How Community-Based Partnerships Address Health-Related Social Needs: Examples and Insights from Four States

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Introduction

States are increasingly using a variety of approaches to provide individuals and families with services and support to address health-related social needs (HRSNs) or non-medical drivers of health (NMDOH). Recent all-of-government policy support for addressing unmet HRSNs and social drivers of health and promoting health equity, including guidance from the Centers for Medicare and Medicaid Services (CMS), has underscored the importance of these efforts for improving population health.

Among the states that are doing this work, there is growing recognition that, in addition to stable financing mechanisms to pay for HRSN services, new or adapted multi-sector relationships, infrastructure, and capacity are necessary to successfully scale and sustain these efforts. As a result, many states are choosing to leverage partnerships supported by intermediary organizations—such as those serving as the backbone for accountable communities of health (ACHs)—and consisting of health care providers, health plans, social service providers, other sectors, and community members to design and implement efforts to address unmet HRSNs in the communities they serve. Notably, these multi-sector, community-driven partnerships have increasingly demonstrated that authentic and meaningful partnership with people who have lived experience is essential to developing effective programs that address unmet needs and, in turn, improve population health.

In May 2024, The George Washington University's Funders Forum on Accountable Health and the National Academies of Sciences, Engineering, and Medicine's (NASEM) Roundtable on Population Health Improvement co-hosted the first of a series of webinars on the features and structures of multi-sector, community-driven efforts that can enable meaningful and lasting systems and policy change to improve population health and advance health equity (NASEM, 2024). This first webinar highlighted the various approaches and multi-sector, community-driven partnerships that four states with diverse policy and political environments—Ohio, Rhode Island, Texas, and Washington—are leveraging to engage community-based organizations (CBOs) and residents in addressing HRSNs within their communities. The webinar also described the successes and challenges the states have experienced.

The contents of this commentary highlight the latest progress and lessons learned from these four states, including the importance of individual perspectives and community partnership as the states develop and implement programs to address unmet health and social needs.

State Profiles

Examples from the four states featured in the webinar illustrate just a few of the types of efforts taking root across the United States and are intended to show the range of ways state agencies and other stakeholders are building the infrastructure and relationships necessary to bring together health care, public health, social services, other sectors, and community residents. It is worth noting that even as states grapple with significant challenges like the unwinding of Medicaid continuous coverage requirements, there has been continued interest and momentum in reframing an approach to health care that includes addressing social needs.

Ohio

Ohio is a Medicaid expansion state, with most Medicaid beneficiaries receiving services through a Medicaid managed care organization (MCO). Ohio MCOs are required to demonstrate their commitment to improving population health outcomes in the communities they serve through community reinvestment activities. Currently, the Ohio Department of Medicaid Managed Care Provider

Agreement requires the MCOs to reinvest 3 percent of their estimated annual after-tax underwriting margins to community reinvestment—beginning in 2025, that amount will increase to 5 percent (NASEM, 2024).

Under the auspices of the Ohio Association of Health Plans (OAHP), Ohio's seven MCOs developed a process for improving the health outcomes in the communities they serve, working collaboratively on the needs of beneficiaries and funding projects. In 2023 they funded $25 million and, in 2024, almost $8 million in community projects (NASEM, 2024). The members of the collaborative quickly realized that they needed to hear directly from community residents about their priorities and needs.

The MCOs entered into an agreement with the Center for Community Solutions, an organization with a long history of working with Ohio communities. Two counties were selected for pilots: one urban, Cuyahoga County; and one rural, Athens County in Appalachia. A thorough needs assessment was conducted to gather data on social drivers of health and available Medicaid data on health indicators. Regional Advisory Committees were established in each county with community residents and leaders. These groups review and score proposals for community reinvestments and discuss priorities in their communities. Focus groups were also used to solicit additional information on community needs and priorities. An overall steering committee including MCO health equity and population officers and representatives of the communities has also been established to make final decisions.

Ultimately, the goal is to establish and nurture a long-term community partnership among all of the stakeholders, building trust and advancing community-level systems that will promote equity.

Rhode Island

The Rhode Island Department of Health (RIDOH) began its Health Equity Initiative almost 10 years ago, recognizing that treating individuals and focusing on individual outcomes was not improving health outcomes or bending the health care cost curve. Overall population health outcomes were moving in the wrong direction despite public health initiatives (NASEM, 2024). In response, leadership in the RIDOH started asking: How do we change the system? How do we resolve the problems causing human suffering and inequities in the first place?

The RIDOH began investing in people and community-defined geographic areas, known as the Health Equity Zones (HEZs). This initiative recognized that residents needed resources to address the priorities in their own neighborhoods, which may include food, safety, housing, transportation, or other issues such as employment. The principles defining HEZs are as follows: focus upstream; uphold a place-based perspective; be transformational not just transactional; maintain active partnerships with the community; and invest in capacity. In order to see improved social and environmental conditions in a community, intentional investments are needed for community infrastructure and capacity.

