# 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

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## GLOSSARY OF TERMS

**ACO - Accountable Care Organization**: ACOs are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high-quality care to their Medicare, Medicaid, or private pay patients. (www.cms.gov)

**AHC - Accountable Health Community**: The AHC Model addresses a critical gap between clinical care and community services in the current health care delivery system by testing whether systematically identifying and addressing the health-related social needs of Medicare and Medicaid beneficiaries through screening, referral, and community navigation services will impact health care costs and reduce health care utilization. (www.cms.gov)

**ACH – Accountable Communities for Health:** ACHs are cross-sector partnerships that aim to improve health outcomes for vulnerable populations by addressing social determinants of health. (www.commonwealthfoundation.org)

**§1115 Waivers:** Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program. The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate state-specific policy approaches to better serving Medicaid populations. (https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html)

**CBO - Community Based Organization:** CBOs are public and private not-for-profit resource hubs that provide specific services to a community or a targeted population in the community. (www.phe.gov)

**CDFI - Community Development Financing Institution**: CDFIs share a common goal of expanding economic opportunity in low-income communities by providing access to financial products and services for local residents and businesses. (www.cdfifund.gov)

**HH – Health Homes**: Health homes integrate physical and behavioral health (both mental health and substance abuse) and long-term services and supports for high-need, high-cost Medicaid populations. (www.cms.gov)

**HRSN - Health Related Social Needs:** HRSNs are health-harming conditions to individuals such as food insecurity and housing instability. (www.cms.gov)

**SDOH - Social Determinants of Health:** SDOH are the conditions in the environments where people are born, live, learn, work, play, worship and age that affect a wide range of health functions and quality of life outcomes and risks. (https://health.gov/healthypeople/objectives-and-data/social-determinants-health)

**Whole Person Care:** refers to the coordination of health, behavioral health, and social services in a patient-centered manner with the goals of improved health outcomes and more efficient and effective use of resources. (https://publications.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=14261&lid=)

# EXECUTIVE SUMMARY

This project sought to identify 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 product of the *Maine Rural Health Action Network's*[1] discussion of strategies for rural health systems transformation, the project goal 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. The focus of this project was on these two key components of the demonstration as others in Maine are working on additional essential elements such as data integration and sharing and workforce.

To identify promising strategies, we reviewed the recent literature, interviewed experts involved in national 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 communities in Vermont, Western Idaho, and Oregon that have undertaken significant, collaborative health care, public health, and social service alignment initiatives.

## KEY FINDINGS

Achieving systems of care to address HRSNs in the health care system is still very much a work in progress. With limited evidence regarding the effectiveness of different strategies, policymakers, health care and social service providers, payers, philanthropy, and communities are experimenting and testing different approaches. Key observations from the evidence and experience we have reviewed include:

- *The problem of HRSNs and their impact on health equity and access to care, health outcomes, and health care costs is widely acknowledged and understood.* While there is little consensus on the best solutions, many are taking action to begin to address HRSNs.
- *Some health care providers are taking small but important steps to address HRSNs.* Most are starting with the development and implementation of screening tools and systems, including Electronic Medical Record (EMR)-based tools to effect "closed loop" referrals for patients needing social or other services.
- *The problem of justifying investments by health care providers and payers to address social needs using Return on Investment calculations with short timelines is a major barrier to more aggressive action*.
- *Community-based partnerships between health care, social service, and other community-based organizations (CBOs)s are the foundation of efforts to re-engineer systems of care to better address HRSNs.* Partnerships are platforms for cross-sector collaboration to build new systems by creating the shared vision and decision making and governance structures needed to generate and/or re-direct resources to support initiatives to address HRSNs. Financial incentives are central to bringing health care and CBOs to the table on an equal footing to plan, develop, and sustain whole person systems of care. Initiatives are engaging patients and community members, especially those from under-represented and marginalized populations.
- *Health care providers are facing the decision of whether to "build or buy" as they consider how best to address HRSNs.* In Maine and elsewhere some health care providers are hiring community health workers (CHW) or other staff to address patients' social needs. Others are using their partnerships with CBOs to design services to address patients' HRSNs.
- *HRSNs encompass many complex social needs and systems from housing to food insecurity to transportation.* Most initiatives prioritize specific problems in order to work on the development of

community relationships, workforce needs, and workflow issues needed to build the capacity, infrastructure, and systems to address other HRSNs.

- *Currently, state Medicaid programs are at the forefront of re-designing systems of care.* A number are using §1115 waivers to modify benefit and payment structures to align health care and social services; non-waiver options are also being used.
- *Financing strategies such as hospital and/or primary care capitation and community-based "wellness funds" are among the nascent payment innovations being tested.* Community leaders from diverse sectors (banking, business, education, health care, faith-based organizations, etc.) are driving these efforts, which provide opportunities to meet locally defined needs while engaging community members in decision-making.
- *Many states, health systems, and communities are focused on building a new workforce of community health workers, community paramedics, community care teams, and others and integrating them into the current health and social services systems.* Strategies to use these workers to link patients with community resources are being piloted in several rural Maine regions.
- *Digital health strategies, including community health information exchanges, are critical to enabling health care and CBOs to build a more seamless system to address HRSNs.* Identifying barriers and solutions to data integration and data sharing across organizational boundaries requires not only technical skills but significant investments of time and human resources.

## ELEMENTS OF A RURAL, COMMUNITY-BASED DEMONSTRATION IN MAINE

Maine has important resources and assets that could form the foundation needed to demonstrate new community-level approaches for linking health care, public health, and social services to address HRSNs. Innovative MaineCare policy reforms, prior investments by philanthropy to build community health coalition capacity, and more than a decade of experience with the Maine Shared Community Health Needs Assessment all provide experience and a platform for building more effective community-level systems of care.

Drawing on our analyses of published reports, interviews with health system, community and government leaders, payers, funders, and others, this report outlines the key components of a proposed multi-year demonstration to design and implement a system to identify and address HRSNs in one or more rural communities – i.e., a system that would better support "whole person care."[2] The goal of this proposed demonstration would be to define (using quantitative and qualitative measures) the ideal components of system design, governance, workforce, data, and financing that contribute to a community-driven approach to whole person care. Results would be used to adapt and replicate the resulting model to other rural communities.

The proposed 5-year demonstration would include an intensive 18-month planning period and 3 years of implementation followed by a 6-month evaluation completion period. A rapid cycle evaluation would be designed in the early stages of the demonstration to ensure continuous feedback and learning throughout the demonstration. A Request for Proposals (RFP) would be used to identify one or more potential sites with site visits conducted to assess community readiness. Key demonstration features and strategies include:

- A health-oriented approach within a rural region of Maine;
- Support for strengthening comprehensive and integrated primary care services within the region;
- Approach and specific strategies would be co-created among local partners with advice and guidance as appropriate from a Demonstration Advisory Committee and a Technical Assistance Hub;
- Engagement and involvement by health care providers and community-based organizations and individuals in the community/region that can be built upon;

- A shared vision among community partners, including achieving equity among partners fair and representative decision-making and power-sharing relationships would be central to the demonstration and would be developed during the planning year and refined over time;
- Up-front commitments (financial and otherwise) from state government, public and private payers, funders/investors, and others to subsidize the costs of implementation and evaluation;
- Alignment with current/evolving Value-based Purchasing (VBP) and primary care payment models in Maine – e.g., Accountable Care Organizations (ACOs), Primary Care Plus (PC Plus), Behavioral Health Homes (BHH), and alignment of payer quality metrics;
- Engagement of health systems, provider groups (ACOs), and commercial payers operating in the region; and
- Innovative strategies for restructuring state contracts to promote blended funding across sectors to support services provided by public and private community organizations.
- Additional necessary elements would include strategies for data integration and sharing and workforce development.

Sufficient evidence and best practice examples exist, both nationally and in Maine, to develop and implement a multi-year demonstration. Results of the demonstration would be invaluable to adapting and disseminating the model to other communities and regions. Additionally, the outcomes would contribute to the limited evidence base regarding strategies to effectively address HRSNs of patients in the health system.

## I. INTRODUCTION AND PURPOSE

This project sought to identify 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 project was the product of the *Maine Rural Health Action Network's* discussion of strategies for rural health systems transformation. The specific goal was to seek out strategies that fit the policy and community context to inform the design of community-level rural health transformation initiatives, pilots, or demonstrations in Maine. The project focused on two key components of reform: (1) community and regional partnerships 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.

Achieving greater health equity will require a greater effort to address the underlying social needs of rural communities and populations that contribute to health and resource disparities. The demographic and socio-economic characteristics of rural communities and populations in Maine contribute to high levels of social need. Compared with urban parts of Maine, rural Maine is older and suffers higher rates of chronic illness which, together with high rates of poverty and economic dislocation, food insecurity, other social needs, produce significant health disparities. Moreover, addressing social needs can be challenging given limited availability and accessibility of services in many rural communities.

Another important reason for focusing on rural communities and populations is that it may be easier to test strategies and models for addressing HRSNs in less complex community health and social service systems. Rural communities typically have fewer organizations competing for limited resources and, with the proper incentives and support, may be able to mount effective collaborations and partnerships to get things done quickly and efficiently.

