



REPORT

Investing in Social Services for States' Health: Identifying and Overcoming the Barriers

by Erika Rogan and Elizabeth Bradley

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Table of Contents

Acknowledgments	1
Message from the President	2
Introduction	3
Methodology	5
Findings	7
Principles for Moving Upstream	23
Conclusion	27
Appendices	29
Notes	32
The Authors	37

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Message from the President

Dear Colleague,

Like many of you, I have been intrigued by the research of Elizabeth Bradley and her colleagues, which compares levels of spending on social and health care services across countries and their relationship to population health. The research indicated that countries with a higher ratio of social to health spending tend to have better health outcomes.

Her subsequent book, *The American Health Care Paradox, Why Spending More Is Getting Less*, written with Lauren Taylor, puts into plain language what many of us know—if we want people to live long and fulfilling lives, we could be spending our limited dollars in the United States more wisely.

So when I heard that Dr. Bradley and her colleagues, with support from the Robert Wood Johnson Foundation, were applying her research to the United States, I wanted to see how the Milbank Memorial Fund could help with this important work. As she conducted her empirical research, the Fund assembled a group of state and local public sector health care leaders to react to some preliminary findings.

The research found a similar relationship in the United States—states with higher social to medical spending ratios have better population health outcomes in several areas. This research has significant implications for our public policies regarding the health of populations.

In discussions with Dr. Bradley and her coresearcher Erika Rogan, the Fund's group of leaders attempted to answer the “so what” question—what stands in the way of acting on the evidence about the importance of social spending in improving population health? Their responses—captured in this report—are fundamental and bracing.

In the second part of the report, we move away from the theory. Are there examples where, in spite of the barriers cited, communities are “moving upstream,” investing in social services to prevent downstream health care problems? To answer this question, Erika Rogan traveled to four sites around the country to gain a deeper understanding of the various state's experiences with health and social services investments and programming.

The results and insights are in this report. They speak to the role of public sector leadership, opportunism, collaboration across sectors, and specific activities that reflect distinct local values.

Together, the elements of this report provide important context and nuance for Dr. Bradley's empirical research. More importantly, they provide hope for continued work and progress in improving the health of communities and using resources wisely.

In addition to the authors, the Fund expresses gratitude to the members of its Reforming States Group, who worked with Dr. Bradley and Ms. Rogan, and particularly to our colleagues in Kentucky, Rhode Island, San Diego, and Vermont who shared their work and their time for this report.

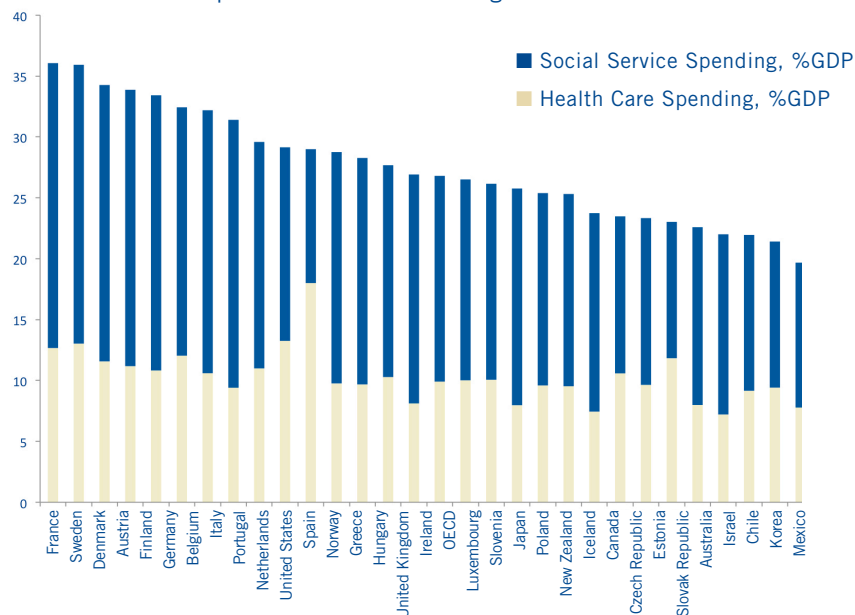
Christopher F. Koller
President, Milbank Memorial Fund

Introduction

The United States spends a greater percentage of its gross domestic product (GDP) on health care than any other country in the world, but has poorer health outcomes than many other industrialized nations.^{1,2} As the financial burden of health care continues to grow, policymakers and researchers alike are interested in understanding why such a mismatch exists and how to resolve it.

