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## Community Level, Multi-Stakeholder Approaches to Improve Healthcare Value

It is well established that social determinants of health are significant drivers of healthcare cost and quality variation, as well as health inequities. States and local communities are experimenting with broader approaches to achieving uniformly high health outcomes. One example is “social-medical” models of care that typically target high utilizers and use an integrated care team to break down silos between health and social services, assess unmet social needs and provide pathways to housing support, nutrition and other social services.<sup>1</sup>

Multi-stakeholder collaborations take this idea one step further. They address a broader population and involve stakeholders beyond case managers and providers, such

as schools, employers and the local public health agency. These models have grown in popularity in recent years as states test innovative approaches that promote community engagement and improved health outcomes.<sup>2</sup>

### What are Multi-Stakeholder Collaborations?

At their core, multi-stakeholder collaborations are a community-based approaches to achieving population health. Some initiatives also pursue health equity or health system efficiency goals. These regional partnerships may embrace public health, education, housing and other social services sectors in pursuit of these objectives.

Multi-stakeholder collaborations seek to align clinical and community-based organizations around goals and offer an integrated and consumer-centered approach to health, healthcare and social needs.<sup>3</sup> For example, Maryland’s **Healthy Montgomery** initiative identified the “Health in All Policies (HiAP)” approach as a key methodology in its strategic plan.<sup>4</sup> The goal of Health in All Policies is to ensure that all decisionmakers are informed about the health, equity and sustainability consequences of various policy options during the policy development process.<sup>5</sup> This emphasis stresses consideration of all factors that contribute to a healthy community through increased multi-sector collaboration and stakeholder engagement.

These models are referred to using various terms, and they vary widely according to the role of the backbone organization, funding sources, populations served and overall focus (see taxonomy table on page 3). This environmental scan explores these variations but also identifies the structural commonalities, profiles some successful programs and discusses strategies to expand the use of this approach to better public health.

### SUMMARY

*Real progress on improving health outcomes and health system efficiency requires collaboration across community stakeholders to ensure that incentives are aligned and the actions of different actors mutually reinforce the community’s health goals. Regional partnerships that include providers, public health, education, housing and other social services have emerged as an innovative strategy for improving population health and healthcare value. These models—variously referred to as accountable health structures, multi-stakeholder collaborations and other terms—vary by target population, funding sources and overall focus. This environmental scan seeks to describe the commonalities in their structure, initial successes, and the barriers and best practices to consider.*

## Participating Stakeholders

Multi-stakeholder collaborations feature partnerships within health and social services to serve a geographically defined population. Stakeholder engagement requirements are sometimes implemented by local government mandates or by the funder, elevating the role of selected stakeholders in the collaborative process.

Some states require accountable health structures to partner with providers and health plans to prioritize delivery system reform.<sup>6</sup> Multi-stakeholder collaborations may also draw from their provider partners in establishing work groups and task forces to develop strategies to improve access to primary care and address health equity issues.<sup>7</sup>

Community-based organizations, which include, but are not limited to, organizations focused on minority health and underserved communities, housing, food and nutrition or obesity prevention, are other key stakeholders. Depending on the collaboration's stated focus and goals, local businesses and schools can also sign on as partners either through financial means or by publically pledging their commitment. Partnerships with local school districts and/or businesses typically focus on wellness goals like obesity and chronic disease prevention.

## Backbone Organization

The backbone organization—also known as the convener—is responsible for coordinating and integrating participating stakeholders.<sup>8</sup> The backbone organization is essential to ensuring stakeholders' alignment and active engagement in the agreed-upon priorities, which generally include delivering improved care coordination, enabling healthy behaviors and improving economic opportunity within the community. Most importantly, they manage the pooled financial resources and performance indicators used to measure progress over time.<sup>9</sup>

## Funding

Multi-stakeholder collaborations require financial support for both their start-up costs and continued implementation of selected interventions. Funding can come from state and federal sources—such as State Innovation Model (SIM)

grants and CMS Section 1115 DSRIP Medicaid waivers—or from private-sector sources, such as accountable care organizations (ACOs), local hospitals and health systems, as well as foundation grants and other private stakeholders in the community.

Federal funding typically includes some restrictions, including defined eligibility criteria or specific implementation requirements, whereas private funding is typically less restricted.