To identify promising strategies, we reviewed the recent literature, interviewed experts involved in national 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 communities in Vermont, Western Idaho, and Oregon that have undertaken significant, collaborative health care and social service alignment initiatives. **Section II** of this report discusses the background of the project. Informed by the evidence and our discussions, **Section III** summarizes key observations regarding partnership and governance and financing and payment strategies. In **Section IV**, we outline key components of a demonstration designed to build, implement, and test strategies for aligning health, social service, and other systems to address to advance whole person care.

While this project focused on two key elements of the demonstration, namely partnership and governance structures and financing and payment approaches, additional elements of the demonstration will be critical as well, as outlined in framework for the demonstration discussed in **Section IV**. These include the development and use of: (1) provider and community level data and data integration strategies to allow cross-sector access to important patient-related information, (2) telehealth strategies to expand access to needed health and social services, and (3) community health workers, community paramedics, community care teams, and other staff who are skilled in linking patients to community-based resources and services.

The final section summarizes the rationale for the demonstration. A list of interviewees is included as *Appendix*.

## II. BACKGROUND

The health of rural Mainers and the condition of Maine's rural health systems are reflected in declining population health indicators and increasing financial vulnerability of rural health providers. Many of Maine's health indicators are headed in the wrong direction, largely driven by social and economic circumstances which have been exacerbated by the pandemic, especially in rural communities and populations suffering economic dislocation and generational poverty. Throughout Maine and elsewhere, health care, public health, social service and other community-based organizations (CBOs) are working to build an infrastructure of collaboration and service coordination and integration to address food insecurity, housing, transportation and other health-related social needs (HRSNs) that impede equitable access to health care and contribute to poor health outcomes. HRSNs refer to the social needs affecting the health of individuals. In contrast, the Social Determinants of Health is a term used to reference the broader community and social context in which economic stability, educational access and quality, and other social and economic factors influence the health of communities and populations.[3,4,5,6]

There is growing evidence indicating that unaddressed social needs affect health care access, costs, and outcomes, especially among vulnerable populations.[4] Examples abound: the food insecure patient with diabetes unable to control her hemoglobin A1C because of poor nutrition, the individual whose unstable housing circumstances contribute to missed primary care appointments causing disruption to his continuity of care and significant adverse outcomes for the individual and financial costs to the health care system, and the domestic violence victim whose health care is limited to repeated emergency department visits.

With growing evidence of the importance of HRSNs to the health of patients, health care providers, policymakers, payers, and communities are searching for effective strategies to better address HRSNs.[7] The National Academies of Science (NAS) suggests five key steps for identifying and addressing social risks and needs:[8]

**1. Awareness**

Identifying social risks and needs among patients and in the populations and communities served

**2. Adjustment**

Adjusting clinical care processes to take into account social needs, especially as they might affect adherence to clinical care and outcomes

**3. Assistance**

Connecting patients to resources in the health system or the community to reduce social risk

**4. Alignment**

Partnering with community social service and other providers to create a more seamless, integrated delivery of services to meet patients' needs

**5. Advocacy**

With partners, promote policies that encourage a realignment of resources and assets to support a more integrated delivery of social care

Operationalizing the five steps in health care and community settings is challenging. Critical strategies and tasks include:

- implementing *screening and referral protocols and systems* across health and social service providers,
- developing a *workforce* of community health workers (CHW), community paramedics, and/or lay navigators with deep experience and skills addressing HRSN to help patients secure the services they need,
- designing and implementing *digital strategies* to enable caregivers to share vital information across service systems, and, most importantly,
- developing *funding and financing* strategies that incent and support these functions.[8]

Helping health care organizations and providers understand the daily lives of patients and families with HRSNs will be essential. Patient and family buy-in is central to patients becoming more capable of working with health care and social support providers to address their social needs. Therefore, in addition to expanding their understanding, health care providers may need additional skills in motivating and supporting patients' priorities for change to address their social needs.

Building an infrastructure to support new systems of care requires strong and sustained collaboration among health care, social service and other community organizations. Formal *partnerships and governance structures* are needed to achieve effective alignment among diverse community-based organizations and payment systems. Successful partnerships must be grounded by a common vision that improving on the status quo will only be possible through collaboration that crosses boundaries and requires all stakeholders to enter into new and more equitable power-sharing relationships. Leadership at many levels is a critical element needed to change how health care, public health, and social services are delivered locally and regionally. Such partnerships are unlikely to develop and be sustained, however, without new financing arrangements that contain incentives to bring stakeholders to the table and to allow more flexibility for what care is available, how it is delivered, and how it is measured.

Maine is at a positive tipping point as private and public sector organizations explore strategies to move "upstream" to address social needs affecting health and the health system. The following are among the potential building blocks for a new approach to organizing and delivering health care and social services in rural regions:

- Promising and experienced community coalitions, collaborations and/or partnerships in a number of regions (including recent Maine Health Access Foundation (MeHAF) community initiatives);
- A strong, "can-do" rural culture with existing interpersonal and inter-organizational relationships and trust in many communities;
- Accountable Care Organizations (ACOs) that could provide valuable payment and care management infrastructure;
- Growing interest among Medicaid, Medicare, and private payers in "value-based" payment arrangements with greater potential flexibility for addressing HRSNs;
- A Maine Shared Community Health Needs Assessment (MSCHNA) initiative with 11 years of collaboration among the state's four health systems (including all member hospitals), many independent hospitals, and state government to identify and address health needs in Maine's 16 counties and across the state;
- Progressive digital health policies and capacity, including near universal use of EMRs, a functional, statewide Health Information Exchange (HIE), increasing adoption of screening platforms to identify HRSNs, and COVID-related expansion of telehealth;
- Expanding interest in and use of Community Paramedicine, Community Care Teams, Community Health Workers, and other health workers to fill gaps in care in rural areas of the state; and

- Creative pandemic responses in many Maine communities to address social health needs and an infusion of pandemic-related federal funding that can be learned from and leveraged.

While these and other building blocks may be *necessary* to build an effective and sustainable system of care that addresses both health care and social needs, they are *not sufficient*. The architecture and construction of community-based systems requires careful design, planning, and implementation to ensure strong collaboration, alignment, and functionality among the multiple providers, payment, and data systems.

Additionally, while there has been hope that federal and commercial payers would devise new payment systems that could more directly and adequately fund social services needed to address HRSNs, progress on that front has been disappointingly slow, despite growing evidence that significant needs exist. A recent (2019-2020) series of seven Rural Health Listening Sessions held by the Maine Department of Health and Human Services' Rural Health Transformation Team clearly identified HRSNs as a priority, including "whole-patient care to help people stay healthy" along with interrelated services and supports, assessments, referrals, and communication.[9]

In late 2020, the Centers for Medicare and Medicaid Services announced the launch of the "Community Health Access and Rural Transformation" (CHART) model demonstration, citing an aim "to continue addressing disparities by providing a way for rural communities to transform their health care delivery systems by leveraging innovative financial arrangements as well as operational and regulatory flexibilities". [10] CMS issued a Request for Proposals (RFP) for rural hospitals and communities, but no Maine organizations applied. In subsequent discussions with rural hospitals and health systems across the state hosted by the Maine Department of Health and Human Services, organizations expressed significant concerns with the proposed design and specific features of the CMS CHART demonstration, voicing particular concern about the proposed new rural hospital payment model, which proposed moving from the current fee-for-service (FFS) system to capitated payment.

Given the inability of the CHART pilot to attract one or more rural communities to apply for participation, the question of whether Maine could design its own "rural health system transformation" initiative arose and motivated the development of this project. To that end, we sought to identify community partnership and financing strategies that could form the basis for a demonstration to achieve greater alignment between our health and social service systems. In doing so, we specifically sought to identify strategies that fit Maine's health policy context and its rural communities, health care, public health, and social service systems. Although we began the project guided by the National Academies' framework mentioned earlier, we have used frameworks, models, and ideas from many organizations and initiatives (e.g., Systems for Health (S4H), Aligning Systems for Health, Culture of Health) to inform our thinking and recommendations. Based on a review of the evidence and discussions with health, social services, and policy leaders in Maine and selected sites around the country, this report discusses a path forward to a demonstration in Maine to advance our understanding of how to deliver "whole-person"[2] care in the rural context to address HRSN and, ultimately, to improve health outcomes.

## III. PARTNERSHIP AND FINANCING STRATEGIES TO ADVANCE WHOLE PERSON CARE

Achieving systems of care to address HRSNs is still very much a work in progress. With limited evidence regarding the effectiveness of different strategies, policymakers, health care and social service providers, payers, philanthropy, and communities are experimenting and testing different approaches. Key observations from the evidence and experience we have reviewed include:

- *The problem of HRSNs and their impact on health equity and access to care, health outcomes, and health care costs is widely acknowledged and understood.* While there is little consensus on the best solutions, many are taking action to begin to address HRSNs.