Evidence suggests that the paradox of high spending and poor health outcomes may be related to an overemphasis on health care—the medical services focused on addressing clinical conditions rather than on health—the aggregate state of well-being that is influenced by medical, social, behavioral, and environmental factors.^{3,4} In the public health literature, services targeting the non-medical determinants of health—social services such as income support, education, transportation, and housing programs—are envisioned as “upstream”⁵ from medical determinants because they shape the contexts in which health system interactions occur, individuals behave, and biological systems function. Substantial research has demonstrated that investments in social services can improve health outcomes and reduce health care costs.^{3,6-8} When spending on social services is taken into account, the United States is no longer the biggest spender. Instead, it ranks in the middle of other Organization for Economic Cooperation and Development (OECD) countries (Figure 1). Research has also found that higher levels of spending on social services relative to health care (i.e., a higher ratio of social spending to health care spending) is associated with better performance on several population-level health measures.⁹ Taking this broader perspective on spending for health not only makes the American health outcomes more understandable, but it also gives US policymakers and other health stakeholders new potential avenues for advancing the health of the population.

Figure 1: Social and Health Expenditures as a Percentage of GDP⁹ 2009



Note: Switzerland and Turkey are missing data for 2009

In a recent study¹⁰ with our colleagues, we investigated whether this relationship between spending and outcomes holds within the United States. Using the ratio of expenditures on social services (including education, income support, transportation, environmental pro-

Spending Ratio

$$\frac{\text{Social services + Public health expenditures}}{\text{Medicare + Medicaid expenditures}}$$

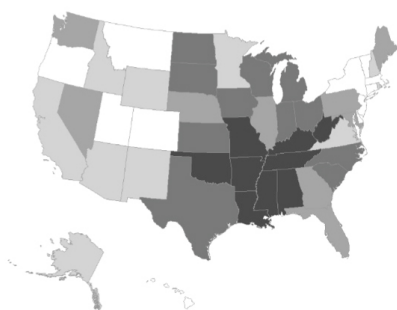
Social services include education, income support, transportation, environment, public safety, and housing.

grams, housing, and public safety) and public health to health care services (Medicare and Medicaid) for a 10-year period, they found that increased spending on social services relative to health care was statistically associated with better health outcomes at the state level, even when accounting for the

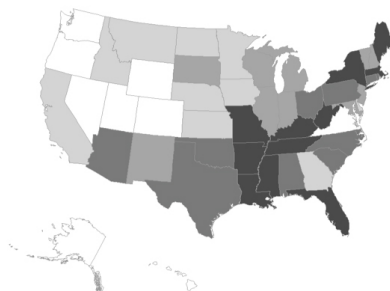
states' sociodemographic, economic, and political characteristics. This result was found across a wide variety of health outcomes, including obesity, asthma, mentally unhealthy days, days of activity limitations, postneonatal mortality, and lung cancer mortality (see Figure 2 for examples). These findings support the notion that social services contribute to health outcomes, despite often being overshadowed by medical services as an approach to achieving health goals. The study also suggests that even within the United States, the mix of spending for health—not just the total investment—may be key for improving population-level health in individual states.¹⁰

Figure 2: State Social-to-Health Spending Ratio and Selected Health Outcomes, by Quintile (2009)¹⁰

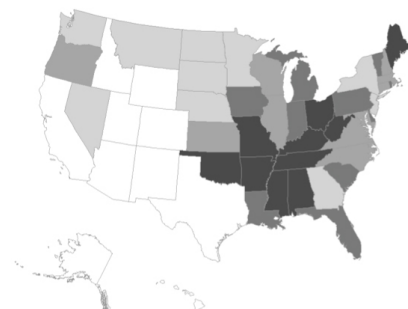
a) Percent of adult population that is obese



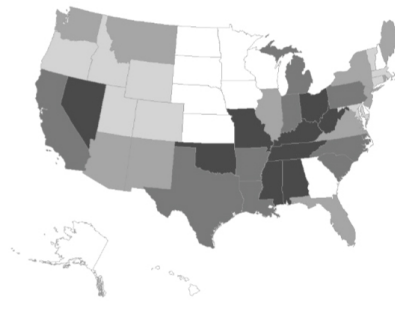
b) Percent of adults who reported 14 or more days in the last 30 days as mentally unhealthy days



c) Lung cancer mortality rate per 100,000 population



d) Social-to-health spending ratio



Legend (a,b,c): dark gray indicates highest quintile (i.e., poorest health outcomes) and white indicates lowest quintile (i.e., best health outcomes).

Legend (d): dark gray indicates lowest social-to-health spending ratio; white indicates highest social-to-health ratio.

To better understand the implications of this work for state policymakers, the Milbank Memorial Fund (MMF) partnered with researchers at Yale University to conduct a study to elicit state officials' perspectives on these emerging research findings. Three questions guided the study:

- Why do health care services in the United States continue to capture a larger share of spending for health improvement than social services?
- What prevents state decision makers from acting on the evidence suggesting that social services spending benefits health?
- How are state policymakers finding ways to act on this evidence?

