised to work together in a well-defined, rural region of upstate New York to improve care outcomes for all through alignment, integration and coordination. Through a total cost of care (TCOC) payment model inclusive of global payments for hospitals, together with an aligned set of outcome-based quality metrics, the pilot aims to improve health outcomes, facilitate care integration, and promote investments in primary care, public health, behavioral health and social determinants.

The pilot will lead with public plans as its core participants, inclusive of Medicare and Medicaid, dually eligible individuals, and state and municipal employees covered by the New York State Health Insurance Plan. As many as 300,000 residents of a six county area would ultimately be eligible to participate. The pilot would be developed throughout 2019 with a phased implementation in 2020. Rigorous measurement and evaluation will ensure timely reporting of results, support pilot refinements as needed and allow for replicability.

North Carolina Department of Health and Human Services. (2019). *North Carolina's Healthy Opportunities Pilots: A Review of Proposed Design for Interested Stakeholders*. North Carolina Department of Health and Human Services. https://www.ncdhhs.gov/media/11697/download
This paper describes the preliminary program design for the Healthy Opportunities Pilots for interested stakeholders, including human service organizations (e.g., community-based organizations and social service agencies), health care providers, care management entities, advocates and others. The Healthy Opportunities Pilots are testing the impact of providing selected evidence-based interventions to Medicaid enrollees and establishing and evaluating a systematic approach to integrating the provision of evidence-based non-medical services into the delivery of health care. For more information, visit the Health Opportunities Pilots website at: https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/healthy-opportunities-pilots

Oostra, R., Zuckerman, D., & Parker, K. (2018). *Embracing an Anchor Mission: ProMedica's All-In Strategy*. ProMedica & The Democracy Collaborative. https://democracycollaborative.org/publications/embracing-an-anchor-mission-promedicas-all-in-strategy
This report offers an in-depth look at how the Toledo, Ohio based health system aligned its institutional operations and clinical practice to better tackle the social determinants of health. From an innovative hospital-owned grocery store in a food desert to investments in preserving affordable housing, this exploration of ProMedica's decade-long journey to understand how their resources as a health care anchor could be used for the wellbeing of the communities they serve is a useful guide for hospitals and health systems embarking on similar shifts. ProMedica's Anchor Mission is embedded in an overall strategy related to addressing the social determinants of health as a whole. ProMedica takes a multi-tiered approach to measuring the success and significance of their Anchor Mission approach to tackling the social determinants of health. Their dashboard measures key indicators in ten overarching areas of focus for social determinants including: economic and community development, education and job creation, thriving, inclusive business and equitable employment, personal finances, social determinant screening, hunger, housing, infant mortality, arts and culture development, and SDOH research.

Pick, M., Lahr, M., & Moscovice, I. (2021). *Rural Initiatives Addressing Community Social Needs*. Flex Monitoring Team. https://www.flexmonitoring.org/sites/flexmonitoring.umn.edu/files/media/FMT_CS_01_2021.pdf
Optimal health is determined by many factors that go beyond access to quality health care. As a result, hospitals in the U.S. have started to address the immediate social needs of their patients (such as food access or safe housing). This case series describes two Critical Access Hospital (CAH)-based initiatives addressing social needs at Lakewood Hospital in Staples, Minnesota and Northeastern Vermont Regional Hospital in St. Johnsbury, Vermont. The goal of the case series is to provide best practices for CAHs and communities that may wish to emulate these programs.

Pourat, N., O'Masta, B., Haley, L. A., & Chuang, E. (2021). *A Snapshot of California's Whole Person Care Pilot Program: Implementation Strategies and Enrollees*. UCLA Center for Health Policy Research. https://healthpolicy.ucla.edu/publications/Documents/PDF/2021/wholepersoncare-policybrief-may2021.pdf
The Whole Person Care (WPC) Pilot program implemented under California's Section 1115 Medicaid Waiver, "Medi-Cal 2020," coordinates medical, behavioral, and social services to improve the health and well-being of Medi-Cal beneficiaries with complex needs. In this policy brief, authors analyze data from the interim statewide evaluation of WPC to present a snapshot of the 25 participating pilots, based on key implementation strategies and enrollee characteristics. The data can be used by organizations that are developing population health management programs for high-need, high-risk Medi-Cal beneficiaries under the California Advancing and Innovating Medi-Cal (CalAIM) initiative, as well as by other programs providing care to low-income patients. [website description]

Pourat, N., O'Masta, B., Haley, L. A., Zhou, W., & Chuang, E. (2022). *Whole Person Care Program Successfully Navigated Around COVID-19 Challenges in 2020*. UCLA Center for Health Policy Research. https://healthpolicy.ucla.edu/publications/Documents/PDF/2022/WholePersonCare-policybrief-jan2022.pdf
California implemented the Whole Person Care (WPC) Pilot program under "Medi-Cal 2020," a Section 1115 Medicaid Waiver program designed to coordinate the care of high-utilizing Medi-Cal beneficiaries across medical, behavioral health, and social service sectors. In this policy brief, authors examine the impact of the pandemic on WPC implementation, enrollment, and health service utilization. Authors found that all WPC Pilots reported at least some COVID-19 pandemic-related alterations to WPC implementation. Total enrollment increased in 2020, with lower rates of new enrollment and disenrollment. The mid-March shutdown also resulted in an initial decline in enrollee health service utilization. However, by the end of 2020, primary care and specialty services had reverted to pre-pandemic patterns, while emergency department and hospitalization rates remained lower than pre-pandemic rates. In this policy brief, authors discuss the implications of these findings for the transition to CalAIM and WPC evaluation.

Resnick, J. (2022). *Using Z Codes to Improve Health Equity in Rural Indiana*. American Hospital Association. https://www.aha.org/system/files/media/file/2022/10/case-study-using-z-codes-to-improve-health-equity-in-rural-indiana.pdf
Hospitals and health systems are working to address the social factors that influence health, including the social needs of their patients, social determinants of health in their communities and the systemic causes that lead to health inequities. Hospitals can capture data on the social needs of their patient population by using the ICD-10-CM Z codes, which identify nonmedical factors that may influence a patient's health status. Z codes became available in fiscal year 2016; however, their adoption has been slow. Cameron Memorial Community Hospital is an independent, critical access hospital in northeastern Indiana. As part of their health equity strategy, the hospital began using ICD-10-CM Z codes to detect and address their patients' social needs.

Rozansky, P. (2011). *Maryland's Local Management Boards: Making a Difference for Children and Families 1990-2010*. Richard A. Henson Foundation and the Annie E. Casey Foundation. https://communitypartnerships.info/wp-content/uploads/2014/05/MD_LMB_Jan_2011.pdf
Maryland's Local Management Boards (LMBs) are known statewide and across the nation as pioneers in the field of community decision-making. This report aims to capture the pioneering work of Maryland's 24 LMBs to implement a locally coordinated service delivery system to improve outcomes for children, youth and families and to assemble evidence about what LMBs have accomplished. An online survey assessed the effectiveness and impact of the LMBs, with over 800 respondents representing parents, government agencies, school districts, LMB board members, service providers, faith leaders, business leaders, community volunteers, and others.

Ruggles, L. (2020). Frameworks for Community Impact - Community Case Study. *Frontiers in Public Health*, *8*, 197. https://doi.org/10.3389/fpubh.2020.00197
The Affordable Care Act of 2008 placed specific community health needs assessment and community benefit reporting requirements on US not-for-profit hospitals. The requirements are straightforward, but come with no expectation for synergy between the needs assessment and the community benefit spending, no direction on how to design systems to improve community health, and with surprisingly little accountability for improving health outcomes. With the help of diverse community partners, one Critical Access Hospital in rural Vermont has successfully linked the needs assessment with community benefit dollars to address upstream contributors of health. In 2014, the Northeastern Vermont Regional Hospital led the creation of *NEK Prosper: Caledonia and Southern Essex Accountable Health Community* with a mission to tackle poverty as the ultimate root cause of poor health in the region. This article outlines how a hospital community health needs assessment ignited a change in how community partners worked together, aligned organizational strategies, and overcame industry jargon barriers to create regional system change to improve health. And how that same hospital has used community benefit dollars to accelerate action at the community level.

Rural Health Value. (2021). *Northern Michigan Community Health Innovation Region* (Rural Innovation Profile). RUPRI. https://ruralhealthvalue.public-health.uiowa.edu/files/NMCHIR%20Profile.pdf
Northern Michigan Community Health Innovation Region (NMCHIR) focuses on social determinants of health needs across a ten-county area in the Northwest Lower Peninsula. The cross-sector partnerships of NMCHIR identify and address community health priorities, including economic security, transportation (community mobility), healthy food, affordable housing, behavioral health, and substance abuse. Individual needs are determined with a screening tool and are referred to the Community Connections Hub, an evidenced based clinical community linkages model that connects individuals and families to community resources.

Rural Health Value. (2022). *Experience in the Pennsylvania Rural Health Model: Barnes-Kasson County Hospital* (Rural Innovation Profile). RUPRI. https://ruralhealthvalue.public-health.uiowa.edu/files/Barnes-Kasson_PARHM_Innovation-Profile.pdf
A Critical Access Hospital in Susquehanna, PA provides insight into their experience participating in the Pennsylvania Rural Health Model, which includes a global budget and transforming care to address community health needs.
Key Points:
- Transformation plans with goals focused on addressing community health needs help guide the hospital's PARHM activities as well as overall hospital strategic planning.
- Participation in PARHM has led to reallocation of staff into new or changing roles to address chronic conditions and to put population health into practice.

- Although Barnes-Kasson hospital leadership identifies the global budget as a useful motivator for redesigning care to be more value-oriented, they have found the payment approach to be complicated, and it has been challenging to establish a predictable budget from year-to-year as a critical access hospital.
- Extensive and valuable peer learning and support has been available through the Rural Health Redesign Center that is supporting model implementation.

Rural Health Value. (2022). *Vermont's All-Payer Accountable Care Organization Model: Mt. Ascutney Hospital and Health Center's Experience* (Rural Innovation Profile). RUPRI. https://ruralhealthvalue.public-health.uiowa.edu/files/Mt_Ascutney_Profile.pdf

Mt. Ascutney Hospital and Health Center (MAHHC) uses panel management, outcome metrics, and best practices to participate in Vermont's All-Payer Accountable Care Organization (ACO) Model to improve the quality of care Vermonters receive while controlling the state's health care spending. Medicare, Medicaid, and commercial health plans in Vermont have partnered to test an alternative payment model statewide that requires health care organizations like MAHHC to innovate health care delivery and achieve shared goals. Participation in the ACO has allowed MAHHC to implement strategies to better meet community needs ranging from prevention to complex care management.

Key Points:

- Established as a joint effort between CMS and the state of Vermont, Vermont's ACO (OneCareVermont) explores new ways to pay for health care services that control the state's health care spending and improve the health of Vermonters.
- As a participant in the joint effort, Mt. Ascutney Hospital and Health Center (MAHHC) has been steadily increasing the number of patients cared for under risk based contracts (rather than fee for service), and uniting the physical health, mental health, and social services sectors to serve patients with complex needs.
- MAHHC is committed to the ACO's goal to include 90 percent of Medicare beneficiaries and 70 percent of "Vermont all payer beneficiaries" (most Vermonters) in the ACO by December 31, 2022.