## Focus Areas and Goals

The focus and goals of multi-stakeholder collaborations vary according to the funding sources (see table on page 3). For example, most federal funding for these initiatives is directed towards Medicaid beneficiaries. Oregon's Coordinated Care Organizations (CCOs), funded through a State Innovation Model (SIM) grant, consist of broad networks healthcare providers (primary care, addiction, mental health, etc.) who have agreed to work with Medicaid beneficiaries in their local communities.<sup>10</sup>

But SIM funding can also finance initiatives that target a broader population. SIM funding is intended to transform the health system, address unmet social needs and promote health equity.<sup>11</sup> Whereas another CMS-funded initiative, **Accountable Health Communities (AHCs)**, are required to focus specifically on providing “navigation services” to assist high-risk individuals access community services.<sup>12</sup>

On the other end of this spectrum are **Accountable Care Communities (ACCs)**, public-private partnerships between a county and local healthcare, business and other community stakeholders. ACCs emphasize shared responsibility and mobilize the entire community to address specific goals, such as obesity prevention.<sup>13</sup> Typically, these models are not dependent on healthcare systems adopting provider payment reforms, but instead rely on stakeholder participation and engagement. These approaches are often coordinated through local public agencies and prioritize addressing the social determinants of health to achieve population health goals.

Conducting both individual and community-level needs assessments are a key component in determining multi-stakeholder collaborations' priorities and focus areas.

# A Taxonomy of Accountable Health Structures

	Accountable Community for Health (ACH)				Accountable Care Community (ACC)
	Centers for Medicare and Medicaid Services (CMS)		Other Sources		
Funding	Accountable Health Communities (AHC) Model	Section 1115 DSRIP Waivers	SIM Grants	<ul style="list-style-type: none"> <li>State funding</li> <li>Private foundations</li> <li>Hospitals (via community benefit requirement)</li> </ul>	<ul style="list-style-type: none"> <li>State funding</li> <li>Private foundations</li> <li>Hospitals (via community benefit requirement)</li> <li>Other private sector investments</li> </ul>
Population Served (within a defined geographic area)	Medicare & Medicaid beneficiaries	Medicaid beneficiaries	All residents	All residents	All residents
Backbone Organization	Health plan, health system, and/or nonprofit organization				Local public health agency
<b>Participating Stakeholders:</b>					
Providers	✓	✓	✓	✓	✓
Health Plans	✓	✓	✓	✓	✓
Community-Based Organizations	✓	✓	✓	✓	✓
Public Health Agencies				✓	✓
Other Local Government				✓	✓
Local Businesses					✓
Educational Institutions					✓
<b>Focus &amp; Goals:</b>					
Alignment of Community-Based and Clinical Initiatives	✓	✓	✓	✓	✓
Promote Health Equity	✓	✓	✓	✓	✓
Cost Containment/Delivery System Transformation	✓	✓	✓	✓	
Early Intervention for Behavioral & Mental Health Needs	✓			✓	✓
Chronic Disease Prevention					✓

<b>Live Well San Diego</b> Type of Multi-Stakeholder Collaboration: Accountable Care Community Total Population in Region: 3.2 million Population Served: Residents of San Diego County, California				
Overall Goals	Backbone Organization	Participating Stakeholders	Performance Measures	Funding
<ul style="list-style-type: none"> <li>• Health and social services delivery reform</li> <li>• Chronic disease prevention</li> <li>• Improve environmental health</li> </ul>	Live Well San Diego was adopted by the San Diego County Board of Supervisors	<ul style="list-style-type: none"> <li>• Regional healthcare providers</li> <li>• Community and faith-based organizations</li> <li>• Local government</li> <li>• Local businesses</li> <li>• School districts</li> </ul>	<ul style="list-style-type: none"> <li>• Live Well San Diego collects primary data, with visualization tools for progress over time publicly available. Behavioral health integration</li> <li>• Developed population health-oriented quality indicators, including: life expectancy; percent of population with a high school diploma; Unemployment rate; and rate of property &amp; violent crimes per 100,000 people</li> </ul>	<ul style="list-style-type: none"> <li>• County government funds</li> <li>• Partnerships with local private companies and community organizations</li> </ul>

## Data and Evaluation

Developing efficient data systems are essential for multi-stakeholder collaborations to inform operations and meet performance goals.

A unique approach to data integration and collaboration support is the **Patient Care Intervention Center (PCIC)** in Texas. PCIC serves local governments, health systems and health plans through data integration services. PCIC’s data infrastructure platform collects data from school districts, county jails, homeless services, police, fire and EMS services and identifies high-need/ high-cost patients through the development of data dashboards.<sup>14</sup> They also facilitate collaboration through a “Master Client Index,” a secure repository of all individuals with linked records across these multiple systems. They are an exemplar for how social and medical data can be collected and analyzed to provide a “big picture” view of how individuals interact with social support systems.