The study included a strategic problem-solving approach¹¹ conducted with a diverse group of state officials from the MMF's Reforming States Group (RSG), a bipartisan group of state executive and legislative leaders who, with a small group of international colleagues, meet annually to share information, develop professional networks, and commission joint projects. The meetings provide trusted forums for health care policymakers in states and other jurisdictions to candidly share experiences and to discuss common challenges. For this study, the participating RSG members met for a one-day session. Site visits were then carried out in Vermont, Kentucky, Rhode Island, and San Diego County. This report presents the results of this study. The specific purpose of the report was to:

1. Identify the root causes for states not making overall budget and policy decisions that optimize their population's health.
2. Identify, describe, and categorize innovative state-level strategies addressing the health of populations, including any challenges and lessons learned associated with the design, implementation, and evaluation of these initiatives. These strategies focus investments of time, effort, and financial resources on services and activities that are situated "upstream" from medical costs and care.
3. Propose policy principles that promote upstream health improvement strategies for the states' populations.

Methodology

To address these questions, we began with a one-day facilitated work session with a diverse cross section of state officials, including legislators and executive branch officers, from California (San Diego County), Colorado, Kansas, Kentucky, Oklahoma, Oregon, Rhode Island, South Carolina, and Vermont (Figure 3). All participants in the session are RSG members. They represented a wide range of political views and constituent values and also had decades of experience in policy design and implementation. As experts in the state policymaking process, session participants were able to offer informed perspectives on opportunities and challenges to improving state health.

We employed a strategic problem-solving model in which participants defined a problem, set an objective, conducted a root cause analysis, and identified and assessed strategies to address the problem in view of its root causes.¹¹ The state officials were asked to consider the following problem statement: “States do not make overall budget and policy decisions that optimize health of the population in the state.” MMF President Christopher Koller and Yale University Professor of Public Health Elizabeth Bradley led the discussion with state officials to examine this problem and its causes, share states’ experiences in investing for their population’s health, and discuss the state officials’ needs in order to develop and implement evidence-based policies to promote health.

Figure 3: Session Participants’ Roles

Executive Officers	Legislators
Secretary/Director, State Department of Health and Human Services (3)	State Senator (2)
Director, County Department of Health and Human Services (1)	State House
Director, State Office of Health Policy (1)	Representative (1)
Staff, Governor’s Policy Office (1)	
Director, State-Sponsored Delivery System Reform Initiative (1)	

In addition to the one-day facilitated session, Yale researcher Erika Rogan conducted site visits between April and October 2015 to four states to meet with state (and local) government officials. These visits provided a deep understanding of the various state experiences with health and social services investments and programming. They also demonstrated the socio-demographic, economic, and political contexts faced by the states’ decision makers. Although the details of the site visits varied, they included interviews with officials overseeing services related to long-term services and supports, housing, Medicaid, mental and behavioral health, public health, older adults, children and families, and people living with disabilities. These interviews emphasized the historical, contextual, and logistical factors that influence financing, implementing, and coordinating services to improve the state or county population’s health. Open-ended questions gave participants the opportunity to explain their positions, attitudes, or experiences.¹² A discussion guide was used for interviews across the sites, and site-specific questions or “probes” were asked to elicit additional details¹³ about the state or county context (see the Appendices).

Findings

Problem and Objective

Before the one-day facilitated work session, participants were given recent empirical research on the ostensible mismatch between social and health investments and health outcomes in the states. They were also given a draft problem statement that “states do not make health care and social services investments in ways that maximize the health of the population in the state.”

Although the state officials generally endorsed the draft statement, the group felt that it did not perfectly capture the primary problem. They identified three key shortcomings of

Session Problem Statement

States do not make overall budget and policy decisions that optimize the health of the population in the state.

the problem as it was initially articulated. First, several participants noted that “maximizing health” may not be feasible at the state level. Instead, they suggested that health might be

“meaningfully improved” or “optimized,” which would better emphasize the actions taken to improve health rather than improved health as the result. Second, others questioned the implication of “investment,” explaining that it might be too narrowly focused on financial outlays. Participants agreed that “budget and policy decisions” more accurately reflected the actions taken by state officials. Third, some participants cautioned that separating health care from social services in the problem statement might unnecessarily connote division between services that often share populations, oversight, resources, and missions. Acknowledging that language can be polarizing, the participants agreed to remove specific references to health care and social services and instead incorporate overall decisions. Hence, the problem statement was rewritten as “States do not make overall budget and policy decisions that optimize the health of the population in the state.” Framing and restating the problem from the officials’ perspectives helped align the group for the discussion on an attainable objective: “to inform and improve overall budget and policy decisions to optimize the health of the population in the state.”

Objective

To inform and improve overall budget and policy decisions to optimize the health of the population in the state.