- *Some health care providers are taking small but important steps to begin to address HRSNs.* Most are starting with the development and implementation of screening tools and systems, including Electronic Medical Record (EMR)-based tools to effect "closed loop" referrals for patients needing social or other services.
- *The problem of justifying investments by health care providers and payers to address social needs using Return on Investment calculations with short timelines is a major barrier to more aggressive action*. The impact and value of such investments are typically neither recognized or tracked, beyond the anecdotal.
- *Community-based partnerships between health care, social service, and other CBOs are the foundation of efforts to re-engineer systems of care to better address HRSNs.* Partnerships are platforms for cross-sector collaboration to build new systems by creating the shared vision and decision-making and governance structures needed to generate and/or re-direct resources to support initiatives to address HRSNs. Financial incentives are central to bringing health care and CBOs to the table on an equal footing to plan, develop, and sustain whole person systems of care. Initiatives are increasingly engaging patients and community members, especially those from under-represented and marginalized populations.[11]
- *Health care providers are facing the decision of whether to "build or buy" as they consider how best to address HRSNs.* In Maine and elsewhere some health care providers are hiring community health workers or other staff to address patients' social needs. Others are using their partnerships with CBOs to design services to address patients' HRSNs.
- *HRSNs encompass many complex social needs and systems from housing to food insecurity to transportation.* Most initiatives are prioritizing specific problems, such as housing or food insecurity in order to work on the development of community relationships, workforce needs, and workflow issues needed to build the capacity, infrastructure, and systems to address these and other HRSNs.
- *Many states, health systems, and communities are focused on building a new workforce of community health workers, community paramedics, community care teams, and others and integrating them into the current health and social services systems.* Strategies to use these workers to link patients with community resources are being piloted in several rural regions in Maine.
- *Currently, state Medicaid programs are at the forefront of re-designing systems of care.* A number are using §1115 waivers to modify benefit and payment structures to align health care and social services; non-waiver options are also being used to better align health, public health, and social services.
- *Financing strategies such as hospital and/or primary care capitation and community-based "wellness funds" are among the nascent payment innovations being tested.* Community leaders from diverse sectors (banking, business, education, health care, faith-based organizations, etc.) are driving these efforts, which provide opportunities to meet locally-defined needs while engaging community members in decision-making.
- *Digital health strategies, including community health information exchanges, are emerging as critical to enabling health care and CBOs to build a more seamless system to address HRSNs.* Identifying barriers and solutions to data access and data sharing across organizational boundaries requires not only technical skills but significant investments of time and human resources.

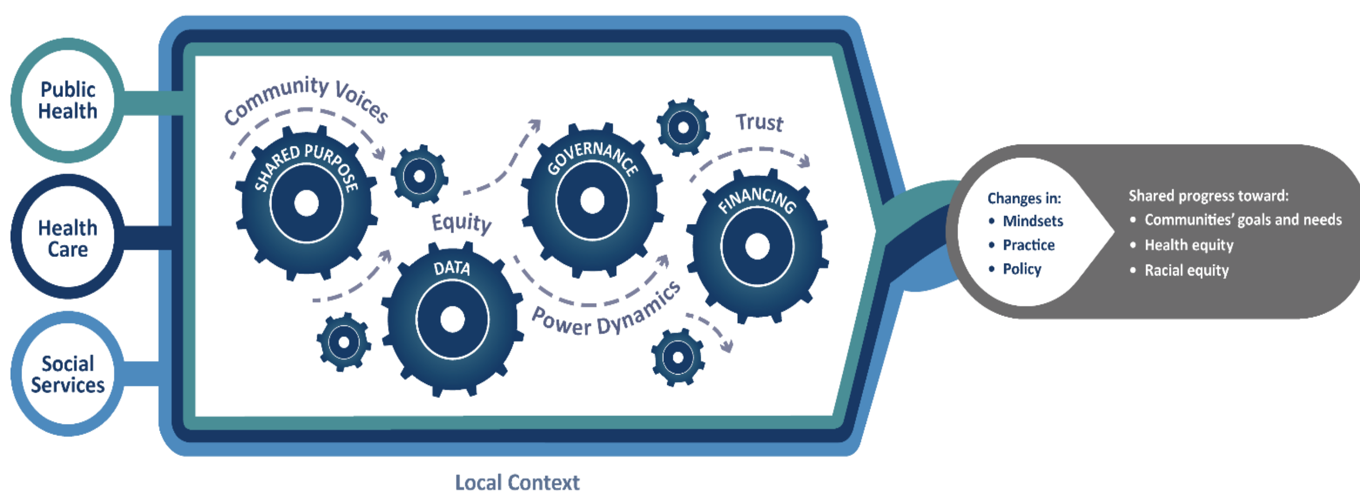
The following narrative elaborates on these and other key observations regarding promising strategies.

## Partnerships and Governance Strategies

Health and social well-being are the responsibility of three key sectors which, to date, have not been well-aligned. The ***public health system*** has responsibilities for population health issues with core competencies and functions related to disease tracking, environmental health, and prevention more broadly. The ***health care system*** provides

services addressing individual preventive, chronic, and acute conditions for patients. And finally, the **social service system** is comprised of many diverse ***public and private organizations*** operating at the community or regional level addressing social needs such as housing, food security, and transportation. Although the term "system" suggests a degree of intentional, planned structure and roles, in fact, all three sectors operate quite independently, creating significant barriers to inter-sector coordination and alignment. As illustrated in the framework below developed by the *Aligning Systems for Action* project of the Robert Wood Johnson Foundation, achieving improved health and wellness outcomes requires an alignment of purpose, governance, data, and financing among these three sectors.[12] As noted, strong multi-sector and community engagement and collaboration to align across these dimensions is foundational to the success of efforts to develop systems of care that address HRSNs. Based on the literature and our discussions in Maine and elsewhere in the country, three factors emerged as essential to effective cross-sector partnerships: (1) the development of a shared and inclusive vision, (2) strong financial or other incentives to bring organizations to the table and sustain their participation, and (3) effective structure, governance, and accountability.

A FRAMEWORK FOR ALIGNING SECTORS

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### Developing a Shared Vision

*The process of developing a shared vision among collaborators is an essential first step in successful and sustainable initiatives.*

*Co-creating a shared vision – among all people and organizations that aspire to collaborate yields not only a statement on paper or a website but the deep commitments and relationships that are essential to effective and equitable implementation of solutions.*

Recognizing, understanding, and accepting that many factors contribute to health is the first step in the journey toward collaboration and action among health care and community-based social service providers. Step two is acknowledging that neither the health care system nor the social services sector has the resources to independently address these factors. Step three is broad recognition that each sector possesses specific knowledge and skills that are essential to whole person care and must be aligned (at minimum) or integrated (ideally) to achieve short- and long-term improvements in individual patient outcomes, population health, and regional vitality. Co-creating a shared vision – among all people and organizations that aspire to collaborate yields not only a statement on paper or a website but the deep commitments and relationships that are essential to effective and equitable implementation of solutions. Crafting a vision that reflects the most important hopes and aspirations of potential partners or collaborators

requires, first and foremost, that everyone involved come to the table ready to engage in honest and open dialogue. According to one interviewee, it is critical that the unequal power dynamics between health care and the social sectors be acknowledged and addressed. In the case of people and organizations that have been marginalized within the community, putting everyone on an "equal footing" may require significant work, given systemic inequities that have historically impacted access to services and resources, in public health, health care and social services systems. The expression of values that underpin individual attitudes and beliefs is central to these discussions.[13] Failure to put these issues explicitly and openly on the table often leads to distrust and tension and can create barriers to developing trusting relationships that are critical to enduring and productive partnerships. Taking the time to develop a common language early on is central to developing a shared vision that all partners embrace.

> *"We need to get health care providers to say why social determinants of health are important as a starting point for working with the community."*
>
> -CBO leader
>
> *"Health care providers really do want to address social needs of our patients but we lack the time and know-how. We need to use the whole bucket of resources in health care AND the community if we are truly going to improve the health of the population."*
>
> -ACO leader

> *"Leaders need to be in the room to have hard conversations about collaboration and money, but shaping the vision needs everyone's input."*
>
> -CBO leader

Community-based collaboration in rural areas tends to draw individuals who wear many hats – related to their day jobs, family life, and volunteer activities. System transformation requires new ways of thinking and doing and those involved must be ready to "leave their organizational hats at the door" in order to build trust among partners. Including individuals with the ability to commit organizational support and resources is critical to shaping a vision that can be actualized.

