ISSUE BRIEF
JULY 2014

The COMMONWEALTH FUND

A State Policy Framework for Integrating Health and Social Services

Tricia McGinnis, Maia Crawford, and Stephen A. Somers

Abstract Recognizing that health is determined by a variety of interrelated factors, states are looking to connect health care, public health, and social services to help achieve improved population health, better care, and reduced cost of care. This issue brief describes three essential components for integrating health, including physical and behavioral health services and public health, and social services: 1) a coordinating mechanism, 2) quality measurement and data-sharing tools, and 3) aligned financing and payment. It also presents a five-step policy framework to help states move beyond isolated pilot efforts and establish the infrastructure necessary to support ongoing integration of health and social services, particularly for Medicaid beneficiaries.

The mission of The Commonwealth Fund is to promote a high performing health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

For more information about this brief, please contact:

Tricia McGinnis, M.P.P., M.P.H.
Director of Delivery System Reform
Center for Health Care Strategies
tmcginnis@chcs.org

To learn more about new publications when they become available, visit the Fund's website and register to receive email alerts.

Commonwealth Fund pub. 1757
Vol. 14

OVERVIEW

Despite considerable obstacles associated with reengineering the nation's medically oriented health care system, Medicaid agencies are beginning to explore health delivery models that connect patients directly to community-based public health and social services. In doing so, they are looking to take advantage of both new and existing funding strategies and Medicaid policy options to promote more effective service linkages.

To help guide these efforts, this issue brief details three components necessary for an integrated system of health and social services:

1. A coordinating mechanism responsible for managing collaboration across services.
2. Quality measurement and data-sharing tools to track outcomes and exchange information.
3. Payment and financing methods that support and reward effective service integration.

Our five-step framework is intended to help states develop an implementation plan that addresses the infrastructure requirements, incentives, and decision-making authority needed to support health and social services integration. Elements of this brief were gleaned from state officials and health policy experts through interviews and group discussions.

BACKGROUND

There is growing recognition that social factors—such as individual behavior, socioeconomic status, and the physical environment—have a greater impact on health outcomes than medical care.[1] Nevertheless, most health care expenditures are for medical services. Further, the planning, financing, and delivery of health care, public health, and social services often occur in isolation. In response to this misalignment of resources, a new vision for integrating health and social services is emerging. Such a system would coordinate, finance, and assess a wide range of services that impact health, including social supports, housing, economic opportunities, education, public health, and community resources.

Federal and state-level policy environments appear favorable for integrating health and social services for many reasons: 1) the Affordable Care Act (ACA) extends Medicaid to millions of vulnerable individuals primed to benefit from integrated services; 2) the ACA's focus on delivery system and payment reform and the creation of the Center for Medicare and Medicaid Innovation has led to the spread of innovative care models like accountable care organizations (ACOs) that promote more coordinated, patient-centered care; and 3) providers are increasingly supportive of approaches that address patients' unmet social needs.[2] New efforts to integrate health and social services can draw lessons from existing programs that coordinate physical and behavioral health and social services.

ADVANCING HEALTH AND SOCIAL SERVICES INTEGRATION: PRINCIPLES FOR STATES AND PARTNERS

- Demonstrate a shared commitment to the integrated vision;
- Increase community accountability for population health outcomes that reflect physical, mental, and social well-being;
- Use financing strategies that foster accountability for outcomes; and
- Use population health data to track performance and refine incentive strategies.

However, policymakers must contend with some challenges. For example, states' health and social services programs often are fragmented because of federal financing streams, poor interagency communication, and insufficient IT capacity. There is also little evidence to support a positive return on investment (ROI) for integrating services.

ESSENTIAL COMPONENTS FOR INTEGRATING HEALTH AND SOCIAL SERVICES

State leaders can target planning efforts by focusing on three core components for integrating health and social services: a coordinating mechanism, quality measurement and data-sharing tools, and aligned financing and payment methods. States pursuing integration of health and social services will need to develop each of these components at the state, community, and provider levels (Exhibit 1).*

1. A Coordinating Mechanism

States can identify or develop a statewide "integrator" to assume responsibility for ensuring coordination and communication across state-level services. This coordinating entity—a state agency, task force, or nongovernmental organization—can engage partners, recommend policy and practice changes, promote information exchange, and assess data.[3] Maryland's Office of Health Reform, for example, facilitates interagency collaboration on state health initiatives. California created a Health in All Policies Task Force, bringing together 19 state agencies to develop health improvement recommendations.