Root Causes

After a consensus on the problem statement and objective was reached, the discussion turned to identifying the root causes of the problem. A *root cause* is a causal factor that drives an identified problem; it is an issue whose reduction, resolution, or removal would eventually solve the problem at hand.¹¹ State officials were encouraged to identify the core “upstream” issues whose removal would ultimately improve upon suboptimal investments in health. Sixteen potential root causes were brainstormed (see the Appendices). The group was then asked to review the initial list for redundancy and to delete any items in the list

that were intermediary causes of the problem (as opposed to a primary root cause). The meeting's facilitators then consolidated the remaining factors into a set of seven root causes. The state officials were then invited to choose the two causes they felt were most responsible for the problem. This resulted in a final list of three overarching root causes:

Root Causes

1. The health of the state's population is not always prioritized relative to other societal goals in the states
2. Incentives, including financial and political incentives, to improve health are misaligned
3. There is a lack of consensus regarding who is responsible for health

1. The health of the state's population is not always prioritized relative to other societal goals in the states;
2. Incentives, including financial and political incentives, to improve health are misaligned; and
3. There is a lack of consensus regarding who is responsible for health.

By identifying and understanding these root causes, policymakers can develop strategies to improve overall budget and policy decisions, which may better optimize the health of state populations.

Root Cause One: The Health of the State's Population Is Not Always Prioritized

A state population's health competes with other political and social issues for attention and resources. Officials in the states thus must make choices concerning the policies and programs that are prioritized, funded, implemented, and maintained, often by sacrificing other options. Although all the attendees agreed that their state's health is important, they also noted that other pressing goals—like infrastructure and economic growth—may sometimes take precedence over health in their states. Some participants thought their state budgets accurately reflected priorities of their state's constituents and/or legislators. Others argued that budgets do not necessarily represent priorities in the state because they could be driven by external factors like federal directives or specific interests of powerful policymakers. While budgets may not always offer insights into the state's priorities, the participants agreed that competing issues on policy and funding agendas were a challenge contributing to suboptimal investments for the state population's health.

Participants observed that health can be superseded by other policy issues because the public pays less attention to health at the population level than to other societal concerns, such as the economy or employment. One reason for this is that population-level health issues typically lack a sense of crisis for the public because they build up over long periods of time. Rarer public health events of shorter duration—like infectious disease outbreaks or natural disasters—are more likely to gain the public's attention, even though their effects on the population's health may be less than the aggregate consequences of prevalent chronic illnesses.

A second reason for the public's low attention is that most of the health issues at the population level are generalized problems affecting large, faceless groups. Such ambiguity may limit the public's attention because people give preferential treatment to identified individual victims over large anonymous groups. Without an "identifiable victim,"¹⁴ the population's health may not result in strong, widespread interest from the public.

A third reason for low public attention is that the total financial cost of a population's poor health may not be observable or fully understood. Some health costs are considered to be "hidden" from individuals¹⁵ because medical service payments are spread across a multitude of payers (e.g., government agencies, individuals, employers) and service providers (e.g., hospitals, physicians), often over long time periods. In addition, the connections between individual costs and societal costs may be too abstract to capture public awareness. Consequently, the public may shift its focus and responsiveness to other issues with more tangible burdens or impacts.

The meeting's attendees also pointed out that population-level health outcomes may not be given priority on policy agendas because of inherent complications in measuring them, which restricts the evidence base on which officials make their decisions. One participant noted that uncertainties in health measurement—including the types of data to collect, the quality of existing evidence, and the usefulness of new information—lead decision makers to rely on existing measures without assurance that they are effective in depicting the state's health and/or needs. Even though state officials do their best to marshal the appropriate data to inform their decisions, they are concerned that without guidance on how and what to measure, their efforts may still lead to inefficiencies or unsatisfactory health improvements. Data gathering, measurement, and evidence-based decision making were also common themes during the site visits. The use of evidence was highlighted as a crucial strategy component in improving investments for health, but challenges in data collection, interpretation, and translation into action persisted across many states.

Root Cause Two: Incentives to Improve Health Are Misaligned

State officials widely agreed that financial and political incentives are not consistently aligned with the evidence of effective ways to improve health, leading to suboptimal investments. Challenges related to incentives were noted in the health care and social service sectors, across sectors, and from external stakeholders.

Given the high cost of medical services, the financial incentives in the health care system were particularly salient to the state officials. On the payer side, strong incentives to earn profits, retain savings, or meet specified targets may override broader goals to enhance health. Interventions that improve health may not immediately show a profit or save money directly, and some interventions may be valuable in ways not captured by predetermined metrics. In one example, a participant described how a care transition program for older adults may be terminated after funding from the Centers for Medicare & Medicaid Services (CMS) expires. Despite the program's success in reducing total inpatient hospital costs and promoting care in more appropriate community settings, CMS may discontinue its

funding because the program has not met the stated goal of reducing unplanned hospital readmissions. Although the state's stakeholders have argued that the readmissions metrics are flawed and should not be used to undermine the program's other health and financial successes, CMS funding will not likely be extended. This example demonstrates that health improvement objectives may not be met when they are not congruent with payers' particular fiscal aims. It also highlights the vulnerability of state programs that engage with both health and social services but strongly depend on federal funding streams that require specific health care objectives.