COMMUNITY PARTNERSHIPS

Documents referenced in this section discuss strategies for effecting successful and sustainable partnerships among health care and other community organizations. Many review common challenges (and strategies to overcome them) in bringing organizations to the table and keeping them invested in building more aligned systems of care.

American Hospital Association, Future of Rural Health Care Task Force. (2021). *The Hospital as a Convener in Rural Communities* [Case Study]. AHA. https://www.aha.org/system/files/media/file/2021/04/rural-case-study-the-hospital-as-convener-in-rural-communities-april-2021.pdf

Nearly 60 million people—20% of all Americans—live in areas designated as "rural." The hospital serves as a crucial resource to promote health and well-being in these communities. Rural hospitals often serve as economic anchors in their community by providing job opportunities and purchasing goods and services within the local economy. However, there remains a significant opportunity for rural hospitals to expand their role beyond that of an anchor institution and serve as a convener for other stakeholders with the shared goal of improving health and well-being. This case study examines the convener role, traditional and non-traditional partners and how hospitals can establish themselves as conveners. It also highlights learnings from two examples of successful conveners—Trinity Health, a large, multi-institution Catholic health system headquartered in Livonia, Michigan, and Carilion Clinic, a not-for-profit health care organization and network in southwestern Virginia. [from the Overview]

Aligning Systems for Health. (2021). *Community Member Experiences with Collaboratives: Preliminary Findings*. Georgia Health Policy Center. https://ghpc.gsu.edu/download/community-member-experiences-with-collaboratives-preliminary-findings/

In July and August 2021, the Georgia Health Policy Center (GHPC) conducted interviews and a focus group with 15 community members who participated in, and in some cases were affected by, collaboratives in their communities. Participants were identified through GHPC partner organizations in California, Mississippi, Florida, and Georgia. This brief reviews themes drawn from the interviews and focus group and was reviewed and revised in partnership with the participants. Using these themes as a framework or lessons learned, institutional partners are aided in attaining successful collaboration with community members.

Aligning Systems for Health. (2021). *The Process of Partnering with Community Members: Preliminary Findings*. Georgia Health Policy Center. https://ghpc.gsu.edu/download/the-process-of-partnering-with-community-members-preliminary-findings/

This brief is a companion to the analysis of the community member experiences drawn from the interviews and focus group with community members conducted in July and August 2021. The brief addresses the goal of building relationships with community partners by presenting lessons learned about the community partnership process and was reviewed and revised in partnership with the participants.

Beers, A., Finisse, V., Moses, K., Crumley, D., & Sullivan, D. (2021). *Fighting Hunger by Connecting Cross-Sector Partners and Centering Lived Expertise*. Center for Health Care Strategies. https://www.chcs.org/media/Report-Fighting-Hunger-by-Connecting-Cross-Sector-Partners-and-Centering-Lived-Expertise_120221.pdf
The substantial overlap in eligibility for Medicaid and food support programs, such as the Supplemental Nutrition Assistance Program (SNAP), provides opportunities for states to coordinate their policies and processes to improve access to affordable, nutritious food. This report stems from the initiatives led by the Center for Health Care Strategies and the Robert Wood Johnson Foundation which explored the cross-sector strategies, opportunities, and barriers to improve the health of Medicaid beneficiaries and those enrolled in food programs. State agencies, including Medicaid and social service agencies, increasingly recognize the importance of integrating individual and community voices into policymaking, especially people from communities of color who experience disparities in food security. Opportunities to increase food access include: (1) develop a sustainable community engagement infrastructure that enable states to build meaningful relationships with and incorporate individuals with lived expertise in policy and program design; (2) center equity, humanity, and dignity in policymaking and in service provision to better serve people enrolled in Medicaid and nutrition programs; (3) address persistent eligibility and enrollment challenges through cross-agency partnerships; and (4) use state levers and authorities to advance coordination and innovations.

Beidler, L. B., Razon, N., Lang, H., & Fraze, T. K. (2022). "More than just giving them a piece of paper": Interviews with Primary Care on Social Needs Referrals to Community-Based Organizations. *Journal of General Internal Medicine*. https://doi.org/10.1007/s11606-022-07531-3
Primary care practices are responding to calls to incorporate patients' social risk factors, such as housing, food, and economic insecurity, into clinical care. While health care likely relies on the expertise and resources of community-based organizations (CBOs) to improve patients' social conditions, little is known about the referral process. The aim of this qualitative study of health care administrators responsible for social care efforts in their organization was to characterize the referrals by primary care physicians to CBOs. Interviewed administrators reported that social needs referrals were an essential element in their social care activities. Administrators described the ideal referral programs as placing limited burden on care teams, providing patients with customized referrals, and facilitating closed-loop referrals. The authors identified three key challenges organizations experience when trying to implement the ideal referrals program: (1) developing and maintaining resources lists; (2) aligning referrals with patient needs; and (3) measuring the efficacy of referrals. The authors conclude that referrals to CBOs were used in primary care to improve patients' social conditions, but despite strong motivations, interviewees reported challenges providing tailored and up-to-date information to patients.

Bhatt, J., Nadler, J., Hewson, A., Chang, C., & Varia, H. (2022). *Advancing Health Equity Through Community-Based Ecosystems*. Deloitte Insights. https://www2.deloitte.com/us/en/insights/industry/health-care/community-health-healthcare-ecosystem.html
Stronger partnerships can help health systems address drivers of health and create a world in which everyone thrives. The authors conducted this study to understand how health care systems improve health equity by strengthening existing ecosystems and increasing connections, tools, and shared goals among the partners. To gather these insights, they interviewed 15 C-suite–level experts in areas such as health equity, diversity, equity, and

inclusion from health systems, CBOs, departments of health, foundations, and technology companies and conducted an extensive literature review. These ecosystem models have different names: public-private partnerships, collective impact, stewardship, or aligned action. Regardless of the model, keys to successful ecosystems often include: establishing relationships with the right partners in the community and ensuring community voices are heard; creating a governance model and developing shared goals; leveraging new technology platforms when possible, and using existing key performance indicators (kpi) to understand progress. every ecosystem will be unique to its geographic area and its participants. While sustaining ecosystems is not without challenges, partnerships that evolve into ecosystems can have a greater impact on the drivers of health and the health of their communities. [From the Executive Summary]

Buck, L., Beers, A., & Mikels-Carrasco, W. (2022). *A Community-Centered Approach to Data Sharing and Policy Change: Lessons for Advancing Health Equity*. Center for Health Care Strategies. https://www.chcs.org/resource/a-community-centered-approach-to-data-sharing-and-policy-change-lessons-for-advancing-health-equity/

This brief highlights key lessons to inform data-sharing partnerships between community-based organizations, state agencies, and individuals with lived expertise and outlines data-sharing considerations for engaging community members in all aspects of data-sharing. Key takeaways: sharing data across state agencies and community-based organizations is critical for advancing health equity and addressing complex health challenges that involve multiple sectors; including individuals with lived expertise in data sharing and policy development can make these efforts more responsive to the needs of community members, particularly those in historically marginalized populations; and insights from individuals with lived expertise provide valuable context to inform data-sharing efforts that is critical to improving health equity. [website description]

Byhoff, E., & Taylor, L. A. (2019). Massachusetts Community-Based Organization Perspectives on Medicaid Redesign. *American Journal of Preventive Medicine*, *57*(6 Suppl 1), S74-s81. https://doi.org/10.1016/j.amepre.2019.07.017

The purpose of the study was to investigate how community-based organizations (CBOs) perceive Medicaid policy changes to address the social determinants of health. This study included 46 key informant interviews, representing 44 CBOs across Massachusetts conducted from September 2017 to March 2018. The interviews were designed to collect CBOs' perceptions of Medicaid policy changes. An Advisory Board was empaneled for feedback on data collection and analysis. Massachusetts was chosen as a study site in light of explicit policy efforts to incentivize health care organizations to take a more active role in social determinants of health, most notably through the creation of Medicaid Accountable Care Organizations. The CBOs expressed optimism about future partnerships with health care organizations, along with the recognition that health care organizations and CBOs can have conflicting agendas, including misaligned outcomes of interest and timelines. CBOs struggled to define a clear strategy for partnership in the face of incomplete information about how the final Medicaid redesign would proceed and what health care providers would be looking for in a partner. Changes to Medicaid policy can catalyze interest in partnership between health care organizations and CBOs. To minimize the impact of conflicting agendas, policymakers and health care leadership should ensure CBOs are part of strategy development and social service program implementation. This article is part of a supplement entitled *Identifying and Intervening on Social Needs in Clinical Settings: Evidence and Evidence Gaps*

Cartier, Y., Fichtenberg, C., & Gottlieb, L. (2019). *Community Resource Referral Platforms: A Guide for Health Care Organizations*. Social Interventions Research & Evaluation Network. https://sirenetwork.ucsf.edu/sites/default/files/wysiwyg/Community-Resource-Referral-Platforms-Guide.pdf
This guide synthesizes research findings regarding community resource referral technology platforms in order to provide health care organizations with a better understanding of the options available and factors to consider prior to implementing any community resource referral platform in a clinical setting.

Cartier, Y., Fichtenberg, C., & Gottlieb, L. (2020). Implementing Community Resource Referral Technology: Facilitators And Barriers Described By Early Adopters. *Health Affairs*, *39*(4), 662-669. https://doi.org/10.1377/hlthaff.2019.01588
Healthcare organizations are increasingly implementing programs to address patients' social conditions and new technology platforms have emerged to facilitate referrals to community social services organizations. To understand the functionalities of these platforms and identify the lessons learned by their early adopters in health care, the authors reviewed nine platforms that were on the market in 2018 and interviewed representatives from 35 early-adopter health care organizations. They identified key informants through solicited expert recommendations and web searches. With minor variations, all platforms in the sample provided similar core functionalities: screening for social risks, a resource directory, referral management, care coordination, privacy protection, systems integration, and reporting and analytics. Early adopters reported three key implementation challenges: engaging community partners, managing internal change processes, and ensuring compliance with privacy regulations. Early engagement with social services partners, funding models that support both direct and indirect costs, and stronger evidence of effectiveness together could help advance platform adoption.

Center for Health Care Strategies, Crumley, D., Mohr Peterson, J., & Ferguson-Mahan Latet, K. (2021, September 29). *Identifying and Addressing Health-Related Social Needs through Primary Care Innovation in Medicaid Managed Care* [webinar]. https://www.chcs.org/resource/identifying-and-addressing-health-related-social-needs-through-primary-care-innovation-in-medicaid-managed-care/
This webinar explored how state Medicaid agencies and health plans can partner with primary care teams to identify and address health-related social needs for the individuals and communities they serve, focusing on ways to strategically design managed care requirements and value-based payment models to advance work relating to health-related social needs. This webinar is part of a learning series from the Center for Health Care Strategies (CHCS), *Strengthening Primary Care through Medicaid Managed Care*, which is examining the tools and levers that states can use to advance comprehensive primary care strategies and equitably improve the health of Medicaid enrollees.

Center for Sharing Public Health Services. (2021). *A Roadmap to Develop Sharing Initiatives in Public Health: Expedited Version*. Center for Sharing Public Health Services. https://phsharing.org/resources/roadmap-expedited/
The Center for Sharing Public Health Services has created a Roadmap to help guide public health departments interested in sharing resources with other health departments or organizations. Sharing resources allows communities to solve problems that cannot be solved — or easily solved — by single organizations. This practice can increase effectiveness (enhancing the quality of existing services or increasing capacity) and efficiency (maximizing the value of each dollar invested in delivering public health services). It can also be a powerful tool to advance health

equity and improve the access to and delivery of public health services in the community. This document is a variation of the full Roadmap. It allows users to do a fast assessment of their existing sharing agreements or new agreements being considered.