Coordinating mechanisms are also important at the community level. David Kindig, at the University of Wisconsin–Madison, developed the concept of a "health outcomes trust," a local entity that receives financial incentives to coordinate services across organizations to address the social determinants of health.[4] This entity could disseminate health data, establish shared goals and activities, and engage local residents.[5] Prevention Institute, a national nonprofit,

* Note that this brief focuses on the state and community levels only.

Exhibit 1. Components to Support Health and Social Services Integration by Stakeholder

Level	Coordinating Mechanisms	Quality Measurement and Data-Sharing Tools	Financing and Payment Methods
State	Integrator agencies/entities Formalized interagency arrangements	Population health metrics Integrated claims database/analysis	Braided or blended agency financing Wellness trusts Multipayer coordination
Community	Health outcomes trusts Accountable care communities	Integrated population health/quality report cards	Communitywide global services payment Community benefit funds Global capitation
Provider	Accountable care organizations Medicaid health homes	E-referrals Integrated patient-level data-sharing	Bundled payments Shared savings Care management per-member per-month Global capitation

Source: Authors' analysis.

has proposed community-centered health homes, in which local health institutions serve as a coordinating entity for collaborative health improvement efforts, like building walking paths, improving food access, and minimizing environmental hazards.[6] Community-based ACOs and newly emerging accountable care communities serve a coordinating function by taking responsibility for providing and paying for a range of services beyond medical care.[7]

2. Quality Measurement and Data-Sharing Tools

Efforts to meaningfully integrate health and social services should be supported by a robust set of tools to measure health outcomes and costs, as well as the capacity to share data, link services, and evaluate and improve programs.

Quality Measurement

It is important for states to choose metrics that reflect realistic quality and accountability goals, understanding that it may take years or decades to fully influence outcomes. Population health metrics could include: life expectancy from birth, condition-specific life expectancy changes, and self-reported levels of health.[8] The Institute of Medicine (IOM) recommends establishing population health measures that are usable for assessing various populations, rigorous, and widely accepted.[9]

Some states are collecting and analyzing health data from sources outside clinical settings, then producing report cards on state or community health.[10] For example, Maryland publishes outcomes on 39 health measures, such as healthy social environments and safe physical

STATE-BASED MODELS OF HEALTH AND SOCIAL SERVICES INTEGRATION

Minnesota's Hennepin Health: This health plan integrates health care, public health, community resources, behavioral health, and social services for high-risk, Medicaid-eligible adults. It is financed by an up-front payment for all Medicaid services, with blending of additional county-based social services funds.

Vermont's Support and Services at Home: This program combines supportive housing with medical services to help Medicare beneficiaries remain in their communities. It offers onsite nursing, care coordination, and supportive community activities. It is funded by a per-member per-month fee through a Medicare demonstration program.

Maryland's Health Enterprise Zones: Five geographic areas in Maryland with high health disparities rates receive state funding to test innovative, multisector programs. Examples include establishing a "health care transportation route" to address rural access barriers; a patient-centered medical home in a senior housing complex; and healthy living activities.

environments.[11] Connecticut created the Health Equity Index, a community-level electronic tool that measures the social, political, economic, and environmental conditions affecting health.[12]

Data-Sharing Systems

Up-front technology investments are needed to support integration efforts, accurately measure program impact, and inform future investment decisions. These include building an integrated data system and establishing the IT supports necessary for implementation. Ideally, such systems would facilitate cross-agency data-sharing and enable providers and community organizations to input and access patient- and population-level information.

State- and community-level data-sharing tools could include integrated claims databases that link and share information across payers, service sectors, and provider networks. One example is the Predictive Risk Intelligence System—known as PRISM—a decision-support tool developed by Washington State to support care management for high-risk Medicaid patients. PRISM integrates data from health and social services programs and creates patient risk scores, identifying consumers most in need of care coordination.

States also are supporting on-the-ground integration through two-way electronic referrals between providers and social service organizations. Massachusetts' e-referral system, for example, will connect a subset of community health centers with community resources such as tobacco quit lines, YMCAs, senior centers, and visiting nurse services.

COMMUNITY-LEVEL INTEGRATION EFFORTS

The Oregon Health Authority (OHA) is implementing ***coordinated care organizations*** (CCOs) to assume responsibility for the cost and quality of physical, behavioral, oral, and nontraditional health services. "Innovator agents" coordinate between CCOs and OHA, relaying state-level data to local CCOs and practice-level information about health improvement strategies to OHA.