On the provider side, participants voiced concerns about payment approaches being misaligned with state health goals, especially when health care providers are reimbursed on a fee-for-service basis. Under such a payment scheme, providers are rewarded according to the number and extent of services provided rather than the appropriateness of those services or the resulting health outcomes. Research suggests that this provides an incentive to overtreat, which may result in such adverse effects as physical disabilities and psychological distress.¹⁶ Overall, a volume-based incentive structure contributes to increased health services utilization and excess costs¹⁷ in the health care system. In the care transition example, hospital administrators were not willing to fund the program because the cost savings did not directly benefit the hospital (i.e., by encouraging care in community settings and lowering inpatient costs, the program reduces Medicare payments to the hospital). Together, financial incentives related to returns on investment and reimbursement for services were described by state officials as frequent drivers of behaviors that are incompatible with health improvement for the state's population.

Besides health care, state officials also agreed that misaligned financial incentives across sectors can lead to inefficient policies and investments for health. Decisions made in other sectors such as education, housing, or transportation may have cost ramifications for health and vice versa.¹⁸ For example, much evidence suggests that housing support for low-income individuals with high service needs is associated with less use of services and lower costs of health care.^{19,20} According to the session's participants, achieving health goals in the states often requires investments from outside the health sector. Officials in these other areas, however, may not consider health improvements as their own benefit or concern. Therefore, they may not be willing to direct resources to initiatives they see as outside their purview. (This is sometimes referred to as a "wrong pocket problem,"²¹ particularly when an investment from one sector generates cost savings in another.) Despite the potential advantages of "all-hands" approaches to promoting health (e.g., Health in All Policies), participants cautioned that incentive misalignment across sectors results in decision-making silos in which agencies or organizations consider only their own investments and benefits.

Furthermore, some of the participants commented that misaligned incentives from outside the state agencies may perpetuate state-level investments that may not be optimal for improving the states' health. For example, some participants referred to the federal matching system for Medicaid, Federal Medical Assistance Percentages (FMAP) to illustrate

how the states are financially rewarded for increasing their medical expenditures for state recipients. Although certain social services are covered by Medicaid (e.g., some limited transportation, personal care, or homemaker services), the program remains largely focused on medical services and institutional care. Accordingly, federal Medicaid funds allocated to the states reflect and contribute to this emphasis on medical care. Despite the federal government's social service-based grants and matching programs (e.g., Social Services Block Grant, Medicaid Home and Community Based Services waivers, Older Americans Act grants), FMAP was regarded as a particularly powerful incentive for medical services because it accounts for a large portion of the states' investment in health. Overall, participants noted the power of financial incentives to influence individual-level, agency-level, and state-level decisions and activities.

According to the participants, in addition to financial drivers, misaligned political incentives can discourage optimal health investments. In particular, officials cited the extent to which interest groups shape state policymaking. Because interest groups do not necessarily represent the issues with the highest collective need, their influence can shift policy away from issues that require more attention or toward issues that may not warrant attention.²² Some attendees remarked that advocacy is generally strongest for groups that have more financial resources, contribute more to political campaigns, have greater control over information dissemination, and can otherwise guide the policy dialogue in their favor. One state official commented that the state's hospital association was able to stop the adoption of a new Medicaid payment scheme because of the association's power as a major employer in the state. Several other session participants similarly described health care industry stakeholders (e.g., hospital systems, pharmaceutical companies) as "big business" in their states, emphasizing their financial and political influence. The discussion showed that when the state's health goals and the special interests' goals differ, the interest group's stakeholders may use their influence to promote alternative policies or even terminate programs from which they do not directly benefit.

Furthermore, according to participants, the long time that it takes for many health policies and programs to take effect can diminish their perceived impact or usefulness. Because many US political institutions and administrative systems reward short-term decisions and outcomes, stakeholders may not be willing to make large investments in programs whose returns cannot be observed until well into the future. Long time horizons for results also make it difficult for stakeholders to translate research into policy and practice, as their efforts to develop evidence-based policies may be hampered by outdated, missing, or irrelevant information.²³ Policy options may therefore be restricted to near-term alternatives, and health improvements in the states may remain limited.¹⁸ In sum, financial and political incentives that do not align with health goals for the population may direct both attention and resources away from opportunities to improve well-being in the states.