Centers for Medicare & Medicaid Services. (2021). *A Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tool: Promising Practices and Key Insights*. CMS. https://innovation.cms.gov/media/document/ahcm-screeningtool-companion
This document describes the health-related social needs (HRSN) Screening Tool from the Accountable Health Communities (AHC) Model and share promising practices for universal screening. HRSNs are individual level, adverse social conditions that negatively impact a person's health or health care. HRSNs are distinguished from social determinants of health—the structural and contextual factors that shape everyone's lives for better or worse—and can be identified by the health care system and addressed in partnership with community resources. Identifying and addressing HRSNs can have many benefits, including improvements to individuals' health and reduced health care spending. The guide is intended for health care and social service providers who are increasingly adopting the practice of universal HRSN screening. Chapter 1 introduces the AHC Model and the AHC HRSN Screening Tool. Chapter 2 provides an overview of the AHC HRSN Screening Tool, and presents and describes the related screening tool questions for each domain, describes the scoring process and how to administer the tool outside the AHC Model. Promising practices for universal screening include: cultivate staff buy-in; tailor staffing models to site features; provide dedicated training on screening; use customized scripts to engage patients in screening; to maximize patient participation, consider the timing, location, and process for screening; anticipate population-specific needs; train staff to manage privacy and address safety concerns; institute continuous quality improvement; prepare staff to respond to common questions.

Chang, D. I., Gertel-Rosenberg, A., Blackburn, K. B., & Taylor, B. (2020). *Preliminary Findings on the Role of Health Care in Multi-Sector Networks for Population Health: Notes from the Field*. Nemours. https://www.movinghealthcareupstream.org/wp-content/uploads/2020/03/HealthCareRolesInPopulationHealthNetworks.pdf
Networked approaches to tackling complex social challenges are not new, yet practitioners and researchers are continually working to share frameworks for how to support, fund, and sustain work that cuts across sectors. This issue brief distills findings from 40 interviews (conducted July-September 2019) and provides an update on the interplay of integrative roles and functions and identifies barriers to, and accelerators for, health care to carry out these roles in multi-sector population health networks in a sustained fashion. The brief also includes recommendations for the field and for the provision of technical assistance to health care partners seeking to strengthen their integrator role over the longer-term.

Chappel, A., Cronin, K., Kulinksi, K., Whitman, A., DeLew, N., Hacker, K., Bierman, A. S., Meklir, S. W., Monarez, S. C., Johnson, K. A., Whelan, E.-M., Jacobs, D., & Sommers, B. D. (2022, November 29). *Improving Health And Well-Being Through Community Care Hubs*. Health Affairs Forefront web blog. https://www.healthaffairs.org/content/forefront/improving-health-and-well-being-through-community-care-hubs
The U.S. Department of Health and Human Services' (HHS's) strategic approach to addressing social determinants of health (SDOH) envisions a future in which all individuals, regardless of their social circumstances, have access to aligned health and social care systems that achieve equitable outcomes through high-quality, affordable, person-centered care. While identifying pathways to adequately fund social care is critical to achieving this vision, there is also a need

for communities to develop sustainable partnerships among health care providers, the public health system, and community-based organizations (CBOs), and to develop the data and financing infrastructure needed to support these partnerships. Multistakeholder collaborations to address SDOH have flourished in recent years and have informed what is needed to develop a sustainable operating infrastructure between health care and CBOs to address health-related social needs. This infrastructure is increasingly provided by community care hubs (hubs)—community-focused entities supporting a network of CBOs providing services addressing health-related social needs—which centralize administrative functions and operational infrastructure. The authors discuss the role and functions of hubs, provide examples of these organizations, and explore policy opportunities to maximize their role.

Christens, B. D., & Inzeo, P. T. (2015). Widening the view: situating collective impact among frameworks for community-led change. *Community Development*, *46*(4), 420-435. https://doi.org/10.1080/15575330.2015.1061680
Collective impact is a framework for achieving systems-level changes in communities through coordinated multi-sector collaborations. This article situates collective impact in relation to similar approaches, makes key distinctions between the collective impact framework and principles for grassroots community organizing, and draws on these distinctions to offer recommendations for enhancing collaborative practice to address community issues. The clarification of these distinctions provides possibilities for future innovations in community development practice, evaluation, and research.

Chuang, E., O'Masta, B., Albertson, E., Haley, L. A., Lu, C., & Pourat, N. (2019). *Whole Person Care Improves Care Coordination for Many Californians*. UCLA Center for Health Policy Research. https://healthpolicy.ucla.edu/publications/Documents/PDF/2019/wholepersoncare-policybrief-sep2019.pdf

California's Whole Person Care (WPC) Pilots implemented under the Section 1115 Medicaid Waiver, "Medi-Cal 2020," are designed to coordinate medical, behavioral and social services to improve the health and well-being of Medicaid beneficiaries with complex needs. The authors examined literature on care coordination and developed a framework for assessing the progress of WPC Pilot implementation in eight key areas. Three years into the program, results show that WPC Pilots successfully implemented many essential care coordination processes, but they continued to further develop needed infrastructure. These findings highlight opportunities and challenges in implementing a cross-sector care coordination program for patients with complex health and social needs. [website description]

Chuang, E., Pourat, N., & Haley, L. A. (2021, March 10). *Using Whole Person Care to Coordinate Health and Social Services for Medicaid Populations during the COVID-19 Pandemic* [Webinar]. Systems for Action, Research-in-Progress Webinar, online. https://systemsforaction.org/sites/default/files/resource_files/March%2010%20ResProg.pdf
This study evaluates the effectiveness of California's Whole Person Care (WPC) initiative in coordinating health and social services for Medicaid beneficiaries with complex needs during the COVID-19 pandemic, analyzing data from network surveys, Medicaid claims data, and key-informant interviews to assess program effectiveness from multiple perspectives. Projects in 26 counties engaged Medicaid health plans, medical providers, mental health agencies, social service organizations, and public health agencies in collaborative models of care and payment that target specific population groups with complex needs in each county, including people experiencing homelessness, those transitioning from incarceration, and patients with multiple

chronic medical conditions. Using a quasi-experimental research design, researchers assessed changes in collaborative community networks, service delivery patterns, and patient outcomes for program participants and matched comparison groups across 26 county-level projects before and after the onset of the COVID-19 pandemic.

Collective Impact Forum. (2017). *Backbone Starter Guide: A Summary of Major Resources about the Backbone*. Collective Impact Forum. https://collectiveimpactforum.org/resource/backbone-starter-guide-a-summary-of-major-resources-about-the-backbone/
For collective impact efforts, backbone support plays a critical role in helping a collaborative achieve its results, but it can be difficult to know where to start when building the backbone. What role should the backbone play? How can it be structured? How does it sustain itself? The Backbone Starter Guide is a new resource for those thinking about how to start a backbone, or for established backbone teams who are bringing in new members and partners. The starter guide includes a short overview of the collective impact approach and addresses: the backbone's purpose and functions, different types of backbone structures, leadership skills for backbone staff, the importance of centering equity within a backbone's work, and he role of the funder in supporting a backbone's sustainability.

Eder, M., Henninger, M., Durbin, S., Iacocca, M. O., Martin, A., Gottlieb, L. M., & Lin, J. S. (2021). Screening and Interventions for Social Risk Factors: Technical Brief to Support the US Preventive Services Task Force. *JAMA*, *326*(14), 1416-1428. https://doi.org/10.1001/jama.2021.12825
Evidence-based guidance is limited on how clinicians should screen for social risk factors and which interventions related to these risk factors improve health outcomes. This article describes research on screening and interventions for social risk factors to inform US Preventive Services Task Force considerations of the implications for its portfolio of recommendations.

Elevate Health. (2021). *Elevate Health Brief*. Elevate Health. https://elevatehealth.org/media/elevate-health-at-a-glance
Elevate Health's mission is to build and drive community coalitions that transform health systems and advance whole-person health for all. They work with community partners, patients and providers to transform multisector systems of health and seek to increase savings, eliminate health gaps, and improve health equity for the residents throughout Pierce County, WA. [website description]

Gaskins, A. S. P., Steinitz, R., & Hacke, R. (2020). *Investing in Community Health: A Toolkit for Hospitals*. Center for Community Investment and Catholic Health Association. https://centerforcommunityinvestment.org/community-health-toolkit
This toolkit is designed to help health care organizations look at their resources in a different light, expand their efforts to support their communities, and maximize their impact on community health by harnessing the power of their investment capital. It delves into a number of key topics: distinguishing between financial contributions and investment strategies, understanding the value of investment strategies for addressing the social determinants of health, and mobilizing investment capital to improve community health. [website description]

Georgia Health Policy Center. (2022). *Assessment for Advancing Community Transformation (AACT) Action Planning: Prioritizing Areas for Community Transformation*. Georgia Health Policy Center. https://ghpc.gsu.edu/the-assessment-for-advancing-community-transformation-tool/
The AACT tool is community-driven and -directed and requires no outside support to use the tool or interpret results. The validated AACT tool brings people together to get a deeper understanding and agreement on where the group is in its work together and consists of:

Six Key Themes: collaboration, communication, advance equity, plan for action, measure to improve, and sustainability; 22 Subthemes which include drill-down questions on main topic areas; Four Stages: a continuum to describe current status of efforts from 'not yet started' to 'sustaining' for each of the 22 questions; One Community Score: community members independently score then meet in deliberate conversation to agree on one score for each of the 22 items and an overall score, establish a baseline, and prioritize action steps. The AACT is not designed to compare or rank communities; rather it is intended to help communities determine where attention can be focused to accelerate community transformation.

Gillam, R. J., Counts, J. M., & Garstka, T. A. (2016). Collective impact facilitators: how contextual and procedural factors influence collaboration. *Community Development*, *47*(2), 209-224. https://doi.org/10.1080/15575330.2015.1133684
Collective impact (CI) has primarily been applied to solving organic adaptive problems that evolve over time. While this framework aligns broadly with the collaboration literature, the dynamic, and at times forced, nature of this work in practice poses challenges. This study used a quasi-experimental design to test a CI model of the facilitators of mandated collaboration measured by the Levels of Collaboration Scale and the Wilder Collaboration Factors Inventory. Findings show that: (1) policy mandates have a significant, positive correlation with collaboration; and (2) the only significant predictor of collaboration is informal relationships. This analysis suggests a hybrid process, combining key elements of CI with a focus on relationship building, to support effective collaboration practice.

