States Demonstrating the Business Case for Multisector Efforts: An Emerging Value Framework

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Introduction

Regardless of their political and policy environments, including the presence or absence of Medicaid expansion, states are increasingly supporting a variety of interventions to address health-related social needs (HRSNs) due to the proven and promising impact of these approaches. The COVID-19 pandemic reinforced what many have known for some time. Within communities, "the conditions in which individuals and families are born, grow, work, live and age"—also known as the social drivers of health (SDOH)—result in unmet HRSNs such as food insecurity, housing instability, interpersonal violence, and transportation challenges (WHO, 2023). These unmet HRSNs can be associated with poorer health outcomes, increased health care costs and utilization, and health disparities and inequities (Whitman et al., 2022; HHS, 2023). Now, equipped with new guidance and flexibility to pay for HRSN services through various payers including Medicaid and the Children's Health Insurance Program (CHIP), as well as lessons from tested models for HRSN-related screening and referral such as the Centers for Medicare and Medicaid Services' five-year Accountable Health Communities demonstration, several states are implementing their own approaches to addressing and paying for these needs. Some are leveraging direct payments from Medicaid and other payers to community-based organizations (CBOs), while others are utilizing indirect approaches such as braiding and blending funding streams and encouraging partnerships between intermediary or "backbone" organizations (e.g., accountable communities of health, public health institutes, community care hubs, and regional health hubs), health care providers, and health plans (TFAH, 2018).

Among the states that have successfully embarked on this work, there is recognition that new multisector relationships, infrastructure, and capacity must be established to scale and sustain these efforts. In many cases, backbone organizations have played a key coordinating and administrative role. Because of the significant investment necessary to implement and build capacity for services, including any needed data infrastructure, there is not surprisingly a need to demonstrate the measurable value of these approaches to state agencies and other investors. While funding opportunities for such infrastructure investments are limited, the authors offer a framework for assessing the long-term value that backbone organizations can bring to communities—not only in addressing HRSNs but also in tackling the upstream factors that impede optimal health and wellbeing at the population level.

A New Value Framework for Multisector Partnerships

Accountable Communities for Health (ACHs) and other similar multisector, community-based partnerships bring together health care, public health, social services, other local businesses and partners, and residents to address the unmet health and social needs of the individuals and communities they serve (Mittmann et al., 2022). The foundation of these models is a trusted backbone organization that serves to align the community with partners, facilitate shared resources, apply an equity lens to the work, and fulfill coordination and administrative functions. The value of ACHs and related multisector activity to community health can be viewed along a continuum—involving short-, medium-, and long-term components—from mounting evidence on return on investment (ROI) for delivering HRSN services (short term), to demonstrating the value of investments in community capacity needed to ensure meaningful and sufficient linkages to services through screening and referral efforts (medium term), to making the case for these multisector partnerships as civic assets (long term). Just as libraries and schools are important assets to civic infrastructure, multisector partnerships like ACHs can be developed to serve as civic assets that can be

leveraged and adapted to address and engage community members in dialogue about solutions on a range of HRSNs and SDOH, for example by responding to food insecurity, addiction and overdose, depression and suicide, maternal mortality, and many other pressing challenges that may affect a community. At this latter end of the spectrum, ACHs can ultimately drive systems change by advancing policies and practices that can help communities become healthier, more equitable, and more resilient (Gaynair et al., 2020). These efforts are synergistic with a growing recognition of the importance of civic engagement and voting as a determinant of health (Healthy People 2030, n.d.; NASEM, 2024).

Although composed of short-, medium-, and long-term components, this value continuum (see *Figure 1*) is not necessarily unidirectional; partnerships at various stages of development may focus on one or more components of value, while others may demonstrate value across this continuum. In the following section, the authors provide illustrative examples of how ACHs and similar partnerships are demonstrating value across the continuum.