Root Cause Three: There Is a Lack of Consensus on Responsibility for Health

Participants in the session noted a lack of consensus regarding who has—and who ought to have—responsibility for keeping populations healthy. They cited several accountable

parties, ranging from individuals themselves²⁴ to collectives^{25,26} such as families, communities, employers, health care providers, and varying jurisdictions of government. Although state officials acknowledged some core ideological disagreements regarding the extent to which health ought to be a collective versus individual responsibility, they agreed that all groups they cited during the meeting have at least some accountability. Attendees also suggested that perceptions of personal versus collective (and types of collective) responsibility may depend on the population or the health issue in question. That is, some groups of people or medical conditions may be associated with collective interest and shared responsibility, whereas others may be left to individuals to address.²⁷ State officials pointed out that ambiguous and inconsistent responsibility for health leads to fragmented health promotion efforts that have little likelihood of success and may even be counterproductive.

Moreover, participants emphasized that the lack of consensus is difficult to overcome because it is intertwined with societal norms and values. They noted that decisions related to social and health issues are generally value laden, which can result in policies or programs that do not necessarily reflect the relevant evidence. In other words, when developing policies, decision makers are guided not only by data but also by their own morals and beliefs. Added to this is the variation in societal norms and values among and across the states. The calculus of personal and collective responsibility for health—as complicated as it is—may produce different results in a frontier state with a more isolated population than in a more urban state with crowded, diverse communities. Nevertheless, state policymakers in all settings continue to face the challenge of balancing and integrating evidence and values.

Moreover, subjective views can play a role in setting policy agendas, designing approaches to address health issues, and utilizing data to support policy arguments.²⁸ One state official described the power of values and beliefs in policymaking in an example in which legislation for a teen health program was not passed in the state senate, despite evidence of its effectiveness, because it did not align with some policymakers' beliefs in individual responsibility for health. Another attendee, in contrast, described how evidence-based policymaking and diverse value frameworks may coexist. In this case, the participant's state legislature divided funding for a teen pregnancy program so that multiple interventions could be implemented to establish both individual (program beneficiaries) and collective (the state) accountability. While values-based conflicts may be resolved, participants maintained that navigating constituent and policymaker belief systems related to responsibility for health remained a key issue in their efforts to improve the states' health.

State Strategies to Address Root Causes

Despite the widespread challenges identified in the session, government agencies and their partners across the United States are nonetheless taking action to make populations healthier. To learn more about the ways in which state health is being addressed, we visited three states and one municipality to gather information from those “on the ground.” Their experiences and insights, presented here, show the various sites' different approaches to improving health. We sorted our findings from the site visits into four broad strategies: cul-

tivating legitimate public-sector leadership, navigating the political environment, using evidence to support decision making, and targeting populations that have high medical and social needs. These strategies reflect the diversity and breadth of the states' actions, although they are not hierarchical or mutually exclusive. Most of the examples are drawn from our site visits, and when applicable, state strategies discussed during the facilitated session are included.

Site Visit Strategies

- Cultivating legitimate public-sector leadership.
- Navigating the political environment.
- Using evidence to support decision making.
- Targeting populations that have high medical and social needs.

Strategy One: Cultivating Legitimate Public-Sector Leadership

Officials in leadership positions were described as critical to aligning incentives, prioritizing activities, and motivating collective action—both within and across agencies—to improve state health. Site visits revealed that leadership is vital to overcome the frequently balkanized nature of health care and social services administration. Participants stated that employees commonly feel allegiance to their immediate departments. They noted that strong loyalty could lead to an unwillingness to share duties or information and, in some cases, even result in hostility among departments. A history of operating as separate units contributed to the ongoing fragmentation. As one official stated, “[There was] a feeling of ‘this is mine, this is my area, this is how we have always done things.’” But the participants described key individuals in government leadership roles as having the ability to transcend administrative, organizational, or political boundaries in order to progress toward health goals for the population. The individuals in these roles did not hold the same organizational positions across the sites. At the different locations, participants referred to the governor, the secretary of a state-level health agency, or the director of a critical initiative or department. Participants remarked that in their states, these officials exhibited the abilities and attributes to encourage diverse—and sometimes adversarial—stakeholders to cooperate in order to meet particular goals.

A key factor contributing to the leadership skills of these individuals, according to participants, was the ability to gain and maintain the trust of colleagues both within and outside their home agency. This trust was generally rooted in the person's knowledge and experience. For example, participants commented that the person usually had

You [have to] build trust first. That is what leads to teamwork and how you get to transformation.

a professional background (e.g., long tenure in the agency, at a related organization, or as a care provider) that gave him or her legitimacy within the relevant agency. Others mentioned that the person maintained the confidence of external partners by taking positions in various collaborative or integrated committees, cabinets, boards, or task forces. These connections to other agencies or sectors illustrate what management scholars call an “interlocking directorate,”²⁹ a strategy by which organizations can make their environments

more favorable by engaging the heads of related entities. Participants acknowledged that in this case, such linkages have served to promote cooperation and resource sharing among the states' decision makers. Establishing legitimacy and developing a trusting atmosphere, as one participant noted, was perceived as central to cultivating teamwork throughout the organization and with partners, and ultimately transforming the way work is done.