Grounds, K., Johnson, B., & Christenson, C. (2021). *Leveraging Community Information Exchanges for Equitable and Inclusive Data: CIE Community Profiles*. 211/CIE San Diego. https://ciesandiego.org/wp-content/uploads/2021/12/Community-Profiles-FINAL.pdf
In this brief, the 211/CIE San Diego is highlighted along with six other communities working to build better systems of care that truly benefit the people they serve. Engaging community members who are most impacted by services is one of the most critical elements to the successful design and implementation of a CIE. As such, these Community Profiles were developed to explore strategies and provide examples of how community members can be involved in the development and maintenance of community data systems, like CIEs. The Community Profiles detail current and planned work for engaging community members including novel approaches, challenges, and lessons learned: approaches to community member engagement (e.g., contribution of lived experience, leadership, input, and decision-making); challenges and opportunities to encourage more community members and CBO participation; and resources and policy that could support continued growth in this area. See also: *A Vision for the Future and the CIE Data Equity Framework* https://ciesandiego.org/data-equity/

Hamad, R., & Galea, S. (2022). The Role of Health Care Systems in Bolstering the Social Safety Net to Address Health Inequities in the Wake of the COVID-19 Pandemic. *JAMA*, *328*(1), 17-18. https://doi.org/10.1001/jama.2022.10160
This viewpoint article highlights four ways in which health care organizations and systems can engage in efforts to support the strategies and upstream policies to bolster the safety net and narrow health gaps going forward. These include ensuring that health care systems and practices enroll their patients in programs for which they are eligible, engaging with nonprofit organizations to invest in communities at a population health level, testing evidence-based initiatives and evaluating cross-sectoral upstream solutions, and advocating for greater investments in the social safety net.

Kania, J., Williams, J., Schmitz, P., Brady, S., Kramer, M., & Juster, J. S. (2022). Centering Equity in Collective Impact [Article]. *Stanford Social Innovation Review*, *20*(1), 38-45. https://ssir.org/articles/entry/collective_impact
A decade of applying the collective impact approach to address social problems has taught us that equity is central to the work. When we look honestly at the roots of challenges facing many communities, we find that we must move from working in communities to working with communities and supporting work by communities. Without explicitly articulating the work to center equity and making space to do that work, collective impact efforts will fall short in their potential to dismantle long-standing inequities, repair historical injustices, and advance better outcomes for those who have been left behind. Other global communities are doing their own equity work relevant to local and culturally specific contexts.

Lasker, R. D., Weiss, E. S., & Miller, R. (2001). Partnership synergy: a practical framework for studying and strengthening the collaborative advantage. *Milbank Quarterly*, *79*(2), 179-205, iii-iv. https://doi.org/10.1111/1468-0009.00203
The substantial interest and investment in health partnerships in the United States assumes that collaboration is more effective in achieving health and health system goals than efforts carried out by single agents. A clear conceptualization of the mechanism that accounts for the collaborative advantage, and a way to measure it are needed to test this assumption and to strengthen the capacity of partnerships to realize the full potential of collaboration. The mechanism that gives collaboration its unique advantage is synergy. A framework for operationalizing and assessing partnership synergy, and for identifying its likely determinants, can be used to address critical policy, evaluation, and management issues related to collaboration.

Mattessich, P., & Johnson, K. (2018). *The Wilder Collaboration Factors Inventory, 3rd Edition*. https://www.wilder.org/sites/default/files/imports/Wilder%20Collaboration%20Factors%20Inventory_3rd%20edition_8-18.pdf
The Wilder Collaboration Factors Inventory, a free tool to assess how your collaboration is doing on research-tested success factors, has been updated with two new factors introduced in the third edition of *Collaboration: What Makes It Work, and* includes all of the original questions, plus new questions related to the two new factors. There is also a free online version of the inventory for groups to use (https://wilderresearch.org/tools/cfi-2018/start) Permission to use the inventory is granted for private, non-commercial, and education purposes only, and requires an acknowledgement of the source and author of the work. For additional information, including the book *Collaboration: What Makes It Work*, visit the Wilder organization website at: https://www.wilder.org/wilder-research/resources-and-tools#collaboration

McGuire, J. F. (2019). *Aligning Health Care and Social Services: A Primer on Social Services*. Robert Wood Johnson Foundation. https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2019/rwjf456301
This primer provides background context for McGuire's research, and describes the rich history of the social services sector, where the sector stands today, and opportunities for alignment with health care.

McGuire, J. F. (2019). *Aligning Health Care and Social Services: Recommendations for Effective Engagement*. Robert Wood Johnson Foundation. https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2019/rwjf456301/subassets/rwjf456301_1
This brief outlines key findings and recommendations for establishing a more productive and rewarding relationship between the health care and social services sectors. A future alignment between the health care and social services sectors will benefit patients and providers alike, and may achieve efficiencies in both sectors. However, that alignment will not be successful if the social services sector lacks the resources to adequately meet its foundational social, economic, and independent living support roles that build well-being, self-sufficiency, and community engagement. Health care needs a strong social services sector that can both diminish risk through these core functions and reliably respond when health care-related non-medical service delivery or coordination is needed to achieve quality and cost improvements. Both sectors require significant relational, cultural, partnership, capacity development, and workflow changes and a commitment to adequate planning, collaborative goal setting, intervention piloting, and course correction. [website description]

Miller, E., Nath, T., & Line, L. (2017). *Working Together Toward Better Health Outcomes*. Center for Health Care Strategies. https://www.chcs.org/resource/working-together-toward-better-health-outcomes/
Across the country, health care organizations and community-based organizations (CBOs) that provide human services are increasingly partnering to address both the clinical and the social determinants of health. The Partnership for Healthy Outcomes- a project of the Center for Health Care Strategies, Nonprofit Finance Fund, and the Alliance for Strong Families and Communities- sought to capture and analyze lessons from these emerging cross-sector partnerships. This report, informed by a survey of more than 200 health care related partnerships serving one or more of all 50 US states, explores the many ways that health care organizations and CBOs are partnering in shared pursuit of better health outcomes. It provides important lessons to inform partnerships that seek to improve access to care, address health inequities, and make progress on social issues like food, education, and housing. See also a companion set of case studies detailing successful partnerships serving varied populations and geographic areas across the country: https://www.chcs.org/resource/bridging-community-based-human-services-health-care-case-studies/

Naeem, J., Salazar-Contreras, E., Sundaram, V., Wainwright, L., Kosel, K., & Miff, S. (2022). The Dallas Accountable Health Community: Its Impact on Health-Related Social Needs, Care, and Costs. *NEJM Catalyst*, *3*(9), CAT.22.0149. https://doi.org/10.1056/CAT.22.0149
Leaders at the Parkland Center for Clinical Innovation describe the challenges and successes associated with their 5-year involvement in a federally supported study of care delivery efforts to address health-related social needs through community collaboration and patient navigation. The program resulted in lower utilization, a decrease in health care expenditures, and a positive ROI.

National Academies of Sciences, Engineering, and Medicine. (2021). *Models for Population Health Improvement by Health Care Systems and Partners: Tensions and Promise on the Path Upstream: Proceedings of a Workshop*. National Academies Press. http://nap.edu/26059
This workshop explored the growing attention on population health, from health care delivery and health insurance organizations to the social determinants of health and their individual-level manifestation as health-related social needs, such as patients' needs. The workshop

showcased collaborative population health improvement efforts, each of which included one or more health systems. This publication summarizes the presentations and discussions from the workshop. [website description]

National Quality Forum. (2019). *National Quality Partners (NQP) Social Determinants of Health Data Integration* (Action Brief). https://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=90600
The NQP Social Determinants of Health Data Integration Action Team addressed current challenges in integrating social and the impact of addressing non-medical risk factors and data. Organizations, encompassing community-based organizations, primary and specialty medical care, and behavioral health, must establish partnerships and policies to standardize SDOH assessments, share data, and build a workforce to overcome SDOH barriers and achieve better health outcomes. Integrating SDOH and clinical/behavioral/long-term support services data to support meaningful action and respond to social needs at the organizational/community level is a necessary first step toward leveraging data to improve care, care delivery, health, and health outcomes.

Petchel, S., Gelmon, S., & Goldberg, B. (2020). The Organizational Risks Of Cross-Sector Partnerships: A Comparison Of Health And Human Services Perspectives. *Health Affairs*, *39*(4), 574-581. https://doi.org/10.1377/hlthaff.2019.01553
What factors do health and human services leaders assess when considering collaborative opportunities, and what do they worry about? How organizational decision makers perceive risk can influence the success or failure of cross-sector partnerships designed to address social determinants of health. This article captures insights from leaders at twenty-two health and human services organizations in Oregon who were involved in the Centers for Medicare and Medicaid Services' Accountable Health Communities initiative in 2019 and familiar with efforts by their local health systems to identify people with unmet social needs and refer them to community programs. The authors explore perspectives on the risks and benefits associated with this cross-sector work. Leaders from both sectors perceived collaboration risks to reputation, sustainability, and compliance with regulatory or funder requirements. They also had difficulty gauging the reliability of partners that were sometimes perceived as competitive or coercive. Risk perceptions were manifested differently across sectors, which has implications for the design, implementation, and governance of cross-sector initiatives. [Journal abstract]

Pourat, N., O'Masta, B., Haley, L. A., & Chuang, E. (2021). *A Snapshot of California's Whole Person Care Pilot Program: Implementation Strategies and Enrollees*. UCLA Center for Health Policy Research. https://healthpolicy.ucla.edu/publications/Documents/PDF/2021/wholepersoncare-policybrief-may2021.pdf
The Whole Person Care (WPC) Pilot program implemented under California's Section 1115 Medicaid Waiver, "Medi-Cal 2020," coordinates medical, behavioral, and social services to improve the health and well-being of Medi-Cal beneficiaries with complex needs. In this policy brief, authors analyze data from the interim statewide evaluation of WPC to present a snapshot of the 25 participating pilots, based on key implementation strategies and enrollee characteristics. The data can be used by organizations that are developing population health management programs for high-need, high-risk Medi-Cal beneficiaries under the California Advancing and Innovating Medi-Cal (CalAIM) initiative, as well as by other programs providing care to low-income patients. [website description]

Pourat, N., O'Masta, B., Haley, L. A., Zhou, W., & Chuang, E. (2022). *Whole Person Care Program Successfully Navigated Around COVID-19 Challenges in 2020*. UCLA Center for Health Policy Research. https://healthpolicy.ucla.edu/publications/Documents/PDF/2022/WholePersonCare-policybrief-jan2022.pdf
California implemented the Whole Person Care (WPC) Pilot program under "Medi-Cal 2020," a Section 1115 Medicaid Waiver program designed to coordinate the care of high-utilizing Medi-Cal beneficiaries across medical, behavioral health, and social service sectors. In this policy brief, authors examine the impact of the pandemic on WPC implementation, enrollment, and health service utilization.

Prybil, L., Scutchfield, F. D., Killian, R., Kelly, A., Mays, G. P., Carman, A., Levey, S., McGeorge, A., & Fardo, D. W. (2014). *Improving Community Health through Hospital – Public Health Collaboration: Insights and Lessons Learned from Successful Partnerships*. Commonwealth Center for Governance Studies, Inc.
https://uknowledge.uky.edu/cgi/viewcontent.cgi?article=1001&context=hsm_book
The report discusses the ingredients for successful public health-health care partnerships and offers case studies of effective and sustainable partnerships in California, Maine, Minnesota, Maryland, Florida, and elsewhere throughout the country.