Meaningful involvement of people with relevant lived experience of different social needs is crucial to building a shared vision. Removing barriers to wide and representative involvement may include explicit recognition process of structural issues such as racial and gender inequities, stigma, cultural bias and history that may inhibit buy-in as well as barriers such as lack of money for childcare, transportation, or translation services.[14,15,16,]

Ongoing, sustained community input is essential and requires constant care and feeding using strategies such as Community Advisory Boards[17] or Collaborative Action Networks that are charged with developing strategies and measures related to issues such as housing, mental health and physical well-being.[18,19,20]

### Incentives for Engagement and Partnerships

*Effectively addressing the health-related social needs of patients requires, at minimum, a reciprocal relationship between the health care system (i.e., primary care, hospitals, rural health centers, behavioral health and others), and community-based organizations where both sectors find benefit and value in collaborating.*

HRSNs of patients can be numerous and complex. Chronic conditions such as congestive heart failure or diabetes often require intensive medical and pharmacologic interventions but effective management of these conditions is likely to be affected by social factors such as economic status, nutrition, and social isolation. In addition to chronic conditions, preventive care, such as annual wellness visits or routine screenings like mammograms or colonoscopies is also affected by social factors. Implementing strategies that address the underlying social needs that affect health outcomes requires an alignment of health care providers and social service providers and services with continuous engagement of patients. Defining the roles and responsibilities of the different sectors is

critical. The question of whether health care organizations should "build" their own capacity or "buy" it from community partners is often contentious and challenging to effective collaboration and may reflect underlying tensions and power differences between health care and social service organizations. Our interviews revealed that, facing the decision of whether to "build or buy", some health care providers are choosing to build their own workforce and services without seeking the assistance of or coordinating with CBOs. In contrast, other health care providers are using their partnerships with CBOs to design services to address patients' HRSNs. Engaging CBOs in the design of appropriate community-based services is critical to avoid further fragmentation and medicalization of community services.

> *"We want the vision to be broad and optimistic – 'if the needs of children were met and families were thriving, what would we see?' and then we work backwards to figure out what we need to do by working together."*
>
> -CBO leader

Examples of cross-sector collaboration are numerous but many fail due to inconsistent leadership, unbalanced power dynamics, and the lack of meaningful incentives to keep stakeholders at the table. Additional barriers include a lack of understanding of funding streams, business models that focus on short-term financial savings, and external pressures, all exacerbated by language and culture that are unique to each sector. Sharing experiences, common challenges, and opportunities before crafting interventions can help create a more level playing field for collaboration. Innovative tactics such as convening an annual Vision Day, where all partners and all community members are welcomed to contribute to building a shared vision, also help build relationships among sectors.

Financial incentives are a powerful influencer of collaborations between health care and community-based organizations. The growth of VBP programs in health care, where payment is impacted by patient outcomes and providers are rewarded for helping patients improve their health, reduce the effects of chronic disease, and live healthier lives, can provide incentives for providers to find ways for patients to obtain wraparound services and resources needed to achieve these outcomes. To date, however, the lack of provider acceptance of down-side risk has limited the potential power of those incentives.

Cross-sector collaborations to address HRSNs tend to be more effective (and sustainable) when benefits and value accrue fairly to both health care providers and CBOs. Immediate progress on short-term needs (such as food insecurity), while also addressing long-term problems (such as homelessness), contributes to success. Although the health and cost impacts of HRSN-investments have not been widely studied, health care providers and community partners are taking measured steps to begin to lay the groundwork for broader interventions.[21,22,23]

### Effective Structure, Governance and Accountability

The structure of multisector collaborations varies considerably depending on the driving forces behind collaboration, vision and values of participants, sectors and organizations involved, prior history, leadership, resources (financial and other), geography, population and culture. Sensitivity and attention to these factors is critical to the design and function of organizational infrastructure – which may build on an existing entity whose mission (ideally) is aligned with the initiative or it may necessitate creating a new structure. Given the time and resources required to accomplish the latter, new or expanded initiatives often elect to start by partnering with an existing organization via formal or informal agreements, where resources such as physical space, support staff, technology, HR, and fiscal and administrative management can be procured and paid for on an as-needed, flexible basis. Ideally, a neutral organization or agency with a well-established track record of brokering trusted relationships serves as the administrative home of the partnership to simplify oversight and management and to provide a single point of accountability for partners and funders.[17,24]

*Approaches to governance by cross-sector collaborations vary widely across multisector initiatives but five essential functions have emerged from successful collaborations among health care and community-based organizations – in rural as well as non-rural regions: 1) structure; 2) process; 3) accountability; 4) engagement; and 5) effectiveness.*

*Structure* relates to the way in which decisions are made and by whom. Boards of directors or trustees typically have formal organizational relationships and structures such as Executive Committees and may have fiduciary roles to play as gatekeepers of budgets and funding. Advisory or Steering Committees may be formally or informally established but guidance regarding purpose, representation, roles and responsibilities and terms of service are considered essential elements for efficient implementation.[25] One interviewee emphasized that neutral and experienced facilitation is helpful in building a common vision and trust in partnerships.

*Process* refers to strategies and procedures that ensure clear, timely, and regular communication among participants to assure preparation for informed decision-making, such as meeting agendas, minutes, and background materials. Investing in community members' professional development to develop leadership or other needed skills assures that all collaborative members are participating on an equal footing, including those individuals and organizations that have been marginalized in the past, and addresses issues of inequity among representatives of professional organizations and community members.[14]

*Accountability* is central to governance and means that the individuals who are entrusted with implementing decisions made, whether elected, appointed, or volunteer, are responsible (unless otherwise determined) for carrying out decisions made transparently and efficiently. If problems are encountered in implementation, those individuals have the obligation to seek advice expeditiously from others involved so progress is not derailed. Accountability also implies access to relevant data and the resources needed to obtain, process, and report data needed to assess the effectiveness or impact of the collaboration. Discussions and decisions about data sources, metrics, benchmarks, methods and frequency of reporting are all critical conversations and decisions to be considered by the governance body (e.g., Board, Advisory Committee, Steering Committee or other decision-making entity).[26,27]

*Engagement* is more than getting people to come to the table – it is about listening, showing interest and empathy, understanding, and practicing patience – so that individuals who come to the table not only want to stay but are moved to constructively take part in the work of building a collaborative undertaking. Engagement is a process that can require ongoing discussions about barriers and issues such as stigma and bias (perceived and real), structural issues such as gender and racial disparities, and changes that are needed to equitably distribute power among people and organizations. A perception exists in many places that the health care system has unlimited resources and has the authority to wield power and control over organizations (such as CBOs) that are perceived to hold fewer resources and authority. Unmasking this often-unspoken barrier has helped some collaborations break through perceptions and achieve productive relationships. Data-gathering and analysis have been shown to be effective engagement strategies, from interviews or focus groups of community members to regional community health needs assessments or mapping community assets.[28]

The *effectiveness* of governance and partnership strategies is ideally measured both quantitatively and qualitatively and is separate but related to the process of measuring the effectiveness of the initiative in reaching its goals and desired outcomes. Assessing short, intermediate, and longer-term outcomes requires discussion and agreement about meaningful outcomes and the use of both quantitative and qualitative measures. Quantitative measures can include process indicators, such as the number of meetings held, demographic characteristics of those involved, issues discussed and resolved, and activities completed. Qualitative measures might involve

anonymous surveys of collaborators, partners, funders, staff, and patients and interviews and observations that seek to measure perceptions, attitudes, and experience with governance processes such as inclusion, transparency, fairness, equity, engagement, and value.[26]

While many frameworks exist for multi-or cross-sector collaboration, the *Collective Impact* model and the more recent *Constellation Model of Social Change*, both developed by the Stanford Institute for Social Innovation[14,29,30] have been adopted and adapted widely in Maine and other rural sites nationally. *Collective Impact* is defined as the commitment of a group of actors from different sectors to a common agenda for solving a specific social problem, using a structured form of collaboration. Specific roles of a backbone organization and complementary roles played by partners are supported by a common governance structure, making the framework relevant for collaborations among discrete sectors (social services and health care) seeking to solve a common problem such as the poor health status of patients who are disproportionately affected by social needs. Designation and support for a neutral entity to provide "backbone" functions, such as convening, communication and coordination, and strategic planning, ensures that these responsibilities are taken care of and means that partners can participate fully in planning and implementing collective actions rather than spending time on administrative tasks.

The fact that all of the rural sites we interviewed are using some form of *Collective Impact* or the *Constellation Model of Social Change* as a framework for organizing and managing their partnerships is a strong indication of its applicability to cross-sector collaborations in rural communities and regions. Adapting the framework to ensure equitable sharing of decision-making power was (and is) a key feature among sites that have achieved some measure of sustainability.

## Financing and Payment Strategies

New financing and payment strategies and models are central to reforms targeting HRSNs.[31,32] In its recent report on integrating social care into the health care delivery system, the National Academies of Sciences identified several important financial barriers that have contributed to the fragmentation of our health care, public health, and social service sectors. Three are especially important: (1) the current, limited definitions of what constitutes "health care"; (2) the methods of provider payment; and (3) the challenges of accountability in payment reform.[8]

- The predominantly fee-for-service (FFS) payment system currently used in the health system only pays for specific clinical services tied to diagnosis (and billing) codes contained in the International Statistical Classification of Diseases and Related Health Problems-10th Revision (ICD-10). Although there are certain codes in the ICD-10 that allow for limited identification of social needs "diagnoses" (Z55-65), few providers are actually using these codes within their EMR and billing systems. Therefore, the flexibility to receive payment for services to address HRSNs has been limited. In comparison, most social services are paid for through a variety of federal and/or state grant or contract mechanisms with specific requirements that limit flexibility in the use of funds. This has contributed to very siloed financing of health care and social services, contributing, in turn, to service fragmentation across these sectors.
- Within this framework that limits the definition of health care, FFS payment models have constrained the willingness and ability of providers to address patients' social needs. In addition to incentivizing volume over value (a measure of quality and cost), the payment models have been biased toward technical services (e.g., surgery, imaging) over services that involve more "cognitive" skills (e.g., primary care). The services and skills required to identify and address social needs clearly fall in the latter category.
- A related problem has been the challenge of measuring units of service, outcomes, and costs in the social services sector, creating significant hurdles for any payment reforms that might promote greater access to social and other community services to address HRSNs.