Participants also noted that the people in leadership roles saw the value in, and took action to foster, collaboration among the groups with which they were affiliated or oversaw. For some, this meant uniting related entities organizationally or geographically in order to

[The person in a leadership role] needs to build and rebuild relationships, bridges, [and] trust. State government is all about relationships.

facilitate communication and coordination among different parties. One official commented that her state's secretary of health and human services "brought in a culture of coordination" by locating

several associated departments in the same office building. Although some staff may have initially viewed the move as a nuisance, she observed that they became more accepting of the change after seeing its positive effect on collaboration. For others, collaboration was encouraged by a person in a leadership position, though not through formal reorganization but through political savvy. During one site visit, an official commended the agency director's understanding of the "levers of influence" in decision making, stemming from the director's previous experience in a regional leadership position. This gave the director an understanding of local decision-making dynamics and key stakeholder perceptions of agency boundaries and service coordination. Because engagement with frontline groups such as local agencies and service providers is a central component of organizational change and program effectiveness,³⁰ an ability to view the agency's activities from these perspectives is seen as a valuable skill for individuals in leadership roles. Indeed, an official who was interviewed credited this knowledge as the basis of the director's success in persuading stakeholders to collaborate and work toward common goals.

Collaboration is not limited to intra-agency work. In some places, it was fostered by establishing a common vision or mission among diverse state and local partners. In San Diego, for example, the clear, collaborative vision from leadership in the county's Health and Human Services Agency (HHS) led to a variety of cross-sector partnerships under Live Well San Diego (LWSD), a countywide movement to improve the population's health.

LWSD's goals—build better health, live safely,

I don't see how anything we do is not aligned with Live Well [San Diego].

and thrive—underscore the diverse roles played by HHS, related county-level agencies, private-sector organizations, and other community partners. The goals are both strategic and inclusive; they are narrow enough to direct the activities for a healthier county but also broad enough to encompass a range of public- and private-sector partners who want to improve the well-being of San Diego's residents.

At some site visit locations, collaboration was achieved by holding ongoing meetings of groups that (ought to) work together or creating a liaison role within a department in which one person informed other groups about the various activities and opportunities to collaborate. One participant in a liaison role described how her position allowed her to “see the big picture” and to “connect the dots” between services. By attending meetings and committees across departments, she explained that she recognizes when these groups have overlapping populations, needs, or goals. As a result, she is able to link them to one another to share resources or coordinate their work. Collaborative efforts have included connections within and across entities providing health care services (e.g., Medicaid, health plans, hospitals, nursing homes) and social services (e.g., housing providers, schools, eligibility services). As one participant explained, staff have truly coordinated when the person in the leadership position ran their composite agency as a single organization rather than a set of confederated entities. Another pointed out the importance of institutionalizing coordination. Because “operational excellence is not enough” to maintain teamwork, he noted, it was important for officials to foster “collaborative leadership” within the agency and among partners in order to maintain synchronization and cooperative relationships.

In each state, contextual factors were said to play key roles in enabling strong leadership. Participants mentioned critical events or environmental factors that created “windows of opportunity” to coordinate or integrate social services and health care. For example, in an organizational shift in San Diego County, a newly appointed official put several departments together in order to align their reporting and activities. This was seen as an opportunity to integrate health and social services administratively, beginning with a comprehensive strategic plan spanning numerous service areas and enhanced authority for the director of the newly coordinated entity. It also set the stage for financial coordination in which funds are “braided”³¹ with the goal of maximizing resources. In another example, shared concerns about Vermont’s rising health care costs led to a bipartisan agreement to overhaul the primary care financial incentive structures. This political accord set the stage for Vermont’s Blueprint for Health, a statewide reform to better align payment with health improvement goals.

In addition to windows of opportunity, the participants cited community-driven action as influencing the context in which government officials attempt to improve state health. Many also observed that community groups can shape policy directly by taking on leadership roles themselves. In some cases, county public health departments or other local agencies may be familiar with the community, enabling them to lead “from the ground up.” In other cases, nongovernmental organizations may lead in improving the state’s health.