Public Health Leadership Forum. (2018). *Partnering to Catalyze Comprehensive Community Wellness: An Actionable Framework for Health Care and Public Health Collaboration*. PHLF.
https://hcttf.org/wp-content/uploads/2018/06/Comprehensive-Community-Wellness-Report.pdf
The Public Health Leadership Forum and the Health Care Transformation Task Force developed a framework to help catalyze and facilitate collaborative working relationships between the public health and health care sectors. Such partnerships are an essential component of the "comprehensive community wellness approach," one in which effective, collaborative relationships across sectors ensure more seamless care and prevention services for all. Under this approach, public health, health care, and social service and community organizations intentionally build high-functioning partnerships to address health needs in their communities, and invest in the time, staff, information platforms, and oversight structures needed to sustain them. The framework outlines essential elements of collaboration and presents key tactics and strategies for forming or reshaping effective partnerships. [website description]

Raday, S., Krodel, N., & Chan, A. (2018). *Human Services Organizations: Partnering for Better Community Health. Actionable Advice from the Healthy Outcomes Initiative*. Nonprofit Finance Fund.
https://nff.org/report/human-services-organizations-partnering-better-community-health
This report explores how collaboration between human services organizations and health systems can help people experience better health outcomes. The report and comprehensive resources capture knowledge and insights from the Healthy Outcomes Initiative, a multi-year project supported by The Kresge Foundation, and are intended for those new to human services and health collaborations as well as pioneering practitioners. [website description]

Redding, M., & Wilk, R. (2019). *The Pathways Community HUB model – An Accountable Approach to Engage Communities in Improving Outcomes* [Network News article]. Midwest Clinicians' Network. See: https://www.pchi-hub.org/our-model
A Pathways Community HUB (PCH) is an organized, outcome focused, pay for performance network of community-based organizations that hire and train community health workers to reach out to those at greatest risk, identify risk factors and barriers, and assure connections to

medical, social, and behavioral health services. PCHs work with community-based organizations, agencies, and providers, to build a large network of available services. PCHs must be neutral, transparent, and accountable to the community, and all partners agree to standardized data collection.

Ruggles, L. (2020). Frameworks for Community Impact - Community Case Study. *Frontiers in Public Health*, *8*, 197. https://doi.org/10.3389/fpubh.2020.00197
The Affordable Care Act of 2008 placed specific community health needs assessment and community benefit reporting requirements on US not-for-profit hospitals. The requirements are straightforward, but come with no expectation for synergy between the needs assessment and the community benefit spending, no direction on how to design systems to improve community health, and with surprisingly little accountability for improving health outcomes. With the help of diverse community partners, one Critical Access Hospital in rural Vermont has successfully linked the needs assessment with community benefit dollars to address upstream contributors of health. In 2014, the Northeastern Vermont Regional Hospital led the creation of *NEK Prosper: Caledonia and Southern Essex Accountable Health Community* with a mission to tackle poverty as the ultimate root cause of poor health in the region. This article outlines how a hospital community health needs assessment ignited a change in how community partners worked together, aligned organizational strategies, and overcame industry jargon barriers to create regional system change to improve health. And how that same hospital has used community benefit dollars to accelerate action at the community level.

Shaw, J. G., Wagner, T., Rosenbaum, E., & Lawrence, J. (2021). *Integrating Health and Social Services through a Novel Independent Practice Association*. Systems for Action. https://systemsforaction.org/sites/default/files/resource_files/Stanford%20University%20School%20of%20Medicine-Healthy%20Alliance_Project%20Summary.pdf
This study, funded as part of the Robert Wood Johnson Foundation's Systems for Action research program, investigated the impact of a novel independent practice association (IPA) formed among community-based social service organizations (CBOs) to address social determinants of health among residents of upstate New York. The Healthy Alliance IPA allows diverse CBOs offering services for housing, transportation, food, and other social needs to join together in a shared-governance association that facilitates referrals, care coordination, and performance-based contracting with health plans and medical providers. This study focused on the outcomes experienced by racial and ethnic minority populations and also examines the roles played by CBOs led by Black, Indigenous, Latino and other persons of color. The research team is led by Stanford University School of Medicine in partnership with the Healthy Alliance IPA, Albany County Department of Health, Rensselaer County Department of Health, and other community partners. See also the associated webinar.

Spencer, A., & Nuamah, A. (2021). *Building Effective Health System-Community Partnerships: Lessons from the Field*. I. Center for Health Care Strategies. https://www.chcs.org/media/Community-Partnership-Pilot-Brief_3.2.21.pdf
This brief shares considerations for health care organizations and government entities seeking to build effective partnerships with the individuals and communities they serve to better address their health and social needs. It draws from the experiences of two sites — Hennepin Health care in Minneapolis and the Los Angeles Department of Health Services Whole Person Care Program — that participated in the Community Partnership Pilot. [website description]

Taylor, L. A., & Byhoff, E. (2021). Money Moves the Mare: The Response of Community-Based Organizations to Health Care's Embrace of Social Determinants. *Milbank Quarterly*, *99*(1), 171-208. https://doi.org/10.1111/1468-0009.12491
Recent health policies incentivize health care providers to collaborate with community-based organizations (CBOs), such as food pantries and homeless shelters, to address patients' social determinants of health (SDOH). The perspectives of health care leaders on these policy changes have been studied, but the perspectives of CBO managers have not. In order to understand how CBOs in Massachusetts are perceiving and responding to new Medicaid policies that encourage collaboration between health care organizations and CBOs, researchers interviewed 46 people in leadership positions at CBOs in Massachusetts. They found that Massachusetts CBOs perceive health systems as potential sources of revenue, due in part to an ongoing Medicaid redesign that encourages the integration of health and social services. However, this perception is driving CBOs to appear more like health care organizations, and the impacts of these changes on welfare remain unknown.

Trust for America's Health. (2021). *The Improving Social Determinants of Health Act of 2021 (S. 104/H.R. 379)* (Fact Sheet). TFAH. https://www.tfah.org/wp-content/uploads/2020/08/SDOH-bill-fact-sheet.pdf
This fact sheet provides background on social determinants of health and a summary of the SDOH Act of 2021 as a mechanism to increase the capacity of public health systems to fully address SDOH priorities. Organizations supporting the Act are listed, current as of October 2021.

Turi, J., Sax, R., & Schultz, E. (2022). *Rethinking value: Perspectives on the benefits of cross-sector collaboratives serving populations with complex health and social needs* [Brief]. Camden Coalition. https://www.nationalcomplex.care/wp-content/uploads/2022/02/CCH-Rethinking-Value-2.14.22.pdf
Cross-sector collaboration is recognized as an important step in improving health equity and addressing the collective challenges facing health care, the social sector, and public health organizations at the community level. However, different sectors and community stakeholders continue to operate under siloed cultural, operational, and funding structures and contexts. The authors explored how different organizations and community members define and measure the value of cross-sector collaboration through key informant focus groups with organizations and affiliated community members involved in cross-sector collaborations. These conversations led to the identification of four underlying dimensions that contribute to participants' understanding of "value:" intrinsic benefits, community engagement, outcomes, and sustainable system-level change. The findings show that defining value as primarily linked to financial considerations does not reflect the nuanced and holistic understanding of this concept. As such, the authors suggest that the understandings of "value" would be even more rich and dynamic across the full and diverse ecosystem of such collaboratives, demonstrating the importance of exploring and defining "value" as part of collaborative work. [website description]

Wodchis, W. P., Shaw, J., Sinha, S., Bhattacharyya, O., Shahid, S., & Anderson, G. (2020). Innovative Policy Supports for Integrated Health And Social Care Programs In High-Income Countries. *Health Affairs*, *39*(4), 697-703. https://doi.org/10.1377/hlthaff.2019.01587
As high-income countries face the challenge of providing better and more efficient integrated health and social care to high-needs and high-cost populations, they may require innovative policy supports at both the national and local levels. We categorized policy supports into four areas: governance and partnerships; workforce and staffing; financing and payment; and data

sharing and use. Our structured survey of thirty integrated health and social care programs in high-income countries in 2018 found that the majority of programs had policy supports in two or more areas, with supports for governance and partnerships and for workforce and staffing being the most common. Financing and payment and data sharing and use were less common. Local partnerships empowered integration across sectors, and new staff roles that spanned health and social care embedded this integration in care delivery. National policies—including bundled financing and investment in data—enabled integration and cross-sector accountability.

FINANCING

New financing and payment strategies and models are central to reforms targeting HRSNs. This section contains articles and documents on innovative strategies states and communities have employed to better use existing and new funding and community resources to align and expand HRSN-related services.

Aligning in Crisis, Georgia Health Policy Center, & George Washington University. (2021). *Investing in Community Health Through Local Wellness Funds*. Robert Wood Johnson Foundation, Aligning in Crisis. https://www.alignforhealth.org/resource/investing-in-community-health-through-local-wellness-funds/

This case study examines how state, county, and city policymakers can now leverage significant federal relief funds to establish and support sustainable local wellness funds that improve community well-being and advance health equity during the COVID-19 pandemic recovery and beyond. [website]

Bostic, R. W., & Orlando, A. W. (2018). Sustainable Financing Structures for Population Health: Historical Patterns and Insights for the Future: Commissioned Paper. In National Academies of Sciences, Engineering, and Medicine (Ed.), *Building Sustainable Financing Structures for Population Health: Insights from Non-Health Sectors: Proceedings of a Workshop*. NAS. https://doi.org/10.17226/24760

The goals of the workshop were to learn from the long-term, sustainable financing strategies used in other sectors, to explore how those approaches could be applied to population health, and to consider structures that work across sectors. This publication summarizes the presentations and discussions from the workshop.

Butler, S., & Higashi, T. (2020). *Budgeting to promote social objectives – A primer on braiding and blending*. Brookings Institution. https://www.brookings.edu/wp-content/uploads/2020/04/BraidingAndBlending20200403.pdf

In this report, the authors describe examples of the many ways government at different levels actually does permit the "braiding" and "blending" of public funds to pursue broad objectives, such as better children's health or improved housing. The authors review dozens of examples and techniques used to promote collaborative budgeting, such as intermediary bodies to foster agency cooperation, providing better information on budget flexibility to subsidiary governments, the use of waivers, and improved data sharing. However, the authors conclude In their report that much more could and should be done by government at all levels to encourage greater agency and budgetary collaboration. [website description]

Clary, A., Kartika, T., & Rosenthal, J. (2018). *State Approaches to Addressing Population Health Through Accountable Health Models*. National Academy for State Health Policy. https://www.nashp.org/wp-content/uploads/2018/01/Accountable-Health-Models.pdf

In October 2017, the National Academy for State Health Policy (NASHP) convened state health officials representing 10 state Medicaid accountable health models to discuss strategies for using accountable health structures to promote population health. Participants also discussed strategies to assess these structures' impact on health, determine their return on investment, and develop sustainable funding approaches. This brief highlights policy levers, performance measurement strategies, and sustainable financing options that states can use to support accountable health structures.

Clary, A., & Riley, T. (2016). *Pooling and Braiding Funds for Health-Related Social Needs: Lessons from Virginia's Children's Services Act*. NASHP. https://static1.squarespace.com/static/632be03c30bc581b81337668/t/639a20ae8edfe9389f2928f4/1671045294738/Blending-and-braiding.pdf
The suggestions presented in this document were formed by an ad-hoc group of state officials during an invitation-only meeting convened in September 2017 by the de Beaumont Foundation, in partnership with the Association of State and Territorial Health Officials and the National Academy for State Health Policy. They represent important analysis of recent federal proposals to blend, braid, or block-grant funds for public health and prevention, and may help chart a way forward for states interested in maximizing their ability to coordinate work and resources across programs.