Notwithstanding these barriers, new financing and payment models, often referred to as "value-based purchasing" (VBP), have begun to change the payment landscape and may provide opportunities for greater flexibility to address the social needs of patients. In addition, policy and regulatory changes in the Medicare and Medicaid programs are providing greater flexibility in funding services to address HRSNs. And finally, partnerships in some local communities are experimenting with home-grown funding approaches such as "wellness funds" to pay for innovative initiatives to address social needs. In this section we highlight some of the major approaches that are being employed both in Maine and elsewhere in the country that are designed to support financing and payment strategies to address HRSNs.

**Identifying Social Needs in the Health Care Context**

To date, social needs have not been considered the domain of health care and health care providers have not sought to identify or address them. With the growing recognition of the effects of social need on health care outcomes, however, health care providers have begun to seek ways to integrate a recognition of those social needs into the health system. In addition, payers have begun to consider whether and how to adjust payments for health care to account for the effects of social needs on health care outcomes. As noted earlier, health care providers in Maine and elsewhere are beginning to deploy screening tools to identify social needs in their patient populations. Some are also using EMR-based tools to better manage referrals to address HRSNs. For example, *The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)*, developed by a consortium including the National Association of Community Health Centers, is widely used by Federally Qualified Health Centers (FQHCs) in Maine and elsewhere.[33] Also, the Center for Medicare and Medicaid Innovation (CMMI) developed an *Accountable Health Communities (AHC) screening tool*.[34,35,36] But in most cases, it appears health systems and providers are developing their own HRSN screening tools. Interviewees noted that some of the factors to consider in deciding whether to adapt an existing tool or develop a new one, include the:

(1) Capacity to address specific needs (e.g., contracts with community-based organizations, existing relationships, knowledge of community assets, staff trained to screen and address);
(2) Availability of local resources/referral network; and
(3) Ease of use within a clinical setting; and

The problem of shared access to patient information on HRSNs across provider organizations has limited efforts to coordinate care to address HRSNs. To address this problem, Vermont, which operates a statewide, multi-payer ACO under its §1115 waiver from CMS has developed a shared electronic care coordination platform used by providers across the ACO to coordinate care. The ACO has embedded its screening tool, *the Vermont Self-Sufficiency Outcomes Matrix*, into this platform, making it accessible to care team members at both the community and health system levels.[14]

*The problem of shared access to patient information on HRSNs across provider organizations has limited efforts to coordinate care to address HRSNs.*

People we spoke with in Maine and elsewhere noted that the implementation of screening for HRSNs is not a simple process. While implementing a tool within an existing EMR may be a challenge for some providers, the most significant steps involve changing workflows in primary care practices to appropriately (and sensitively) capture the social needs information and then establishing procedures for making and tracking referrals and monitoring progress toward meeting needs. Before implementing HRSN screening tools and referral systems, many health care organizations have partnered with

community organizations to assess the availability and capacity of local agencies and services to meet HRSNs. As discussed below, the *Maine Shared Community Health Needs Assessment*, public health accreditation processes, and other local collaborative partnerships provide ample opportunities for assessing community capacity and needs. Hospital Implementation Plans, required as part of the triennial CHNA, provide a potential foundation for collaboration with other health care providers within a region as well as CBOs or both. One interviewee noted that the limited availability and capacity of social service organizations in their rural region has created a reluctance among primary care practice to introduce social need screening.

*The limited availability and capacity of social service organizations in their rural region has created a reluctance among primary care practices to introduce social need screening.*

**Changing Payment Models**

*ACO and AHCs:* As noted earlier, VBP models may offer opportunities to fund infrastructure and services to address HRSNs. Public and private payers have adopted *Accountable Care Organization (ACO)* and *Accountable Health Community (AHC)* models that involve risk-based capitation payment structures that allow high performing health care providers to earn savings that are shared with the payer; so-called "two-sided" risk arrangements also put providers at financial risk in the event of poor performance. In Maine currently, all ACOs are functioning under one-sided risk models (i.e., ACOs share savings and do not have "downside risk), with some considering moving to two-sided risk as soon as 2022, for both Medicare and Medicaid.

Health care providers that earn "shared savings" can potentially use those savings to hire care coordinators (e.g., community health workers, community care teams, or community paramedics) to work more closely with social service and other CBOs, fund "gap-filling" services, implement information systems and tools to identify socially vulnerable patients, and/or make other investments needed to meet quality targets and achieve cost savings.

Although the concept of shared savings as a potential source of funding to support services to meet HRSNs is appealing, most ACOs report that their modest savings are insufficient to represent a significant investment in new services to address HRSNs. That said, at least one ACO in Maine reports using savings to create "gaps in care" funding to address short-term social needs such as transportation or emergency housing. However, shared savings payments are not always timely and may not be a sustainable strategy to support the kinds of services that require upfront or ongoing investments.

While ACOs, at least in their current configuration, may not be a realistic source of funding for services needed to address HRSNs, they and their health system sponsors are a critical source of leadership and partnership support needed to assess community needs, develop and implement collaborative strategies to address them, and advocate for needed policy changes. As discussed earlier, ACOs and AHCs (and the hospital and health systems that support them) can partner with CBOs to re-engineer how HRSNs are addressed.

*Primary Care Payment Reform:* Primary care payment reform has been central to efforts to strengthen the primary care foundations of the health system.[37] To date, most reform efforts have employed enhanced payment strategies to support the expansion of team-based care and care coordination capacity. A more recent initiative, Medicare's *Primary Care First* launched in 2021, uses a combination of capitated payments (representing about 60% of primary care payments) and reduced FFS payments with regional and historical performance benchmarks to determine savings (or losses).

MaineCare, the state's Medicaid program, is pursuing a primary care-based reform initiative, *Primary Care Plus (PC Plus),* designed to consolidate and update its VBP arrangements.[38] As currently envisioned, this initiative would employ a partial capitation (planned as of 2023) for primary care that aligns with Medicare's *Primary Care*

*First* payment and performance monitoring model.[39] MaineCare also hopes private payers will align their primary care payment structures to encourage participation among providers.

In its review of primary care payment models, the National Academies of Sciences notes that while most payment models have been shown to have limited effect in helping practices address HRSNs, "enhanced primary care payments", delivered through non-FFS mechanisms (e.g., capitation), can enable primary care providers to better coordinate with social services to enhance access to those services for vulnerable patients.[37]

*Medicaid Payment Options:* In addition to ACO and AHC models of VBP, Medicaid programs have a variety of options for financing services to address HRSNs.[40,41,42] As noted, CMS has granted waivers to a number of states under the authority of §1115 to significantly redesign the financing and delivery of services in their Medicaid programs. In Oregon, for example, the state's reform is built around regional Community Care Organizations (CCOs) that contract on a capitated basis with the Medicaid program to provide the full range of services for beneficiaries.[21,43] The CCO's represent formal, regional partnerships of health care, dental, behavioral health, social service, and other organizations. Paid on a capitation basis, CCOs have considerable flexibility in determining the mix of services needed to meet cost and quality performance targets. In North Carolina, the state's Medicaid program has an approved §1115 waiver to implement its *Healthy Opportunities* initiative which, among many features, will incorporate payment to pre-paid health plan pilots for select services to address HRSNs.[44] In Rhode Island the state's Medicaid program contracts with "Accountable Entities" (a version of an ACO) with the inclusion of strategies to address social needs of patients as a central feature of the model.[45] And as previously mentioned, the Vermont One Care all-payer, statewide ACO model also operates under a §1115 waiver through which providers could have greater flexibility to fund capacity and services designed to address HRSNs.[46]

Maine DHHS officials we spoke with indicate there are no immediate plans to seek a comprehensive §1115 waiver, citing the time it takes to prepare the application, get approval from CMS, and the ongoing administrative (operational and financial) costs of waiver implementation. Instead, the state is pursuing reform strategies that can be adopted within authorities available through the normal State Plan Amendment process. For example, MaineCare is currently seeking approvals for a targeted housing support initiative targeted to homeless beneficiaries that will allow the program to pay for housing navigation and other services designed to ensure greater housing stability and thereby avoid excessive and unnecessary use of health care services. Based on our review and discussions, additional options worth considering include:

- Work with providers to develop risk profiles of populations and/or geographic areas using risk social vulnerability or risk profiling analyses;[47]
- Consider risk-adjusting payments to providers, including risk adjustment for HRSNs when possible;[48]
- In risk-based arrangements, consider whether MaineCare might require a certain percentage of shared savings be devoted to addressing HRSNs;
- Encourage or require providers to use ICD-10 diagnosis and payment codes to identify individuals with HRSNs and develop payment models to support their efforts to screen patients for HRSNs;[50]
- Use the performance measurement and reward systems in its VBP initiatives (including ACOs, Health Homes, and PC Plus) to incorporate process measures (tied to requirements of providers) related to HRSNs. For example, the first measure for health screening might include adoption and degree of implementation of a screening tool/system. In systems that already have such tools/systems in place, a process measure might be the percentage of eligible patient screened for HSRNs.
- Beyond performance measures, consider bonus payments for promoting the use of CHWs, Community Paramedics, or other non-traditional but culturally appropriate staff;

- Require, encourage, and support training for housing, transportation and other provider staff to promote an understanding of social needs; and
- Explore policy and regulatory options for blending funding across Medicaid and social service funding sources.[49]

These and potentially other strategies represent "ideas worth considering"; they are not proven strategies. Evaluating current and potential payment models to identify barriers to addressing HRSNs and creating opportunities for addressing them may generate other important strategies.