The most successful collaborations not only have data systems to support coordinated operations but

also clearly define performance indicators and set measurable short- and long-term goals to benchmark their progress. For example, **Live Well San Diego**, a collaboration based in San Diego County, California, developed an information exchange that coordinates care teams and optimizes case management by bringing data together from multiple sources. Although the exchange is primarily used internally by case managers, there are opportunities to use its client-facing interface for push alerts, notifications and other features that will improve adherence to clinical or social service recommendations and ultimately improve health outcomes (see box for more information on the Live Well San Diego initiative).

Live Well San Diego also defines multiple indicators to measure performance over time. These include lowering the percentage of residents experiencing food insecurity, as well as increasing the county’s overall life expectancy and percentage of residents healthy enough to live independently. While population health measures like these require long-term measurement to demonstrate

### North Sound Accountable Community of Health

Type of Multi-Stakeholder Collaboration: Accountable Community of Health

Total Population in Region: 1 million

Population Served: Medicaid beneficiaries in Snohomish, Skagit, Island, San Juan and Whatcom Counties, as well as 8 Tribal nations (Washington)—245,308 served

Overall Goals	Backbone Organization	Participating Stakeholders	Performance Measures	Funding
<ul style="list-style-type: none"> <li>• Combine clinical and mental health care</li> <li>• Care coordination for Medicaid patients</li> <li>• Chronic disease management</li> <li>• Prevent unintended pregnancies</li> <li>• Promote health equity</li> </ul>	<p>North Sound ACH is a 501(c)3 nonprofit, governed by a Board of Trustees consisting of local health sector and community leaders</p>	<ul style="list-style-type: none"> <li>• Regional healthcare providers</li> <li>• Community organizations</li> <li>• Local government</li> <li>• Local businesses</li> <li>• Consumers</li> </ul>	<ul style="list-style-type: none"> <li>• Project Plan score, assessed by an independent contractor</li> <li>• Behavioral health integration</li> <li>• Intragovernmental Transfer (IGT) investment and participation</li> </ul>	<ul style="list-style-type: none"> <li>• Medicaid Section 1115 DSRIP Waiver</li> <li>• Incentive rewarded via Designated State Health Programs (DSHP) funding</li> <li>• Community benefit grants from local hospitals</li> </ul>

Within its three main focus areas of delivery system transformation, rightsizing the provider workforce and improving population health, North Sound ACH conducts cultural competency and literacy trainings for case managers and other healthcare professionals, establishing a Dental Health Aide Therapist (DHT) workforce pilot with Tribal partners to address access issues, and has enhanced EHR use and HIE readiness.<sup>17</sup> North Sound ACH is primarily funded through the Healthier Washington Medicaid Transformation initiative. Collaborations must meet very specific criteria for its project plans and priorities, governance structure and level of data sharing and integration with other government agencies. In Demonstration Year 1, North Sound ACH received the largest ACH Project Plan Bonus out of Washington’s nine participating collaborations.<sup>18</sup>

improvement, Live Well San Diego created a stable infrastructure that facilitates this longer perspective.

Often, the primary area of focus determines the performance measures used by the collaboration. For example, Oregon’s **Coordinated Care Organizations** (CCO) report on 17 incentive measures focused on disease prevention and chronic disease management. All CCO’s in the state use the same measures, developed by a central Metrics and Scoring Committee, as mandated by the state.<sup>15</sup>

Washington’s **Accountable Communities for Health** (ACHs) also face distinct performance measures under

the state’s Section 1115 grant.<sup>16</sup> These performance measures are tied to incentive payments. See box above for a profile of Washington’s North Sound ACH, a multi-stakeholder collaboration serving Medicaid recipients in the northwestern region of the state.