Multisector Partnerships Demonstrating Value Across the Continuum

Short Term (HRSN Delivery System)

Some ACHs and related multisector partnerships have demonstrated ROI from delivery of HRSN services through improved health outcomes, decreased utilizations, and reduced costs. Greater Cleveland United Way, which is a Collaborative Approach to Public Good Investments (CAPGI) site in Ohio, is funding medically tailored meals for older adults with chronic conditions. There are 12 stakeholders, including hospitals, insurers, and local foundations, that comprise the investment group. The United Way is the trusted broker. This model is built on ROI for investors, and is evaluated based on ROI, although nonfinancial value may also accrue to participants or investors (Taylor and Nichols, 2024).

As another example, the North Carolina Healthy Opportunities Pilots were authorized $650 million through the Medicaid 1115 waiver to develop the capacity of CBOs and bridge health care and social services. The Network

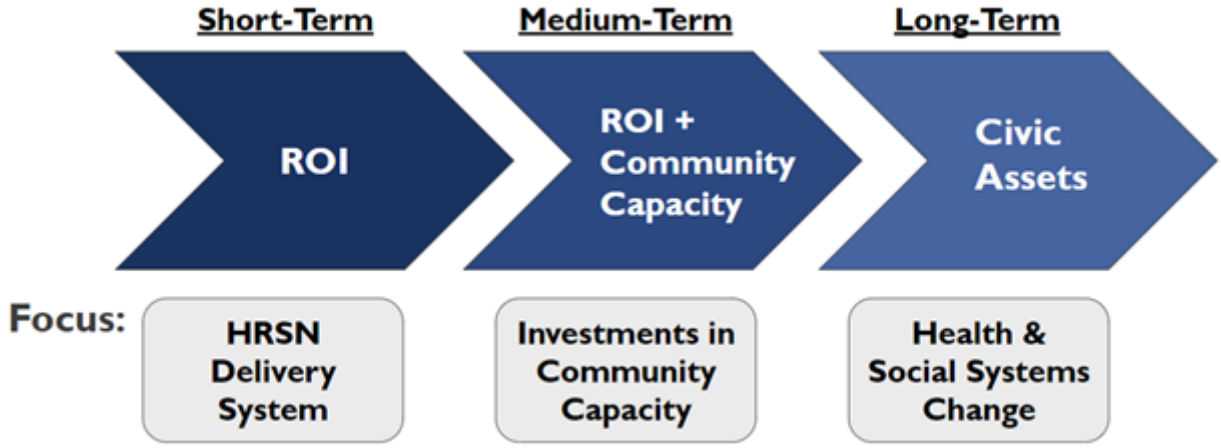

Figure 1 | ACH Value Continuum
SOURCE: Reid, A. M., J. Heinrich, J. Trott, and H. Mittmann. 2024. States demonstrating the business case for multisector efforts: an emerging value framework. *NAM Perspectives*. Commentary, National Academy of Medicine, Washington, DC. https://doi.org/10.31478/20240802a

Leads, working with health service organizations (HSOs), CBOs, and the state Medicaid program, are responsible for integrating these investments. For example, Impact Health, the Network Lead in western North Carolina, invests in creating accountable infrastructure and partnerships, as well as increasing ROI. The 1115 waiver evaluation is based on health outcomes and costs for the populations participating in the program (Funders Forum, 2023).

Medium Term (Investments in Community Capacity)

Several organizations are partnering with their local residents, community service organizations, foundations, state agency colleagues, and others as they identify gaps in services and build the capacity to address identified community needs. For example, in Texas, the Greater Longview Optimal Wellness (GLOW)—Gregg County ACH is one of six Texas Accountable Communities of Health sites in existence since 2021 (TACHI, 2023). The GLOW program began with a focus on reducing non-emergency calls to the EMS/Fire Department and subsequently worked to increase food bank services in the community for residents with food insecurity, a frequent reason for 911 calls. They recently received a grant

from the Substance Abuse and Mental Health Services Administration (SAMHSA) to address mental health and substance use disorder services in the community, the number one reason for initial EMS contact. At the same time, since the beginning of the program, GLOW reduced the average number of 911 calls per patient by approximately 50–55%, and the number of non-transport calls from 19% to 4% per patient (approximately half of whom are Black/African American or Hispanic/Latino) (Funders Forum, 2023). GLOW is successfully measuring ROI for partners, measurably increasing community capacity to meet demand for necessary services, and actively maintaining a system to exchange relevant data regarding service needs for program participants.