*Private Payer Options:* Some private payers in Maine are evaluating how they might modify benefits and/or payment structures to better address the underlying HRSNs that contribute to high health care use and poorer quality if left unaddressed. For example, one health plan is actively promoting the use of the ICD-10 codes (96160 and 99401-4) that could be used to bill for screening and assessment, preventive services, and risk reduction. There has been limited use of these codes to date, however. In addition, the non-billing Z codes can be used to identify the reasons why patients are presenting for care, including the identification of circumstances or factors that may be influencing health status.[50]

One of Maine's major private insurers, Harvard Pilgrim Health Care, is exploring options for creating a community center in Baileyville where it insures employees at the Woodland Paper mill. With initial funding from the Harvard Pilgrim Foundation, the planning committee is working with community and regional stakeholders to identify opportunities for enhancing access to health care and social services in this rural part of Washington County.

We did not speak with all of the major private health plans in Maine. Nor were we able to speak with employers regarding their strategies for addressing HRSNs in their health plans and/or other human resource programs. As in many parts of the country, larger employers and their health plan partners in Maine have adopted a wide variety of "wellness" plans as part of their health benefit programs. Adopted with the expectation of achieving cost savings in health plan expenditures, many of these plans have underperformed relative to expectations.[51,52] As such, employers' willingness to expand their wellness programs to include social and economic factors and needs affecting the health (and cost) of their employees may be low. Nevertheless, employers and health plans have an important role to play in the communities where they are located, advocating for and supporting community-level efforts to address underlying social and economic problems and needs that are known drivers of health care use and spending.

*Medicare and Medicare Advantage Plans:* Given their unique (essentially capitated) model, Medicare Advantage (MA) plans offer another potential opportunity for directing resources to identify and support HRSNs. In Maine, the share of Medicare beneficiaries enrolled in private MA plans has grown substantially in the last five years and now constitutes 43 percent of eligible beneficiaries.[51] There has been a corresponding growth in available MA plans in the state, though plan availability and enrollment is substantially lower in Maine's rural versus urban counties.[51] Since 2019, all MA plans have had the option of covering non-medical services as long as these benefits are intended to "diagnose, prevent, or treat an illness or injury, compensate for physical impairments, act to ameliorate the functional/psychological impact of injuries or health conditions, or reduce avoidable emergency and health care utilization to all beneficiaries."[53] Services might include safety devices for the home that reduce the risk of injury, transportation to health-related services, such as the doctor's office or pharmacy, pest removal, or adult day-care services. According to a recent Commonwealth Fund study, the percentage of MA plans offering supplemental benefits grew substantially from 2018 to 2020; benefits included meal provision (20% of plans to 46% of plans), transportation (19% to 35%), in-home support services (8% to 16%), and acupuncture (11% to 20%).[53] MA plans are currently an unlikely vehicle for financing new services to address rural social needs in rural Maine given their limited availability in rural counties and the corresponding low enrollment rates. That said,

recent trends suggest that we may see future expansions of the MA program into some rural parts of the state with corresponding opportunities for offering expanded benefits to address social needs.

In addition to MA plans, health plans have expanded their offerings of Dual Eligible Special Needs Plans (D-SNPs) which is a category of plan that enrolls individuals who are entitled to both Medicare (Title XVIII) and medical assistance from a state plan under Medicaid (Title XIX). These plans typically enroll older individuals and individuals with disability who need special support services in addition to health care. The expansion of D-SNP plans in Maine offers another opportunity for MaineCare to encourage private plans to expand social support and other services that address enrollees' social needs.

*Community Level Financing Innovations:* In addition to initiatives led by major public and private payers, local hospitals, health systems, and their community partners can create innovative financing mechanisms to support and align health and social services with social needs. Two strategies in particular are worth highlighting:

Hospitals, Hospital-based Health Systems and Community Benefit*:* The community benefits laws and CHNA processes offer an important opportunity not only for building local community partnerships that could prioritize HRSNs, but also for encouraging greater hospital commitments to and contribution of resources toward addressing HRSNs. While non-profit hospitals have long been required to report on the level of "Community Benefit" they provide in exchange for their tax-exempt status, the Affordable Care Act (ACA) strengthened those expectations and could provide another potential mechanism for redirecting funds to address HRSNs. Currently all 33 general, acute care hospitals in Maine are not-for-profit (NFP) entities are required to report on their "community benefits". ACA-related changes to the community benefit regulations also require non-profit hospitals to (1) conduct triennial community health needs assessments (CHNAs), (2) develop implementation plans for addressing those needs, and (3) report publicly on their progress in meeting the identified needs.

The so-called "charity" or "uncompensated care" that hospitals provide constitutes the largest percentage of hospitals' community benefits. However, the community benefit laws create an expectation that hospitals undertake themselves and/or with their community partners activities and commit resources to address community needs identified through their CHNAs. In 2012, four health systems, (MaineHealth, Central Maine Healthcare, Northern Light, and MaineGeneral) and the Maine Center for Disease Control and Prevention signed an agreement to establish a collaborative, Maine Shared Community Health Needs Assessment (MSCHNA) initiative. In essence, the MSCHNA created a common data collection framework and community engagement process for the conduct of assessments in all 16 counties in Maine. Currently, each hospital is responsible for developing and implementing its own health improvement plan pursuant to the needs identified in the assessment. The MSCHNA has proven its value to the participating health systems and hospitals as evidenced by multiple renewals of the underlying agreement.

The MSCHNA represents an unrealized but potentially vital resource for efforts to better address HRSNs in Maine. On the one hand, the MSCHNA produces extensive county-level data on health and social needs vital to identifying unmet HRSNs. In addition, the project's community engagement framework and activities create opportunities for building or expanding upon existing community level collaborations and partnerships to develop improvement strategies targeted to addressing HRSNs. To date, however, hospitals' health improvement plans have been largely framed by the hospitals to meet their requirements and needs; most hospitals and their community partners have not collaboratively developed or implemented those plans.[13]

Public attention to the concept of Community Benefit and the tax exemption benefits of non-profit hospitals has grown recently, offering potential further leverage to influence hospitals to create more meaningful contributions to community health. For example, the Lown Institute reports on their calculation of each hospital's "fair share

spending" – a measure of the financial benefit received by each hospital from their tax-exempt status vs their actual spending on community benefit activities.[54] Such public reporting efforts could potentially offer a useful lever to advance hospital spending on HRSNs.

Community Wellness Funds: In two of the communities we interviewed (Caledonia and South Essex, Vermont and Yamhill, Oregon), collaborative, multi-sector partnerships involving health care, public health, social service, business, and other organizations have developed small but growing "wellness funds" that have provided resources for special initiatives targeted to the social needs of the communities in their service area. In Oregon, the Yamhill Community Care Organization initially used a small percentage of their retained revenue (savings) from its contract with the Medicaid program to initiate their fund. It has continued to do so, growing the fund by approximately $1.0M annually. Use of these funds have to be evidence-based initiatives with a focus on longer term improvements in population health. For example, the fund recently supported a project to test an innovative school-based early learning program focused on social and emotional learning to address school behavior problems. In Vermont, the Caledonia – South Essex AHC, which has an ACO arrangement with Vermont OneCare, invests one percent of its shared savings in the NEK Prosperity Fund, which supports small projects in the community. Although the fund is currently small ($58,000), the plan is to grow the fund to $5-6M to support the development and growth of local businesses, as a Community Development Financial Institution (CDFI). The project has proven to the partnership that even in a relatively under-resourced community, it is possible to generate funding for important community economic and social needs.[55]

These examples demonstrate that with strong partnerships and leadership among organizations from multiple sectors, rural communities can generate capital to invest in important initiatives that address HRSNs. In both instances, these partnerships were led by health care organizations committed to using a small percentage of their resources earned from ACO shared savings to seed investments in priority health needs in the community.