When collaborations need to demonstrate return on investment or cost effectiveness, developing performance measures is more difficult. Many programs lack the infrastructure to define and measure the most relevant outcomes and accurately estimate cost savings.<sup>19</sup> Some organizations track hospital utilization data (e.g., ED use,

### Greater Detroit Area Health Council

Type of Multi-Stakeholder Collaboration: Accountable Care Community

Population Served: residents of St. Clair, Oakland, Macomb, Livingston, Washtenaw, Wayne and Monroe counties (Michigan); several initiatives span across the state

Overall Goals	Backbone Organization	Participating Stakeholders	Performance Measures	Funding
<ul style="list-style-type: none"> <li>Chronic disease prevention and management</li> <li>Cost containment</li> <li>Promote comprehensive data collection, analysis and reporting</li> </ul>	<p>GDAHC is a 501(c)3 nonprofit, membership organization that was founded as the Detroit Hospital Council. It is governed by a Board of Directors, which consists of local community leaders across the health spectrum</p>	<ul style="list-style-type: none"> <li>Michigan Department Health and Human Services</li> <li>Medical societies</li> <li>Health systems</li> <li>Health plans</li> <li>Community advocacy groups</li> <li>Local businesses</li> <li>Other government agencies</li> </ul>	<p>GDAHC is accountable to its members and releases annual Reports to the Community with financial statements and descriptions of all activities (events, programs, and initiatives) completed during that year.</p>	<ul style="list-style-type: none"> <li>Membership dues</li> <li>Private grants</li> <li>Community benefit grants from local hospitals and health systems</li> </ul>

The Greater Area Detroit Health Council (GDAHC) is one of the country’s oldest multi-stakeholder collaborations focusing on healthcare. Founded in 1944, it acts as a convener for various cross-sector initiatives focusing on cost containment, the opioid crisis and addressing the social determinants of health throughout Southeast Michigan. It utilizes a membership model that makes use of working committees addressing increasing access to care, reducing health disparities, improving healthcare quality and decreasing healthcare costs.<sup>23</sup> It also disseminates toolkits and other educational materials on the above-mentioned priority areas. Through a combination of state and private grant funding as well as sponsorships by local companies and organizations, GDAHC serves as a convener and lynchpin for continued research and evaluation of healthcare value-oriented initiatives.

preventable hospitalizations, excess hospital stays), high cost imaging or drug use to assess program performance.<sup>20</sup>

### Challenges

Evaluations to date are few.<sup>21</sup> Nonetheless, researchers have identified some common challenges for further adoption and viability of these models. These include financial sustainability and improving interoperability and further integrating information technology.

**Financial sustainability:** While multi-stakeholder collaborations in many states receive SIM grants or other state/federal funding, they also report difficulties meeting the social and logistical needs of their population beyond

the start-up phase.<sup>22</sup> Because grants typically operate in one to three-year cycles, collaborations often shape action plans around their funding instead of the activities themselves. Pursuing partnerships with local stakeholder and private entities may provide more stable, longer-term financing. An example of this strategy is the **Greater Detroit Area Health Council** (GDAHC), which employs a membership model to supplement their private grant and state funding streams (see box above).

**Improving interoperability and further integrating information technology:** Multi-stakeholder collaborations describe difficulty integrating data from electronic health records (EHRs), claims data, health

information exchanges (HIEs), and other sources. As mentioned above, doing so is essential to reduce the risk of duplicating efforts within community based organizations or healthcare providers.

## Recommendations

At their core, multi-stakeholder collaborations are a community-based approach to achieving population health goals. In doing so, collaborations may also address healthcare efficiency goals and/or health equity. Recommendations for success include:

**Ensure community participation and buy-in through advisory groups:** Consumers can ensure that their multi-stakeholder collaborations are consumer-driven and -oriented through participation on steering committees and advisory groups that determine the initiative's strategic plan and directives. For example, **Washington's Accountable Communities for Health**, which cover the entire state and are aligned with their Medicaid Regional Service Areas, are each governed by a variety of advisory committees staffed by local community leaders as well as those within the health sector. Engaging community members and advocates ensures continued support and efficacy of multi-stakeholder collaborations' overall approach and strategy.

**Broaden funding by expanding partners and contributors:** Funding uncertainties and data sharing issues can hinder multi-stakeholder collaborations and prevent meaningful progress towards their goals. Partnerships with local businesses can shore up funding streams and open opportunities to engage community members in chronic disease prevention initiatives while improved coordination with healthcare stakeholders can serve more health system efficiency-oriented goals. Aspiring multi-stakeholder collaborations need to critically assess existing and potential partners in their specific locales to determine what they can bring to the table.

## Conclusion

Accountable Health Structures or multi-sector collaborations are a key approach for improving population health by surfacing population needs and

aligning a broad range of stakeholders to address those needs. Other goals can include improving health equity and realizing better healthcare value. Despite the very limited evaluation data, a multi-sector approach seems essential to achieve goals where success is determined by social, economic and environmental factors.

## Notes

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