Rhode Island, an early Medicaid expansion state, is working across state government and the private sector to bring resources to the HEZs so residents can lead efforts to address priorities in their communities. Residents have the power to shape investments to improve their lives, enhance outcomes for everyone, and respond to needs that may be broader than health care or public health indicators. State health department leaders assert alignment across state agencies with a braided funding model along with philanthropic resources, which allows community residents to address a range of identified needs and priorities and sustain these investments in people and place.

Texas

With leadership and support from Episcopal Health Foundation (EHF) and three other philanthropic organizations in Texas, a learning collaborative was established among the two Texas health plan associations, the state's 20 MCOs, the Texas Health and Human Services Commission (which oversees Medicaid among other programs), CBOs, and other stakeholders to drive policy and practice to address the non-medical drivers of health (NMDOH) of Medicaid beneficiaries. Recent state legislation requires standardized screening related to non-medical needs and allows community health workers and doulas to be providers under Medicaid for case management of children and pregnant women. While the state recently expanded postpartum coverage for pregnant women up to 12 months, it has not expanded general Medicaid coverage.

Together, the Texas Association of Health Plans and the Texas Association of Community Health Plans realized they needed the perspectives and voices of Medicaid beneficiaries and pregnant women to shape their efforts. To engage this group, a subset of the learning collaborative (the four philanthropic organizations and a cross section of the MCOs), developed a plan to solicit information on the needs of pregnant women in their state.

Each MCO recruited current or recently pregnant women to participate in focus groups across the state. Information from the focus groups was compiled and reported with

assistance from the EHF. The MCOs identified structural barriers such as the need for additional information about pregnancy and what to expect, difficulty accessing common over-the-counter medication, challenges signing up for Medicaid as compared to the Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and lack of CBO capacity to provide services. They also learned that medical providers do not routinely ask about social needs. Beyond food, transportation, housing, and employment, participants reported other critical issues such as domestic violence, lack of child care, need for clothing and baby essentials, and access to services for women with limited English proficiency.

The MCOs are now able to more effectively plan how they will make the necessary investments to address the needs of pregnant women in the communities they serve. They also gained a deeper appreciation for the importance of community voice, the perspectives of beneficiaries, and the significance of trust building when responding to community needs.

Washington

Washington state, a Medicaid expansion state, has nine regional ACHs that cover the entire state, including tribal nations. Each ACH is unique due to the varying demographic characteristics and geographic regions of the state, but all are non-profit organizations that include health systems, public health, health plans/MCOs, primary care, behavioral health, CBOs, and social service providers. Governance structures are diverse, but all ACHs include residents and community leaders—examples include Better Health Together's (BHT) Community Voices Council, which provides guidance and feedback to BHT networks, and HealthierHere's designated governance board seats for CBOs, Tribes, community members, and consumers (BHT, n.d.).

The ACHs in the state lead efforts to address HRSNs in their communities. There is a need to address fragmentation and improve the integration of health care and social services, expand CBO and social services infrastructure and capacity, and build networks with centralized administrative and technical supports.

As part of the second Medicaid 1115 waiver, ACHs will serve as community hubs and facilitate the delivery of HRSNs, making infrastructure and community workforce investments and expanding care coordination in collaboration with community partners. Community residents, as part of the governance structures, drive the actions of ACHs in investing in community partners as they seek to improve community outcomes.

Key Themes

These examples underscore the importance of taking time to include community voice and build trust among key stakeholders as they address identified priorities in their communities, no matter the political or policy environment. This was true in Texas and Ohio as well as Rhode Island and Washington. Building partnerships is critical in making services responsive to identified needs and priority areas. Texas described approaches to purposefully engage community members in priority identification. Ohio took things one step further in standing up an advisory structure with community engagement. Further along the spectrum, Rhode Island and Washington have more formalized and robust community member participation in governance structures to drive decision making and resource allocation.

MCOs are important partners in the provision of services under Medicaid in most states. Working with MCOs as part of multi-sector, community-driven partnerships provides considerable opportunities to address unmet health and social needs, and these partnerships can be leveraged to address underlying drivers of these needs and affect sustainable systems change. In both Texas and Ohio, MCOs provide considerable leadership and infrastructure support in addressing HRSNs within the communities they serve.

Community capacity for providing needed social services is a critical facilitator for improved population health. States are finding diverse ways to build this necessary capacity and finance these efforts in ways that are sensitive to the needs of diverse geographic areas and cultures, be they urban or rural communities.

Developing approaches to engage community residents in decision making is not easy. The process takes considerable time to understand needs beyond the provision of health care services and the involvement of sectors outside of health care and public health. The approaches taken by these four states are varied and continue to evolve as they address unique opportunities to improve the health and well-being of their residents.

Conclusion

The importance of including community residents and leaders in the development of programs and services that affect them cannot be overstated. The four examples provided in this commentary reflect the diversity and strength of community residents engaged in meaningful ways to ensure that

services are responsive to identified needs in the community. Going further, community partnerships are also critical to ensuring that residents have a voice in the governance of these initiatives and that resources are distributed equitably and reach the populations most in need.

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