The ***Camden Coalition of Health Care Providers***, as part of its community-based ACO, engages with representatives from local public health, housing, and transportation agencies to facilitate coordination at both the patient and the community level to better serve high-need patients in Camden, New Jersey.

Maryland has created ***local health improvement coalitions*** to monitor community and population health, identify and respond to hot spots of health needs, and create local plans for health improvement. These coalitions engage a diverse range of stakeholders, including individuals working in housing, education, corrections, and business.

Nemours Health and Prevention Services convenes partners from multiple agencies in Delaware, such as health, education, and child care, to achieve shared children's health goals. Nemours and its partners work to make and sustain policy and practice changes that create healthy environments.

3. Aligned Financing and Payment Methods

Sustaining a meaningful level of health and social services integration requires long-term financing sources and payment models with incentives to encourage ongoing integration.

Financing

The appropriate financing formula will depend on many variables and may shift over time. One option during an initiative's early phases is to apply for grant funding or seek state funds. Maryland helped secure $4 million in the state's 2013 budget for Health Enterprise Zones by projecting a long-term ROI. States also could consider the social impact bond model, in which the state partners with private-sector investors to run small pilots, paying the investors only if the pilot achieves performance targets.

Massachusetts created the Prevention and Wellness Trust Fund, which is allocating almost $60 million over four years to fund competitive, community-level grants for evidence-based prevention activities. Insurer and hospital assessments paid for the fund, which was the first of its kind.[13] Another revenue-raising option is to use a small percentage of

insurance premiums, as Vermont currently does to fund health IT efforts. States also could require nonprofit hospitals to allocate a portion of their community benefits spending to population health improvement.[14]

Blended or braided financing—often used in early childhood programs—are strategies for pooling money from different sectors. Blended funding involves commingling funds from different sources into one pot to draw down dollars as needed; costs do not have to be allocated and tracked by funding source. Braided funding coordinates multiple, distinct funding streams to pay for a service package; tracking and accountability for each stream is maintained at the administrative level.

Finally, given that state Medicaid agencies would save money if integrated programs result in improved health, states may examine ways to use these savings to fund nonmedical care. Some states already have been successful at obtaining waivers to use Medicaid dollars to pay for nontraditional health workers, nonmedical services, and local initiatives.[15]

Payment

States could reallocate a portion of social services and public health funding and include a "population health" payment to cover nonmedical services in Medicaid managed care capitation rates. Alternatively, capitation payments could be made directly to a fully integrated multipayer entity that purchases health and nonhealth services for patients.

States also could bundle payments to cover clinical, public health, and social services specific to a population. Payers can draw on lessons from how states used Medicaid funding to cover nonmedical services that address children's needs. For example, Massachusetts Medicaid is running a pediatric asthma bundled payment pilot program that provides nontraditional services and supplies (e.g., mattresses, vacuums, and air conditioners) to mitigate environmental triggers.[16]

States also may consider promoting community- or provider-level budgeting or shared-savings approaches. For example, community health budgets could include a blend of public health, Medicaid, and social services funds. Within those budgets, a population-level shared-savings model could distribute savings to entities that contribute to population health improvements.

IMPLEMENTATION PLANNING FRAMEWORK

With the three core program components in mind, states can develop a strategic plan for integration of health and social services. Five key planning steps include:

Step 1: Establish goals. States can create measurable goals based on their current needs, circumstances, and priorities. They can look to existing resources for insights about the types of goals to pursue (see box: Sources to Inform Program Design). States may consider different goals for different patient populations across a spectrum of complexity.

Step 2: Identify gaps and opportunities. States can determine the types of health and social services integration they wish to pursue by identifying current gaps and opportunities. Local governments and consumer organizations can be

SOURCES TO INFORM PROGRAM DESIGN

- Existing state health improvement plans
- Community health needs assessments and state or communitywide evaluations of the impact of social service, public health, and clinical interventions on health and health care outcomes
- Financial or ROI analysis for statewide or community integration interventions
- The Kaiser Family Foundation's State Health Facts data
- The National Prevention Strategy and Healthy People 2020 goals
- The Institute of Medicine's Community Health Development Process
- Proposals for and assessments of payment, delivery reform, and quality improvement initiatives, including the Centers for Medicare and Medicaid Services' (CMS) Center for Medicare and Medicaid Innovation State Innovation Models Initiative, CMS Health Care Innovation Awards, CMS State Demonstrations to Integrate Care for Dual Eligible Individuals, and the Robert Wood Johnson Foundation's Aligning Forces for Quality and Roadmaps to Health Community Grants

helpful in identifying areas where needs are not being met. In some cases, communities may be resource-rich but ineffective in linking neighborhoods, patients, and providers to resources. States also can identify existing investments that may be reallocated to support integrated care delivery goals.