**Measurement and Payment Accountability**

In addition to problems measuring inputs of social care, there are comparable challenges defining outputs and outcomes. In health care, outputs and outcomes are defined using measures and statistics centered on both process (e.g., visits, tests or screenings performed) and outcomes (e.g., morbidity and mortality). In the absence of agreement on comparable measures related to HRNSs, state Medicaid programs and others are actively developing and experimenting with measures to begin to develop an inventory of measures for the future.

The challenge of justifying interventions based on a Return on Investment (ROI) calculations has slowed adoption of initiatives to address HRSNs. The cost and health outcomes of interventions or services to address social needs can rarely if ever be measured in a one- or two-year timeframe. The often-cited example of early childhood learning programs demonstrates that point. As a result, it is very difficult to convince health care providers to direct funding to social needs-related initiatives that might otherwise have been invested in core operations. For health plans, the frequent "churn" of subscribers or enrollees means that the potential benefits of investments (e.g., lower ED use) at a point in time are unlikely to accrue to the health plan beyond 1-3 years.

*Interim solutions will require larger, more focused, and sustained investments by the health system, together with more creative leveraging of existing (and new) social need funding.*

*CBO Interviewee*

This is sometimes described as a "wrong-pocket" problem – i.e., investments by one organization or sector eventually result in savings that accrue to a different organization. Interesting, theoretical solutions to this problem are being tested with funding from the Robert Wood Johnson's *Systems for Action (S4A)* research initiative.[56] As one

interviewee noted however, interim solutions will require larger, more focused, and sustained investments by the health system, together with more creative leveraging of existing (and new) social need funding.

## IV. KEY ELEMENTS OF A RURAL, COMMUNITY-BASED DEMONSTRATION TO ADDRESS HRSNs AND ADVANCE WHOLE-PERSON CARE

### Introduction

As noted earlier, Maine has important resources and assets that could form the foundation needed to demonstrate new community-level approaches for linking health care, public health, and social services to address HRSNs. Innovative Medicaid policy reforms, prior investments by philanthropy to build community health coalition capacity, a functional statewide Health Information Exchange, and more than a decade of experience with the Maine Shared Community Health Needs Assessment all provide experience and a platform for building more effective community-level systems of care. In addition, some rural regions in Maine have well-established collaborations among hospitals, health centers, behavioral health providers, and community-based organizations such as Area Agencies on Aging, Community Action Programs, and local food banks. While these initiatives provide patients or clients with specific services such as Meals on Wheels or rides to doctor appointments, the arrangements between health care provider organizations and community-based providers are often not explicitly defined, lack closed feedback loops, and are financially unsustainable.

The evidence suggests that building strong community-level relationships and partnerships with effective decision-making and governance structures are foundational for successfully designing and implementing key system change components such as workforce roles and the use of digital/data technologies and data sharing to enhance cross-sector information sharing. Following the precepts of the Collective Impact model of community development, having a backbone organization that can provide leadership and support to the partnership is vital.

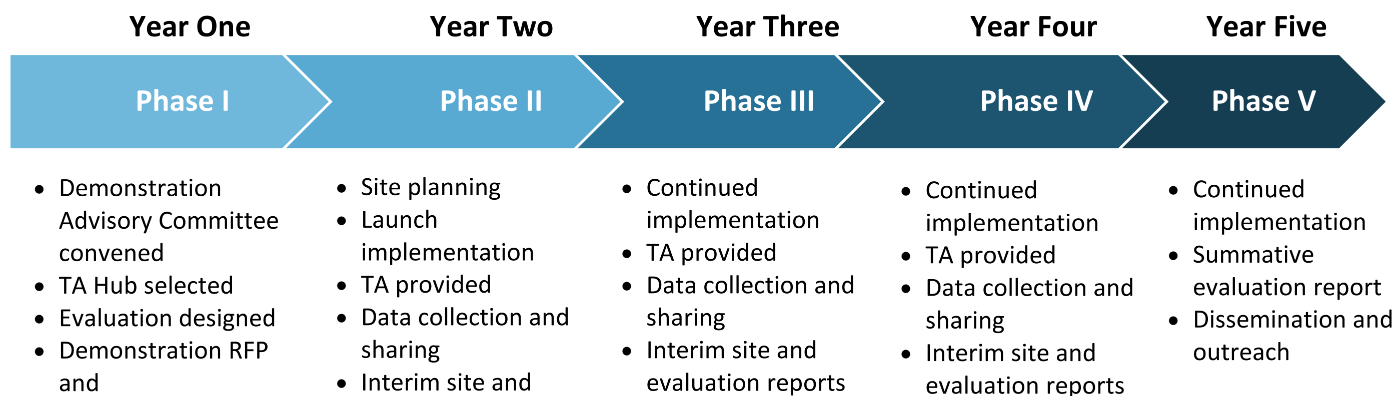
Drawing on published reports, interviews with health system, community and government leaders, payers, funders and others, we outline below a multi-year demonstration initiative to design and implement an approach that could better identify and address HRSNs to offer a more holistic system offering "whole person care." To ensure the engagement and buy-in of community/regional stakeholders and the relevance of selected activities to local resources and culture, the framework and general parameters assume that the specific design, implementation, and evaluation strategies will be co-created by leaders of the site(s) selected. Projects requiring adherence to rigid top-down design and implementation requirements often fail due to their lack of sensitivity to "how things really work" in a given community. Building the expectation that local input is an essential element of the planning phase sends a positive message about the value of community engagement.

*To ensure the engagement and buy-in of community/regional stakeholders and the relevance of selected activities to local resources and culture, the framework and general parameters assume that the specific design, implementation, and evaluation strategies will be co-created by leaders of the site(s) selected.*

Additional design features include a Demonstration Advisory Committee to provide periodic feedback and guidance. Technical assistance to support governance agreements, new finance and payment models, data sharing and evaluation will be provided by a contracted Technical Assistance "hub" tailored to the demonstration. Technical assistance resources will be focused on neutral facilitation, partnership and governance models, financing strategies, and other core elements of the demonstration. A rapid cycle evaluation will be designed early in the demonstration to ensure continuous feedback and application of learning throughout the demonstration.

Flexibility and adaptability are other functional aspects to be woven into the implementation phase. As a "system transformation" demonstration project, heavy emphasis will be placed on observation and documentation of processes throughout both planning and implementation phases to continuously assess what is working (or not working) and support timely decisions on why and how to improve processes.

**Proposed Demonstration Timeline:**




**Demonstration Framework: Guiding Principles**

**Purpose:** To determine how to design better systems of care that integrate social services and health care into whole person care.

**Long-term Goal:** To improve access to care for patients in rural areas of Maine who have specific HRSNs that, if addressed, can improve their short- and long-term outcomes. This goal is based on the premise that patients who have identified but unmet HRSNs often experience problems accessing and using health care services (preventive, chronic, and acute) appropriately, leading to higher costs, poorer health outcomes, or both.

**Demonstration Goal:** To define (using quantitative and qualitative measures) the ideal components of system design, governance, workforce, data, and financing that contribute to a community-based approach to whole person care. Results from the demonstration can be used to adapt and replicate the resulting model to other rural communities and regions.

**Design:** The 5-year demonstration includes an intensive 18-month planning period, 3 years of implementation, and a 6-month final evaluation period. A rapid-cycle evaluation process will be designed in the first six months of the project and continue throughout implementation to continuously inform project implementation and operations. A Request for Proposals will be used to identify one or more potential sites with site visits conducted to assess community readiness. Key demonstration features and strategies include:

- A health-oriented approach seeking to align health care, social service, and public health resources and services within a rural region of Maine;
- Support for strengthening comprehensive and integrated primary care services within the region;
- Approach and specific strategies will be co-created among local partners with advice and guidance as appropriate from the TA Hub and the Demonstration Advisory Committee;
- Engagement and involvement by health care providers and community-based organizations in the community/region that can be built upon;

- A shared vision among community partners, including achieving equity among partners, fair and representative decision making and power-sharing relationships is central to the demonstration and will be developed during the planning year and refined over time;
- Up-front commitments (financial and otherwise) from state government stakeholders, public and private payers, investors and others to subsidize the costs of implementation and evaluation;
- Alignment with current/evolving primary care payment models in Maine – PC Plus, BHHs, ACOs, commercial payer quality metrics;
- Engagement of ACO(s) operating in the region; and
- Innovative strategies for blending funding across sectors using current coverage and payment arrangements for services from public and private sources.
- Additional necessary elements would include strategies for data integration and sharing and workforce development.

Additional features of the demonstration would include:

**Organizational Vision, Mission and Capacity:**

- Leaders of partner organizations must be involved in planning/strategy development and resource commitments;
- Technology and workforce innovations will be included as appropriate; and
- Partners agree to engage in transparent discussions, negotiations, and changes in the system of care (e.g., workflows, staff roles, and contractual and formal/informal referral relationships).

**Patient Population:**

- Patient and/or client populations will be meaningfully included in all phases of the project;
- Specific patient HRSNs that can be addressed with current resources are to be identified, quantified, and negotiated with partners during the planning phase (no wholly new resources are to be developed);
- Existing partnerships with CBOs (Community Action Programs-CAPs, housing, aging, food security, transportation), as well as existing tools and platforms to screen for HRSNs/SDoH in EMRs and add-ons like Aunt Bertha, will be leveraged; and
- Patient population size and characteristics to be included will be a requirement of the RFP, to be finalized after site selection.