Crook, H. L., Zheng, J., Bleser, W. K., Whitaker, R. G., Masand, J., & Saunders, R. S. (2021). *How Are Payment Reforms Addressing Social Determinants of Health? Policy Implications and Next Steps* (Issue Brief). Milbank Memorial Fund and Duke-Margolis Center for Health Policy. https://www.milbank.org/wp-content/uploads/2021/02/Duke-SDOH-and-VBP-Issue-Brief_v3-1.pdf
The movement toward value-based care provides a significant opportunity to address social determinants of health (SDOH) while improving value and quality of care. Value-based care can allow greater flexibility in terms of what services are delivered while providing accountability for long-term sustainability and population health improvements. Although federal, state, and commercial payers are launching innovative new payment models addressing SDOH, questions remain regarding best practices for implementation, impact on cost and outcomes, and ability to scale and spread across different contexts under current policies. This issue brief summarizes the current landscape of payment reform initiatives addressing SDOH, drawing on results from a systematic review of peer-reviewed and gray literature supplemented with scans of state health policies and proposed payment reform models. It also discusses challenges and opportunities related to implementation- data collection and sharing, social risk factor adjustment (statistical methods for accounting for adverse social conditions associated with poor health), cross-sector partnerships, and organizational competencies- as well as policy implications and next steps so that states and payers can use value-based payment to encourage and promote addressing social needs.

Georgia Health Policy Center. (2019). *Bridging for Health: Improving Community Health Through Innovations in Financing*. Georgia Health Policy Center. https://doi.org/10.57709/6HJV-0G64
The Georgia Health Policy Center (GHPC) is the national coordinating center for *Bridging for Health: Improving Community Health Through Innovations in Financing*, sponsored by the Robert Wood Johnson Foundation. Bridging for Health is fostering connections among multisector stakeholders to rebalance and align investments in health. To accomplish this, Bridging for Health focuses on innovations in three areas: financing; collaboration and collective impact; and health equity. [https://ghpc.gsu.edu/project/bridging-for-health/] The Bridging for Health report discusses the process, outcomes, and key learnings related to the site-selection, approaches to technical assistance and peer-learning, the Innovation-to-Action Cycle, and the evaluation framework. Case studies from the seven sites are provided along with an examination of the emergence of pooled community funds as a common financial innovation and the need for additional understanding about fund stewardship, structure, expansion, sustainability, and technical assistance.

Georgia Health Policy Center. (2018). *Local Financing Innovations: Caledonia-So. Essex Accountable Health Community*. GHPC. https://scholarworks.gsu.edu/ghpc_briefs/225
This brief profiles one in a series of innovations highlighting creative health system change. These innovations address upstream drivers of health, do not solely rely upon grants, involve multisector partners, and maintain a long-term focus, rather than fixing an immediate community need. The mission of the Caledonia-So. Essex Accountable Health Community is to improve the health and well-being of the people of Caledonia and southern Essex counties in Vermont by integrating efforts and services, with the goal of reducing poverty in the region. The five identified outcomes they are striving to achieve include fostering a well-housed, well-nourished, physically healthy, mentally healthy, and financially secure population.

Gunter, K. E., Peek, M. E., Tanumihardjo, J. P., Carbrey, E., Crespo, R. D., Johnson, T. W., Rueda-Yamashita, B., Schwartz, E. I., Sol, C., Wilkinson, C. M., Wilson, J. O., Loehmer, E., & Chin, M. H. (2021). Population Health Innovations and Payment to Address Social Needs Among Patients and Communities With Diabetes. *Milbank Quarterly*, *99*(4), 928-973. https://doi.org/10.1111/1468-0009.12522
Fee-for-service and many value-based payment systems constrain options to implement models of care that address social and medical needs in an integrated fashion. The authors present experiences of eight grantee organizations, representing a range of payment models, health care settings, market factors, geographies, populations, and community resources. Findings indicate that grantees are implementing a variety of strategies to address medical and social needs through augmented staffing models such as community health workers or behavioral health specialists, information technology innovations (e.g., software for social needs referrals), and system-wide protocols to identify high-risk populations with gaps in care. Grantees also identify and address social needs (e.g., food insecurity, housing), invest in human capital to support social needs referrals and coordination (e.g., embedding social service employees in clinics), and work with organizations to connect to community resources. Challenges faced by the grantee sites include difficulty in accessing flexible up-front funding to support infrastructure for interventions, and a value-based payment mechanisms that usually rewards clinical performance metrics rather than measures of population health or social needs interventions.

Hester, J. A., Stange, P. V., Seeff, L. C., Davis, J. B., & Craft, C. A. (2015). *Toward sustainable improvements in population health: Overview of community integration structures and emerging innovations in financing* (CDC Health Policy Series No. 2). Centers for Disease Control and Prevention. https://stacks.cdc.gov/view/cdc/27844
This report explores opportunities to establish effective, more sustainable community-focused delivery and payment models to improve population health. Specifically: evolving community-level population health delivery models, key functions, opportunities, and challenges of a community integrator, concept of a balanced portfolio as a crucial component in developing a sustainable financial model, emerging financing vehicles that could be used for specific population health interventions.

Karaca-Mandic, P., & Koranne, R. (2022, March 2). *Social Bonds as a Pooled Financing Mechanism to Address Social Drivers of Health Equity* [webinar]. Research-in-Progress Webinar, online. https://systemsforaction.org/sites/default/files/resource_files/ResProgress_SocialBond_3.2.22.pdf
This webinar introduces a new *Systems for Action* (S4A) study investigating whether a novel type of social bond can pool resources across multiple competing health plans and create stable,

long-term financing for interventions that address social determinants of health. The bond's design would allow multiple health plans participating in Minnesota's Medicaid program to invest collectively in a fund that finances community-based interventions targeting social issues such as food insecurity, housing instability, transportation, and structural racism. Specific bond features allow the financial risks and returns from these interventions to be distributed equitably across health plans and other potential investors, while targeting funding to interventions that promote racial and health equity. The study uses community participatory approaches to engage local health and social service stakeholders in the design of the bond instrument. Monte Carlo simulation methods are used to estimate the impact of bond financing on health and social outcomes for racial and ethnic minority populations over time, while also estimating economic returns to health plans, Medicaid and other investors. The research team is led by the University of Minnesota in partnership with the Minnesota Hospital Association, Minnesota Association of Health Plans, Minnesota Department of Human Services, Minnesota Department of Health, and other community partners. [website description]

Kohli, J., & De Baisi, A. (2017). *Supporting Healthy Communities: How Rethinking the Funding Approach can Break Down Silos and Promote Health and Health Equity*. Deloitte Center for Government Insights. https://www2.deloitte.com/content/dam/insights/us/articles/3608_supporting-healthy-communities/DUP_supporting-healthy-communities.pdf
The authors discuss the Healthy Communities Funding Hub model which proposes a place-based hub where many of the barriers to community-based health improvement effort can be addressed, bridging a gap in many communities which lack an infrastructure for sustainably funding multisector partnerships to improve health. The framework of the model brings together funding from federal, state, local, and philanthropic sources across the many sectors that affect health. Each hub would serve as a trusted intermediary and formal financial manager, equipped with the necessary financial capacities to coordinate health improvement funds, and be a single point of financial accountability to stakeholders. The report provides examples, key factors to consider, and areas for further exploration.

Maine Department of Health and Human Services, Office of MaineCare Services. (2020). *MaineCare Accountable Communities: Glidepath* [Presentation]. Maine Department of Health and Human Services, Office of MaineCare Services.
https://www1.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/Public%20Session_Final.pdf
This presentation reviews the background and substance of MaineCare's strategy for value-based payment reform.

McCarthy, M. L., Li, Y., Elmi, A., Wilder, M. E., Zheng, Z., & Zeger, S. L. (2022). Social Determinants of Health Influence Future Health Care Costs in the Medicaid Cohort of the District of Columbia Study. *Milbank Quarterly*, *100*(3), 761-784. https://doi.org/10.1111/1468-0009.12582
Social determinants of health (SDOH) are an important predictor of future health care costs but little is known about their impact on Medicaid spending. This study analyzes the role of SDOH in predicting future health care costs for adult Medicaid beneficiaries with similar past morbidity burdens and past costs. The researchers found that when controlling for future morbidity burden (measured concurrently with future costs), social risk class was no longer a significant predictor of future health care costs. SDOH are statistically significant predictors of future morbidity burden and future costs controlling for past morbidity burden and past costs. Further research is needed to determine whether current payment systems adequately account for differences in the care needs of highly medically and socially complex patients.

Medicaid and CHIP Payment and Access Commission. (2022). *Financing Strategies to Address the Social Determinants of Health in Medicaid* (Issue Brief). MACPAC. https://www.macpac.gov/wp-content/uploads/2022/05/SDOH-Issue-Brief_May-2022.pdf
This issue brief begins by describing the extent to which Medicaid beneficiaries experience certain social risk factors that affect health. It then discusses the three primary mechanisms—state plan benefits, contracts with managed care plans, and time-limited grants and waivers—that state Medicaid programs can use to deliver and finance SDOH interventions, as well as the statutory and regulatory limits on these uses of funds. The brief also discusses programmatic impediments that make it difficult to expand or sustain these approaches.

National Academies of Sciences, Engineering, and Medicine. (2018). *Building Sustainable Financing Structures for Population Health: Insights from Non-Health Sectors: Proceedings of a Workshop*. National Academies Press. https://nap.nationalacademies.org/catalog/24760/
Resources needed to improve health and address the factors that shape health has been a focus of the Roundtable on Population Health Improvement since its launch and was first addressed in a 2014 workshop that discussed financial mechanisms such as pay-for-success financing and hospital and health system community benefit funding. The Roundtable continued its exploration of this topic, but with a focus on non–health sector models hosting a workshop in 2016 to explore sustainable financing structures that reflect a recognition of the health and non-health factors that shape the well-being of U.S. communities. The goals of the workshop were to learn from the long-term, sustainable financing strategies used in other sectors, to explore how those approaches could be applied to population health, and to consider cross-sector structures.

National Academies of Sciences, Engineering, and Medicine. (2019). Financing Social Care. In *Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health* (pp. 109-136). National Academies Press. https://doi.org/10.17226/25467
This chapter highlights five financial barriers in health care and social care financing long with promising practices and strategies to address those barriers and financing the integration of health and social care.

National Academies of Sciences, Engineering, and Medicine. (2019). *Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health*. National Academies Press. http://nap.edu/25467
This report examines the potential for integrating services addressing social needs and the social determinants of health into the delivery of health care to achieve better health outcomes. This report assesses approaches to social care integration currently being taken by health care providers and systems, and new or emerging approaches and opportunities; current roles in such integration by different disciplines and organizations, and new or emerging roles and types of providers; and current and emerging efforts to design health care systems to improve the nation's health and reduce health inequities. [website description]

National Academies of Sciences, Engineering, and Medicine. (2021). *Models for Population Health Improvement by Health Care Systems and Partners: Tensions and Promise on the Path Upstream: Proceedings of a Workshop*. National Academies Press. http://nap.edu/26059
This workshop explored the growing attention on population health, from health care delivery and health insurance organizations to the social determinants of health and their individual-level manifestation as health-related social needs. This proceeding showcases collaborative population health improvement efforts, each of which included one or more health systems.

National Academies of Sciences, Engineering, and Medicine. (2021). *Financing That Rewards Better Health and Well-Being: Proceedings of a Workshop in Brief (2021)* National Academies Press. https://nap.nationalacademies.org/download/26332
This workshop featured invited speakers and discussions focused on the need to transform the United States' current model of health care financing, which rewards the volume of services provided, to a model that incentivizes integrated payment approaches that are person-centered and holistic in advancing individual, community, and population health. The objectives included identifying examples of care delivery and payment models that are focused on patient outcomes and advancing health equity, considering barriers and opportunities to scaling effective integrated payment models and approaches, and discussing strategies for transforming health financing to improve equity and individual and population health. This Proceedings of a Workshop in Brief highlights the presentations and discussions that occurred throughout the workshop series.