Step 3: Prioritize opportunities for integration. States can prioritize efforts based on: opportunities that project a positive ROI, existing strengths, and input from stakeholders. Many experts suggest using an asset-based approach to choosing priorities, which takes a community's unique strengths and resources into consideration.[17] Finally, states may consider pursuing a balanced portfolio of short- and long-term interventions and a range of partnering organizations and population targets.[18]

Step 4: Establish an implementation roadmap. An implementation roadmap can guide near- and long-term planning activities and highlight policy considerations. A roadmap would include a developmental stage to pilot new ideas (Phase 1); an expansion stage (Phase 2); and an operational stage (Phase 3) (Exhibit 2).

Exhibit 2. Roadmap for Phased Integration of Health and Social Services: Potential State Activities

	Phase 1 Pilot	Phase 2 Expansion	Phase 3 Fully Operational
Coordination Mechanism	• Fund community-based pilots • Create state-level interagency integration task force	• Choose and staff community entities to lead integration	• Implement statewide community-based integrator agencies
Quality Measurement/ Data-Sharing	• Fund evaluations • Develop new metrics task force	• Test data-sharing and tracking pilots	• Create statewide integrated data exchange
Financing/ Payment	• Provide innovation grants • Test payment demonstrations	• Use simplified financing and payment policies	• Implement performance-based payments and blended financing

Step 5: Create a measurement strategy. A robust measurement strategy will include key metrics that link outcomes and goals and promote accountability. Assessing the ROI for integration also will be an important objective. Although few tools exist to quantify the returns associated with full health and social services integration, states can begin to think about how to identify, assess, and measure these results.[19]

CONCLUSION

While barriers exist for integrating community-based services and health care delivery, states have many policy, financing, and regulatory opportunities available. It is an opportune time for states to work with the federal government, local organizations, and health care professionals to establish meaningful integration of physical and behavioral health, public health, and social services to meet the Medicaid population's complex circumstances and needs.

Notes

1 S. Magnan, E. Fisher, D. Kindig et al., "Achieving Accountability for Health and Health Care," *Minnesota Medicine*, Nov. 2012 97(11).

2 Robert Wood Johnson Foundation, *Health Care's Blind Side: The Overlooked Connection Between Social Needs and Good Health* (Princeton, N.J.: RWJF, Dec. 2011).

3 "Integrator Role and Functions in Population Health Improvement Initiatives" (Wilmington, Del.: Nemours, May 2, 2012).

4 D. A. Kindig, *Purchasing Population Health: Paying for Results* (Ann Arbor, Mich.: University of Michigan Press, 1997).

5 Magnan, Fisher, Kindig et al., "Achieving Accountability," 2012.

6 E. Valdovinos, J. Srikantharajah, R. Pañares et al., *Community-Centered Health Homes: Bridging the Gap Between Health Services and Community Prevention* (Oakland, Calif.: Prevention Institute, Feb. 2011).

7 S. Somers and T. McGinnis, "Broadening the ACA Story: A *Totally* Accountable Care Organization," *Health Affairs Blog,* Jan. 23, 2014.

8 R. G. Parrish, "Measuring Population Health Outcomes," *Preventing Chronic Disease: Public Health Research, Practice, and Policy,* July 2010 7(4):A71.

9 Board on Population Health and Public Health Practice, *Toward Quality Measures for Population Health and the Leading Health Indicators* (Washington, D.C.: Institute of Medicine, July 2013).

10 For more information, visit http://www.healthypeople.gov/2020/default.aspx.

11 For more information, visit http://dhmh.maryland.gov/ship/SitePages/measures.aspx.

12 For more information, visit: https://www.sdoh.org/.

13 Massachusetts Public Health Association,"Fact Sheet: The Massachusetts Prevention & Wellness Trust Fund," 2012.

14 G. J. Young, C.-H. Chou, J. Alexander et al., "Provision of Community Benefits by Tax-Exempt U.S. Hospitals," *New England Journal of Medicine,* April 18, 2013 368(16):1519–27.