Long Term (Health and Social Systems Change)

Notably, there are ACHs and similar multisector organizations that have gone beyond building HRSN delivery systems and investing in community capacity and are empowering their communities to effect long-term health and social systems change. These organizations have or are working toward more systematic tracking and reporting on community engagement indicators, health outcomes, and measures of social and other conditions that impact health status. These organizations also demonstrate robust and consistent community engagement as central to their core processes and the durability of their collaborative multisector efforts; as community needs and priorities shift, in turn, these organizations are able to pivot to meet new challenges. These practices, embedded in the ongoing work, exemplify ACHs and related multisector partnerships functioning as civic assets and being well positioned to work further upstream to drive systems change.

San Diego Accountable Community for Health (SDACH), one of 37 California Accountable Communities for Health (CACHI) sites, is an example of a community that is demonstrating value at multiple points along the continuum. SDACH is engaged in a special initiative funded by the state, ACEs Aware, which is a learning collaborative focused on training and paying Medi-Cal providers to identify and respond to the impacts of adverse childhood experiences among their patients. SDACH also established a new organization, San Diego Wellness Collaborative, which functions as a hub to link clinical services and community services, working with managed care organizations (MCOs) as part of the statewide CalAIM initiative. Training and employing community health workers as part of this link also provides economic opportunities in the neighborhoods being served. SDACH is an example of an organization that uses common ROI measures of reduced health care utilization and costs such as emergency department discharges, hospitalizations, and mortality within their data dashboard but is also developing measures of equity—including health measures, education and learning, standards of living, and community and social wellbeing—to capture the broader, longer-term impacts of their work (SDACH, 2021).

The Camden Coalition, a regional health hub in New Jersey, is a second example of an organization that is becoming part of the civic infrastructure of its local community. The Coalition has developed governing mechanisms—establishment of a Community Advisory Committee, which in turn has representation on its Board of Trustees—to ensure the strategic direction of its work is responsive to evolving community needs. The organization started as a collaboration of primary care physicians frustrated by challenges in care for patients with special needs, ultimately developing the "hot spotting" approach to targeted case management. The Camden Coalition measures both ROI and the impact of networks or "ecosystems of care" leveraging the Ecosystems of Care Assessment Framework (Camden Coalition, 2023). As a part of a study with the Georgia Health Policy Center (GHPC), the Coalition is also rethinking the value of cross-sector collaborations such as intrinsic benefits (i.e., nonfinancial rewards that individuals and organizations receive from work such as a sense of self and purpose in giving back to their communities), community engagement, outcomes, and sustainable system-level change (Camden Coalition, 2022).

The Rhode Island Health Equity Zones (HEZs) are another example of civic infrastructure-focused efforts. For example, the backbone organization of the Pawtucket Central Falls HEZ is an affordable housing developer that has led successful efforts to reduce childhood lead poisoning by 44% and pass a city ordinance to ensure streets are designed to be safe and accessible (Rhode Island General Assembly, 2023). This HEZ is also part of a new participatory budgeting project to determine priorities for nearly $1 million in federal funds intended to improve health outcomes, an example of residents exercising voice and power in how dollars are spent to address needs in their communities (Novais, 2022). The Rhode Island HEZs have developed Health Equity Measures that reflect integrated health care, community resiliency, concern for the physical environment, socioeconomics, and community trauma, and are used to assess progress to improve the social, economic, and environmental conditions that impact health (RIDOH, n.d.).

Conclusion

While many backbone organizations can demonstrate ROI through reduced health care utilization and costs, the vision of ACHs and similar multisector organizations is to

improve the SDOH that create capacity for everyone in the community to thrive. As is the case with broader health system transformation, policy makers and funders should be mindful that ROI is just one measure of value. Ability to systematically and consistently engage community members in strategic decision making and resource allocation is essential for building civic muscle to achieve sustainable health and social system change. Over time, investments in ACHs and similar multisector organizations that center community in their work can lead to upstream improvements in the drivers of health and advancement of health equity.

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