National Alliance to Impact the Social Determinants of Health. (2021). *Addressing Social Needs in the Medicaid Program* [Issue Brief]. NASDOH. https://nasdoh.org/wp-content/uploads/2021/10/10-21-NASDOH-Medicaid-and-Social-Needs-Issue-Brief_FINAL.pdf
Medicaid programs are the primary provider of health care benefits to tens of millions of Americans with limited incomes and resources, many of whom are vulnerable to adverse social determinants of health (SDOH) and as a result, are more likely to experience social needs in the Medicaid program. In the brief, NASDOH summarizes select federal authorities that allow states to address social needs in the Medicaid program. The brief calls on states and managed care organizations to leverage the available flexibilities to address social needs and we make recommendations to the Centers for Medicare & Medicaid Services about how they can support the states in their efforts. [Executive Summary]

Nichols, L. M., & Taylor, L. A. (2018). Social Determinants As Public Goods: A New Approach To Financing Key Investments In Healthy Communities. *Health Affairs*, *37*(8), 1223-1230. https://doi.org/10.1377/hlthaff.2018.0039
While research evidence points to the influence of social determinants of health (SDOH) on health outcomes and utilization and access to health for vulnerable populations, sustainable financing and investments in interventions that improve SDOH is lacking in communities. The authors provide an economic argument to show how a properly governed, collaborative approach to financing could enable self-interested health stakeholders to earn a financial return on and sustain their social determinants investments.

Rosenbaum, S. J., Byrnes, M., Rothenberg, S., & Gunsalus, R. (2016). *Improving Community Health through Hospital Community Benefit Spending: Charting a Path to Reform*. George Washington University, Milken Institute School of Public Health. https://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1825&context=sphhs_policy_facpubs
This report assesses the current status of community benefit policy and presents evidence of growing hospital emphasis on population health needs and social determinants as part of the community health needs assessment process. The report concludes with a discussion of policy opportunities for strengthening and expanding hospitals' role as community health actors and partners.

Rural Health Value. (2022). *Experience in the Pennsylvania Rural Health Model: Barnes-Kasson County Hospital* (Rural Innovation Profile). RUPRI. https://ruralhealthvalue.public-health.uiowa.edu/files/Barnes-Kasson_PARHM_Innovation-Profile.pdf
A Critical Access Hospital in Susquehanna, PA provides insight into their experience participating in the Pennsylvania Rural Health Model, which includes a global budget and transforming care to address community health needs. [website description]

Trust for America's Health. (2018). *Braiding and Blending Funds to Support Community Health Improvement: A Compendium of Resources and Examples* [Issue Brief]. TFAH. https://www.tfah.org/wp-content/uploads/2018/01/TFAH-Braiding-Blending-Compendium-FINAL.pdf
This issue brief focuses on two key *mechanisms* to bring funding streams together to support community health improvement – braiding and blending. ***Braiding*** refers to coordinating funding and financing from several sources to support a single initiative or portfolio of interventions (usually at the community level). Braiding keeps funding/financing streams in distinguishable strands, so each funder can track resources. ***Blending*** refers to combining different streams into one pool, under a single set of reporting and other requirements, which makes streams indistinguishable from one another as they are combined to meet needs on the ground that are unexpected or unmet by other sources. [From the Introduction]

Tsega, M., Lewis, C., McCarthy, D., Shah, T., & Coutts, K. (2019). *Review of Evidence on the Health Care Impacts of Interventions to Address the Social Determinants of Health*. Commonwealth Fund. https://www.commonwealthfund.org/publications/2019/jun/roi-calculator-evidence-guide
Holistically addressing high-need, high-cost patients' social and medical needs can improve their health outcomes and lower their health care costs. There is a limited, yet growing base of evidence showing that when health care and community-based organizations work together to assure that the most complex patients have things such as housing, food, transportation and other social needs met, their use of expensive health care services such as emergency department visits and hospitalizations often declines and their use of preventative and primary care can improve. The authors developed this evidence review to make clear the business case for health care and community-based organizations to enter into partnerships to better serve high-need, high-cost patients. This review is intended to be used in conjunction with the Return on Investment (ROI) Calculator for Partnerships to Address the Social Determinants of Health, published by the Commonwealth Fund. [website description]

Wetterman, T., & Tompsett, L. (2022). *Capturing Value in Social Health: Lessons in Developing the Business Case for Social Health Integration in Primary Care*. Commonwealth Fund. https://doi.org/10.26099/grzg-3593
The integration of social health interventions, including screening patients for unmet social needs and linking them with services and other supports, requires long-term funding. Securing this funding requires a clear articulation of the value of such interventions that is supported by data. Analysis of findings from the Health Leads Collaborative to Advance Social Health Integration (CASHI), in which 12 primary care teams from across the country received coaching to develop business cases for their social health interventions provided insights into cost drivers of social health interventions, opportunities for efficiencies, and approaches to spreading these interventions to new sites or populations. Quantifying the financial benefits of social health integration helped institutions see how they could succeed under value-based contracts.

DATA and INFORMATION SHARING

Although the original report on rural HRSNs discussed topics related to screening for HRSNs, issues related to data and information sharing among health care and community organizations were not examined in depth. Given the central role of data and information sharing in aligning services across sectors, this bibliography includes a limited number of items related to these issues.

Beers, A., Hoffmaster, A., & Cavanagh, A. (2020). *Advancing Health, Equity, and Well-Being through Community-State Data-Sharing Partnerships: Thought Leader Insights*. CHCS & Data Across Sectors for Health. https://www.chcs.org/media/Report-Advancing-Health-Equity-and-WellBeing-through-Community-State-Data-Sharing-Partnerships.pdf
This report describes emerging opportunities and contributing success factors for advancing multi-sector data-sharing partnerships to improve health and well-being, and advance equity. The report includes snapshots of state efforts across the nation and provides practical considerations to help guide community-state data-sharing partnerships.

Buck, L., Beers, A., & Mikels-Carrasco, W. (2022). *A Community-Centered Approach to Data Sharing and Policy Change: Lessons for Advancing Health Equity*. Center for Health Care Strategies. https://www.chcs.org/resource/a-community-centered-approach-to-data-sharing-and-policy-change-lessons-for-advancing-health-equity/
This brief highlights key lessons to inform data-sharing partnerships between community-based organizations, state agencies, and individuals with lived expertise and outlines data-sharing considerations for engaging community members in all aspects of data-sharing. Takeaways: Sharing data across state agencies and community-based organizations is critical for advancing health equity and addressing complex health challenges that involve multiple sectors. Including individuals with lived expertise in data sharing and policy development can make these efforts more responsive to the needs of community members, particularly those in historically marginalized populations. Insights from individuals with lived expertise provide valuable context to inform data-sharing efforts that is critical to improving health equity. [website description]

Cartier, Y., Fichtenberg, C., & Gottlieb, L. (2019). *Community Resource Referral Platforms: A Guide for Health Care Organizations*. Social Interventions Research & Evaluation Network. https://sirenetwork.ucsf.edu/sites/default/files/wysiwyg/Community-Resource-Referral-Platforms-Guide.pdf
This report synthesizes research findings to offer a guide to safety-net health care providers regarding the current landscape of community resource referral technology platforms.

Cartier, Y., Fichtenberg, C., & Gottlieb, L. (2020). Implementing Community Resource Referral Technology: Facilitators And Barriers Described By Early Adopters. *Health Affairs*, *39*(4), 662-669.
https://doi.org/10.1377/hlthaff.2019.01588
Healthcare organizations are increasingly implementing programs to address patients' social conditions and new technology platforms have emerged to facilitate referrals to community social services organizations. To understand the functionalities of these platforms and identify the lessons learned by their early adopters in health care, the authors reviewed nine platforms that were on the market in 2018 and interviewed representatives from 35 early-adopter health care organizations. They identified key informants through solicited expert recommendations and web searches. With minor variations, all platforms in the sample provided similar core

functionalities: screening for social risks, a resource directory, referral management, care coordination, privacy protection, systems integration, and reporting and analytics. Early adopters reported three key implementation challenges: engaging community partners, managing internal change processes, and ensuring compliance with privacy regulations. Early engagement with social services partners, funding models that support both direct and indirect costs, and stronger evidence of effectiveness together could help advance platform adoption.

Centers for Medicare & Medicaid Services. (2021). *A Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tool: Promising Practices and Key Insights*. CMS. https://innovation.cms.gov/media/document/ahcm-screeningtool-companion
This document describes the health-related social needs (HRSN) Screening Tool from the Accountable Health Communities (AHC) Model and share promising practices for universal screening. HRSNs are individual level, adverse social conditions that negatively impact a person's health or health care. HRSNs are distinguished from social determinants of health—the structural and contextual factors that shape everyone's lives for better or worse—and can be identified by the health care system and addressed in partnership with community resources. Identifying and addressing HRSNs can have many benefits, including improvements to individuals' health and reduced health care spending. The guide is intended for health care and social service providers who are increasingly adopting the practice of universal HRSN screening. Chapter 1 introduces the AHC Model and the AHC HRSN Screening Tool. Chapter 2 provides an overview of the AHC HRSN Screening Tool, and presents and describes the related screening tool questions for each domain, describes the scoring process and how to administer the tool outside the AHC Model. Promising practices for universal screening include: cultivate staff buy-in; tailor staffing models to site features; provide dedicated training on screening; use customized scripts to engage patients in screening; to maximize patient participation, consider the timing, location, and process for screening; anticipate population-specific needs; train staff to manage privacy and address safety concerns; institute continuous quality improvement; prepare staff to respond to common questions.

Centers for Medicare & Medicaid Services, & Center for Medicare and Medicaid Innovation. (2020). *Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool*. CMS.https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf
This screening tool, used in the AHC Model, provides evidence as to whether systematically screening and addressing HRSN of Medicare and Medicaid beneficiaries has any effect on their total health care costs and health outcomes. Five core domains are addressed: Housing instability, food insecurity, transportation problems, utility help needs, and interpersonal safety. The final version also includes questions in eight supplemental domains of financial strain, employment, family/community support, education, physical activity, substance use, mental health, and disabilities.

Grounds, K., Johnson, B., & Christenson, C. (2021). *Leveraging Community Information Exchanges for Equitable and Inclusive Data: CIE Community Profiles*. 211/CIE San Diego. https://ciesandiego.org/wp-content/uploads/2021/12/Community-Profiles-FINAL.pdf
In this brief, the 211/CIE San Diego is highlighted along with six other communities working to build better systems of care that truly benefit the people they serve. Engaging community members who are most impacted by services is one of the most critical elements to the successful design and implementation of a CIE. As such, these Community Profiles were developed to explore strategies and provide examples of how community members can be involved in the development and maintenance of community data systems, like CIEs. The

Community Profiles detail current and planned work for engaging community members including novel approaches, challenges, and lessons learned: approaches to community member engagement (e.g., contribution of lived experience, leadership, input and decision-making); challenges and opportunities to encourage more community members and CBO participation; and resources and policy that could support continued growth in this area.