15 A. Burton, D. Chang, and D. Gratale, *Medicaid Funding of Community-Based Prevention: Myths, State Successes Overcoming Barriers, and the Promise of Integrated Payment Models* (Wilmington, Del.: Nemours, June 2013).

16 R. Callahan, "MassHealth Pediatric Asthma Bundled Payment Pilot," slide presentation (MassHealth, March 5, 2012); Burton, Chang, and Gratale, *Medicaid Funding of Community-Based Prevention*, 2013.

17 A. Mathie and G. Cunningham, "From Clients to Citizens: Asset-Based Community Development as a Strategy for Community-Driven Development," *Development in Practice,* Nov. 2003 13(5):474–86.

18 Phone conversation with Jim Hester, Consultant to State of Vermont, Sept. 13, 2013.

19 *Health Systems Learning Group Monograph,* Prepared from shared learning for use at: Strategic Investment in Shared Outcomes: Transformative Partnerships Between Health Systems and Communities (Washington, D.C.: Health Systems Learning Group, April 4, 2013).

About the Authors

Tricia McGinnis, M.P.P., M.P.H., is the director of delivery system reform at the Center for Health Care Strategies (CHCS). She works on initiatives that reform the delivery of care and financing of health systems to both improve the quality of care and reduce the cost of care received by Medicaid beneficiaries. Before joining CHCS, Ms. McGinnis served as a senior program manager at Blue Shield of California and worked in research capacities at the Institute of Business and Economic Research and Health Research for Action. Ms. McGinnis holds master's degrees in public policy and public health from the University of California, Berkeley.

Maia Crawford, M.S., is a program officer at CHCS. She works on issues related to payment and delivery system reform, value-based purchasing, and health coverage and access. Before joining CHCS, Ms. Crawford worked at Community Catalyst, a national nonprofit consumer advocacy organization. She holds a master's degree in health policy and management from the Harvard School of Public Health.

Stephen A. Somers, Ph.D., is the president and chief executive officer of CHCS, which he founded in 1995. He has been responsible for the organization's growth into a nationally recognized center for improving care for beneficiaries of publicly financed health care programs, particularly those with chronic illnesses and disabilities. Before starting CHCS, Dr. Somers was an associate vice president and program officer at the Robert Wood Johnson Foundation. Dr. Somers is a visiting lecturer at Princeton University's Woodrow Wilson School of Public and International Affairs. He earned his Ph.D. in the politics of education from Stanford University.

Acknowledgments

The authors acknowledge the following individuals whose input informed the development of this document, as well as Deborah Brown, senior program officer at CHCS, who made significant contributions to this work.

John Auerbach, Northeastern University
Deborah Bachrach, Manatt Health Solutions
Tammy Vehige Calise and Amanda Ryder, John Snow, Inc.
Jeremy Cantor and Sana Chehimi, Prevention Institute
Susan Castellano, Glenace Edwall, and Marie Zimmerman, Minnesota Department of Human Services
Debbie Chang, Nemours
Jennifer DeCubellis, Hennepin Health
Carrie Fitzgerald, First Focus
James Galloway and Laura Seeff, Centers for Disease Control and Prevention
Tracy Garland, National Interprofessional Initiative on Oral Health
Karen Hein, Green Mountain Care Board, State of Vermont
Hilary Heishman, Robert Wood Johnson Foundation
Jim Hester, State of Vermont
Rhonda Hill, Arkansas Center for Health Improvement
David Kindig, University of Wisconsin–Madison
Thomas Land, Massachusetts Department of Public Health
Laura Landy, Fannie E. Rippel Foundation
Carol Lewis, UNC School of Medicine
MaryAnne Lindeblad, Washington State Health Care Authority
David Mancuso, Washington State Department of Social and Health Services
Karen Matsuoka, Maryland Department of Health and Mental Hygiene
Sharon Moffatt and Monica Valdes Lupi, Association of State and Territorial Health Officials
Judith Monroe and Paula Staley, Centers for Disease Control and Prevention
Estelle Richmond
William Roper, UNC Health Care System
Stephen Shortell, UC Berkeley School of Public Health
Winston Wong, Kaiser Permanente

Editorial support was provided by Deborah Lorber.

The
COMMONWEALTH
FUND

www.commonwealthfund.org