**Financing Plan:**

- Total project budget: a minimum of $2M, or approximately $400K annually for 5 years;
- A mix of public and private payers and contributions from local organizations such as hospitals or CBOs is anticipated, augmented by grants from foundations to cover expenses such as salaries, meeting costs, stipends for local governing body participants, the Technical Assistance hub;
- The detailed overall project budget will include both local income and expenses for the local site(s) separate from all other project income and expenses; and
- Current payment arrangements with MaineCare and commercial payers will be optimized to the extent possible to pay for needed services related to patient HRSNs. Additional sources of funding may be needed to cover the costs of providing HRSNs to patients.

**Trackable Measures (quantitative and qualitative):**

- Selection of Technical Assistance Hub

- Selection of a community/region for the demonstration
- Demonstration Advisory Committee convened
- Planning phase deliverables completed
    - Community partners engaged
    - Health care providers engaged
    - Governance structure developed
    - Financing plan developed
    - Implementation plan developed
    - Evaluation and tracking measures established
- Implementation phase deliverables completed
    - Increased access to home and community-based services
    - Strengthened systems to identify and meet HRSNs
    - Strengthened system of governance
    - Increased use of innovative technologies
    - Increased use of innovative workforce/provider approaches
- Evaluation phase (included in the three-year implementation phase) deliverables completed
  Potential evaluation questions include:
    1. Which patients are most likely to benefit from having their HRSNs addressed and what are the steps to identifying and engaging these patients?
    2. What are the most effective ways to identify and address HRSNs and how should patients be involved in both processes?
    3. Which needs can be best addressed by the health care system and which can best be addressed by CBOs; how should those decisions be made and by whom?
    4. What incentives need to be in place to bring health care providers, community-based organizations, patients and others together to work on finding solutions to common problems? What incentives are needed to move interest to partnership and collaboration? What impact does local history and culture have on relationships? Issues of equity?
    5. How can current financing approaches be used to move to more equitable partnerships ("wrong pocket" problems, where financial gains typically accrue to HC and not CBOs)?
    6. How should current financing approaches be changed to support the integration of vital social services into patient care?
    7. What metrics are most reflective of short, intermediate and long-term outcomes; what data sources should be used? Who is responsible for setting benchmarks, data collection, analysis and reporting?

**Objectives:**

1. **Design and implement an open and transparent RFP process** to select a highly qualified site(s) for the demonstration project.
2. **Implement and evaluate: Phase I (18 months)** of the demonstration:
    a. Outreach to and engagement of community-based organizations, especially those with established relationships to culturally and racially diverse populations;
    b. Outreach and engagement of health care provider organizations across the community or region.
    c. Creation and implementation of governance and decision-making structure;
    d. Identification of HRSN that provide the greatest opportunity for shared intervention/action by health care and community partners, potential services and resources to be provided and proposed methods for providing those services and resources;

    e. Identify strategies to align with and support new and evolving MaineCare policy initiatives: PC Plus, Accountable Community Organizations, Health Homes, Behavioral Health Homes, Permanent Supportive Housing initiatives (such as the HOME program – Housing Outreach and Member Engagement) and others TBD; and
    f. Identify strategies to align with and support new and evolving commercial payer policies: screening for SDoH, addressing equity, and financial incentives for provider groups and/or ACOs to meet quality metrics.
3. **Implement and evaluate: Phase II (42 months)** of the demonstration:
    a. Governance and partnerships: Engage local leaders and partner organizations and incentives to inclusion and participation, leadership and decision-making processes, strategies to assess and assure equitable power-sharing;
    b. Financing: Determine parameters of the financial model that is necessary to support short term implementation and potential system transformation;
    c. Workforce: Identify innovative approaches to workforce needs, such as Community Health Workers, Community Navigators and Community Paramedicine, that can be used to meet patients' HRSNs; and
    d. Data and data sharing: Identify sources of data (including screening data and platforms), data sharing priorities and processes.
4. **Identify and describe how the demonstration can inform transformative change at three levels:**
    a. Community (planning and implementation processes);
    b. Local/regional/statewide (what is needed at each level to support); and
    c. Policy (what kind of infrastructure is needed to support sustainable system transformation?)

## V. SUMMARY AND KEY CONSIDERATIONS

Our review of the literature and interviews with rural health policy experts, payers, provider organizations and community leaders, while not exhaustive, provides a strong rationale for moving forward with a demonstration project in Maine. Sufficient evidence and best practice examples exist, both nationally and in Maine, to develop and implement a multi-year demonstration. Results of the demonstration would be invaluable to adapting and disseminating the model to other communities and regions. Additionally, the outcomes would contribute to the limited evidence base regarding strategies to effectively address HRSNs of patients in the health care system.

Health care providers and community-based organizations we spoke with cited frustration with systemic barriers that stymie innovation and cross-sector partnerships. They voiced strong interest in pursuing collaborative approaches to addressing HRSNs that could provide value to both patients and health care and community-based providers. In fact, several in-state interviewees expressed the opinion that developing sustainable solutions to meeting patient non-clinical priorities such as housing, food insecurity transportation is absolutely essential to maintain the viability of Maine's rural communities.

While many details remain to be worked out, we believe the time is right to engage state and local leaders in further developing the vision and the path forward, toward the goal of decreasing disparities and improving the health of people and communities in rural Maine through innovative system transformation.

## APPENDIX: INTERVIEWEES

1. **Jeffrey Brown**, MEd, Principal, Safer Healthcare, LLC
2. **Rebekah Dube**, Pharm.D., Director, ACO Performance and Development, Central Maine Health Care
3. **Robert Chamberlain**, MD, MBA, Chief Medical Officer and **Jennifer Moore**, President, MaineHealth Accountable Care Organization
4. **Gavin Drucker**, MD, Co-President of Northern Light Medical Group, SVP, Northern Light Health, **Ed Gilkey**, MD, MS, MBA, CPE, Vice President/Senior Physician Executive, Northern Light Beacon Health, **Carrie Arsenault**, MBA, President, Northern Light Beacon Health and **Jaime B. Rogers**, LCSW, MBA, Director, Community Care and Behavioral Health Services, Northern Light Beacon Health
5. **Erin Guay**, MPH, Executive Director, Healthy Androscoggin/Central Maine Community Health Corp.
6. **Silas Halloran-Steiner**, MSW, CADC III, Yamhill CCO Health Policy Advisor and **Emily Johnson**, Community Health Specialist, Yamhill Community Care Organization (Oregon)
7. **Glenn M. Landers**, ScD, MBA, MHA, Research Assistant Professor and Director, Health Systems and **Chris Parker**, MBBS, MPH, Director, Population and Global Health, Georgia Health Policy Center
8. **Lisa Letourneau**, MD, MPH, Senior Advisor, Delivery System Change, Maine Department of Health and Human Services, Commissioner's Office, **Olivia Alford**, MPH, Director, Value Based Purchasing and **Michele Probert**, MPP, Director, Office of Maine Care Services, Maine Department of Health and Human Services
9. **Claire Levesque**, MD, Chief Medical Officer, Point 32 Health and **Bill Whitmore**, Harvard Pilgrim Health Care, Maine Market Lead
10. **Joanna Morrissey**, MPH, Maine Shared Community Health Needs Assessment Program Manager, MaineHealth
11. **Alexis Pickering**, MHS, Health Strategist, Western Idaho Community Health Collaborative
12. **Mary Prybylo,** RN**,** MSN, FACHE**,** Chief Executive Officer, Community Care Partnership of Maine (CCPM), **Sandy Nesin,** Esq.**,** Chief Operating Officer, CCPM (and VP, Accountable Care Operations and Population Health at St. Joseph Healthcare), **Lori Dyer,** JD, Chief Human Resources Officer, Compliance Official and Privacy Officer, CCPM (and President/CEO at Penobscot Community Health Center) and **Mary Butler**, Director of Operations, CCPM (and Director of Operations at the Schmidt Institute) Community Care Partners of Maine
13. **Jill Rosenthal**, MPH, Senior Program Director, Allie Atkeson, Elinor Higgins, National Academy for State Health Policy
14. **Martin Sabol**, Director of Health Services, Nasson Health Care and **Barbara Crider**, Executive Director, York County Community Action Corporation
15. **Alex A. Sydnor**, MHA, Chief Strategy Officer, MaineGeneral Health
16. **Jeffrey D. Sedlack**, MD, MBA, FACS, Associate Medical Director, Maine, Harvard Pilgrim Health Care
17. **Shawn P. Tester,** MSOL, CEO and **Laural Ruggles**, MBA, MPH, Vice President of Community Health Improvement, Northeastern Vermont Regional Hospital

## ENDNOTES

1. The *Maine Rural Health Action Network* is a voluntary group of rural health experts and stakeholders from business, philanthropy, education, health care, and social services seeking evidence-based strategies for addressing the rural health crisis in Maine.
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