National Academies of Sciences, Engineering, and Medicine. (2019). *Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health*. National Academies Press. http://nap.edu/25467
This report examines the potential for integrating services addressing social needs and the social determinants of health into the delivery of health care to achieve better health outcomes. This report assesses approaches to social care integration currently being taken by health care providers and systems, and new or emerging approaches and opportunities; current roles in such integration by different disciplines and organizations, and new or emerging roles and types of providers; and current and emerging efforts to design health care systems to improve the nation's health and reduce health inequities. [website description]

National Alliance to Impact the Social Determinants of Health. (2020). *Social Determinants of Health Data Interoperability* [Concept Paper]. NASDOH. https://www.nasdoh.org/wp-content/uploads/2020/08/NASDOH-Data-Interoperability_FINAL.pdf
In this concept paper, NASDOH, with the guidance from the work of the CARIN Alliance outlines key opportunities to enable an interoperable data ecosystem where social needs information is shared seamlessly, privately, securely, and with consent to address individuals' needs effectively and impact SDOH upstream.

National Quality Forum (2019). *National Quality Partners Social Determinants of Health Data Integration* (Action Brief).
https://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=90600
The NQP Social Determinants of Health Data Integration Action Team addressed current challenges in integrating social and environmental risk data in clinical practice by identifying real world exemplars and successful approaches to integrating SDOH data to support both providers and communities in their efforts to eliminate disparities. Considerations for integrating social data into electronic health records, understanding the impact of addressing non-medical risk factors, and capturing data in a way that is actionable will be highly informative to a wide range of stakeholders. [website description]

Resnick, J. (2022). *Using Z Codes to Improve Health Equity in Rural Indiana*. American Hospital Association. https://www.aha.org/system/files/media/file/2022/10/case-study-using-z-codes-to-improve-health-equity-in-rural-indiana.pdf
Hospitals and health systems are working to address the societal factors that influence health, including the social needs of their patients, social determinants of health in their communities and the systemic causes that lead to health inequities. Hospitals can capture data on the social needs of their patient population by using the ICD-10-CM Z codes, which identify nonmedical factors that may influence a patient's health status. Z codes became available in fiscal year 2016; however, their adoption has been slow. Cameron Memorial Community Hospital is an independent, critical access hospital in northeastern Indiana. As part of their health equity strategy, the hospital began using ICD-10-CM Z codes to detect and address their patients' social needs. This brief explores how the hospital is using Z codes to improve health equity for the community they serve.

Wang, J., Rogers, A., Didier, M., LaBarbera, J., Grounds, K., Christenson, C., Austin, L., Krausman, R., Storer, M., & Johnson, B. (2020, August 12,). *Special Session: Building Blocks to an Inclusive Community Information Exchange* Community Information Exchange Virtual Summit, https://vimeo.com/447933693/099a71847a
This session convened 211s, United Ways and backbone organizations that are working towards building a Community Information Exchange (CIE). The video provides a level set presentation on elements of a CIE, a panel of diverse perspectives sharing insights on moving toward multi-sector collaboration and coordination, as well as interactive break-out guided discussions. Participants s will learn about leveraging and elevating the work of 211s, and other collaborative organizations as the landscape continues to change and multi-sector collaboration become imperative to work.

Wodchis, W. P., Shaw, J., Sinha, S., Bhattacharyya, O., Shahid, S., & Anderson, G. (2020). Innovative Policy Supports For Integrated Health And Social Care Programs In High-Income Countries. *Health Affairs*, *39*(4), 697-703. https://doi.org/10.1377/hlthaff.2019.01587
As high-income countries face the challenge of providing better and more efficient integrated health and social care to high-needs and high-cost populations, they may require innovative policy supports at both the national and local levels. The authors categorized policy supports into four areas: governance and partnerships; workforce and staffing; financing and payment; and data sharing and use. Their structured survey of thirty integrated health and social care programs in high-income countries in 2018 found that most programs had policy supports in two or more areas, with supports for governance and partnerships and for workforce and staffing being the most common. Financing and payment and data sharing and use were less common. Local partnerships empowered integration across sectors, and new staff roles that spanned health and social care embedded this integration in care delivery. National policies—including bundled financing and investment in data—enabled integration and cross-sector accountability.

EVALUATION

Many HRSN initiatives are using investments and resources committed by health care, business, philanthropy, and other organizations who are interested in the potential return on investment (ROI) of these initiatives. The items in this section discuss approaches to and the challenges of evaluating HRSN initiatives.

Chuang, E., Brewster, A., Knox, M., & Resnick, A. (2020). *California's Medi-Cal Health Homes Program: Findings from Early Implementation Efforts* (Health Policy Report). California Initiative for Health Equity and Action.
https://healthequity.berkeley.edu/sites/default/files/general/hhp_policy_brief.pdf

California's Medi-Cal Health Homes Program (HHP) provides care management and other services to address medical and non-medical needs of high-risk Medi-Cal enrollees. This brief describes approaches used by Medi-Cal managed care plans (MCPs) to implement HHP. Findings reflect review of MCP readiness documents and interviews with nearly all MCPs who implemented HHP or had planned to implement HHP. Findings suggest the importance of: coordination among MCPs for reducing administrative burden associated with HHP; in-person, field-based outreach to successfully engage and retain eligible beneficiaries; investment in developing community-based care management entities' capacity to deliver HHP services and meet state-mandated reporting requirements. Findings also surfaced common MCP concerns: short implementation timelines; administrative burden associated with claims submission and encounter reporting; reimbursement rates relative to program startup costs and ongoing scope of services. These early experiences offer important insight as policy makers and health services leaders consider upcoming programmatic changes.

Gottlieb LM, DeSilvey SC, Fichtenberg C, Bernheim S, Peltz A. Developing National Social Care Standards.*Health Affairs Forefront*. February 22, 2023.
https://www.healthaffairs.org/content/forefront/developing-national-social-care-standards
This commentary discusses several large-scale national quality and standards-setting initiatives targeted to incorporating social needs into existing quality measurement and regulatory frameworks.

Lanford, D. (2022, June 8,). *TEAM: A Toolkit for Everyone Aligning and Measuring* Systems for Action Research-in-Progress Webinar.
https://www.youtube.com/watch?v=y6QNPV-Ce2Y
TEAM website: http://measuringaligning.org/
This webinar presents a toolkit of strategies developed by the Georgia Health Policy Center's Aligning Systems initiative to achieve alignment, collaboration, and synergy among cross-sector collaborators.

North Carolina Department of Health and Human Services. (2019). *North Carolina's Healthy Opportunities Pilots: Draft Pilot Service Definitions, Pricing Methodology, and Pricing Inputs*. NC DHHS.
https://www.ncdhhs.gov/media/11703/download
The Healthy Opportunities Pilots is the nation's first comprehensive program to test and evaluate the impact of providing select evidence-based, non-medical interventions related to housing, food, transportation and interpersonal safety and toxic stress to high-needs Medicaid enrollees. The federal government has authorized up to $650 million in Medicaid funding for the

Pilots over five years. Through the Healthy Opportunities Pilots, the North Carolina Department of Health and Human Services (NCDHHS) is dedicated to: ensuring members can access Pilot services in a timely manner and in a way that meets their needs and improves their health; demonstrating equity across all aspects of the Pilot program—including through ensuring diverse and equitable participation in the Pilots for Medicaid members and human service organizations; and strengthening community capacity to provide high-quality, member-centered services. Importantly, the Pilots will allow for the establishment and evaluation of a systematic approach to integrating and financing evidence-based, non-medical services into the delivery of health care. If shown to be effective in improving health outcomes and reducing health care costs after rigorous evaluation, the NCDHHS will look to systematically integrate high-value Pilot services statewide through NC Medicaid Managed Care.

Pourat, N., Chuang, E., Chen, X., O'Masta, B., Haley, L. A., Lu, C., Huynh, M. P., Albertson, E., & Huerta, D. M. (2019). *Interim Evaluation of California's Whole Person Care (WPC) Program.* UCLA Center for Health Policy Research. https://healthpolicy.ucla.edu/publications/Documents/PDF/2020/wholepersoncare-report-jan2020.pdf

The California Department of Health Care Services (DHCS) implemented a Section 1115 Medicaid Waiver called "Medi-Cal 2020," which started on January 1, 2016, and ended on December 31, 2020. Under this Waiver, DHCS implemented Whole Person Care (WPC) for high-risk, high-utilizing enrollees who have a complex profile and are high need. A total of 25 Pilots (27 Lead Entities), representing most counties in California, implemented WPC starting in January 2017. WPC requires participating Pilots to identify and enroll eligible Medi-Cal beneficiaries; coordinate care across health, behavioral health, and social services; involve relevant stakeholders; and share data in real-time with the goals of improved care delivery, better health, and lower costs. The interim evaluation of Whole Person Care (WPC) used qualitative data to examine the infrastructure developed, implementation processes, and services delivered by Pilots in WPC, as well as challenges encountered and promising strategies used to overcome them. Overall, the results indicated significant progress in the establishment of needed infrastructure and processes to support effective care coordination, including the development health information technology and the establishment of partnerships for managing care. **NOTE:** The final evaluation of California's Whole Person Care initiative has been completed and is under review by the Centers of Medicare and Medicaid Services.

Pourat, N., Chen, X., O'Masta, B., Haley, L. A., Warrick, A., Zhou, W., & Yao, H. (2020). *First Interim Evaluation of California's Health Homes Program (HHP)*. UCLA Center for Health Policy Research. https://healthpolicy.ucla.edu/publications/Documents/PDF/2020/First-Interim-Evaluation-CA-HHP-Report-sep2020.pdf

This HHP Interim Evaluation report describes the initial implementation processes and infrastructure development of the HHP program by Managed Care Plans (MCP) and the subsequent enrollment patterns, demographics, and services HHP enrollees received. The report also includes health status and utilization prior to HHP enrollment and early trends in health care utilization and care outcomes. Preliminary findings indicate that MCPs had developed comprehensive plans for program implementation and enrolled over 15,000 high-need, high-use Medi-Cal beneficiaries between July 2018 and September 2019.

Roblin, D. W., Khalid, S. I., & Rouillard, C. (2022). Comparison of Social Needs Among US Insured Adults Before and During the Early Phase of the COVID-19 Pandemic. *JAMA Network Open*, *5*(2), e2146700. https://doi.org/10.1001/jamanetworkopen.2021.46700
This cross-sectional study uses survey data linked with electronic health record data to compare the prevalence of social needs among US insured adults before vs during the early phase of the COVID-19 pandemic.

RTI International. (2020). *Accountable Health Communities (AHC) Model Evaluation*. RTI International. https://innovation.cms.gov/data-and-reports/2020/ahc-first-eval-rpt
This report describes the Medicare and Medicaid beneficiaries who were eligible for the AHC Model in the Assistance Track and the Alignment Track through December 2019, including their sociodemographic characteristics, HRSNs, participation in navigation, and navigation outcomes. The report describes bridge organizations and their Clinical Delivery Site partners participating in the AHC Model and their experiences with screening, referral, and navigation. KEY TAKEAWAYS: Early results show high acceptance of navigation and some utilization reductions among the high need population targeted by the AHC Model, but evidence at this early evaluation stage indicating that HRSNs were resolved is limited. Beneficiaries who qualified for the AHC Model intervention were disproportionately likely to be low income; racial and ethnic minorities; and, among Medicare beneficiaries, disabled. Food insecurity was the most commonly reported HRSN. 74% of eligible beneficiaries accepted navigation, but only 14% of those who completed a full year of navigation had any HRSNs documented as resolved. Medicare FFS beneficiaries in the Assistance Track intervention group had 9% fewer ED visits than those in the control group in the first year after screening.

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