Public-sector officials also may capitalize on community-led efforts whether they arise from the private or public sector, from formal organizations or grassroots campaigns, or from small interest groups or widespread initiatives. One participant remarked that government leaders alone cannot change the health of states and local communities, that public support for policy direction is a key component of improving health, especially when government officials change over time. In an example given during the facilitated session, the

residents of Oklahoma voted to amend the state's constitution to create a trust fund from tobacco settlement payments. This fund, called the Tobacco Settlement Endowment Trust (TSET), continues to provide grants for community-led programs that address the state's health issues. By embedding the fund into the state constitution, Oklahoma residents have safeguarded it from competing interests. In Rhode Island, a local effort to establish "health equity zones," which address social and environmental drivers of community health, has attracted interest throughout the state and is now funded by the Centers for Disease Control and Prevention (CDC). One participant commented that this effort has the potential to aid state officials in targeting localized needs, even though Rhode Island does not have county or local public health departments.

According to participants, while community-led efforts and advocacy may not always be necessary to make progress toward healthier states, public opposition (or, to a lesser extent, public indifference) can be a critical barrier to a policy's development and implementation. One state official explained that public resistance to the recent national health care reforms has created challenges to the implementation of public health initiatives in the state, even though these initiatives are not related to the federal reforms. In sum, these states' experiences illustrate several ways in which leadership stemming from the community, whether from civil society organizations or the general public, can influence policymaking environments for officials in leadership roles.

Strategy Two: Navigating the Political Environment

The work of politics—understanding, navigating, and negotiating among competing individual and institutional interests—was noted during discussions with state officials as influencing, but not necessarily imposing on, efforts to improve the health of populations. Although participants highlighted the importance of the state's formal political environment (i.e., the ideologies and party affiliations of those in power in the state senate, legislature, and governor's office) in doing their work, contrasting ideologies were not always perceived as barriers to health improvement or reform efforts in the states. For example, participants in Vermont described how in the mid-2000s, the state's Republican governor and Democrat-controlled legislature found common ground in working on health care delivery issues and provider payment structures that were driving unsustainable cost increases. While legislators differed fundamentally on some of the core health care-financing issues, they agreed that the current payment system, which rewarded a greater use of expensive, specialized services, needed to be remodeled. Along with other nonpartisan systemic reforms, policymakers developed a new multi-payer model focusing on primary care and prevention measures (through primary care practices and community health teams), as well as targeted service coordination for certain populations with complex medical and nonmedical needs. Under the title "Blueprint for Health," the goal of these reforms is to redirect incentives toward prevention, high quality of service, and cost reduction. By keeping the focus on issues on which legislators from both parties could agree, rather than on points of

contention, Vermont stakeholders were able to make progress where there had previously been political gridlock.

In contrast, other participants were concerned that political influences could stymie improvement of the state's health. For example, at the time of the site visits, Kentucky officials were anticipating the next gubernatorial election, and some participants were unsure how the transition in governance would affect their work. In light of a mixed-party legislature (Republican state senate and Democrat state legislature), the next governor's political leanings were expected to substantially influence the direction of numerous state initiatives. This prospect was not unfounded; several officials described how in the past, political turnover in the state had changed the course of health policies and programs. Indeed, new administrations may establish new initiatives, regardless of the objective merits of those in place when they arrive. One stakeholder noted that politically driven changes in services can be a burden for government staff and contractors who must shift focus, produce new materials, and learn new processes, often with few resources. Several participants explained that they try to "memorialize" or "embed" existing programs and processes as much as possible so that they can withstand political change and continue to progress, regardless of party leadership. To this end, a number of current programs and reform efforts have been incorporated into Kentucky's State Innovation Model (SIM) grant proposal, which was recently awarded by CMS.

Participants noted that directives and interests from all levels of government play a role in decision making. In San Diego County, participants observed that state and national-level politics also greatly influenced their work, by dictating the utilization of funds. Because categorical intergovernmental funds have to be spent for specified purposes, these financial resources are not always used in the most appropriate or efficient manner in regard to local needs. In one case, a participant explained that the county was not permitted to move federally transferred funds from one program, which was saving money, to another program, which needed money. (Both programs targeted the same low-income populations but provided different types of assistance.) To optimize the use of intergovernmental transfers, officials recommended making financial decisions with long-term (i.e., beyond political term limits) community needs in mind and making statutory changes to enable multi-sector collaboration. "We need to figure out how to depoliticize funding," said one participant.

There is politics in our dollars.

Participants also described how political views can influence agencies' organizational structures. The current single-cabinet model in Kentucky, for example, was instituted under

Under the Secretary, we are run as one organization. We are not just confederated [departments]. We talk as one. We work collaboratively.

a former governor who believed that consolidation would "improve efficiencies of government," according to participants. For decades, the structure of health care and social services had vacillated between one unified department and separately

operated entities. Administration of these services was fragmented as recently as the late 1990s and early 2000s, and participants observed that “resource wars” (department competitions for funding) frequently broke out during that time. Gubernatorial changes in the mid-2000s reunited the cabinet, which has persisted. Participants noted that the consolidated model is now so ingrained in how they do work that it would be “impossible to split.” The cabinet structure was widely praised during the site visit for its ability to facilitate coordination and share information among staff. One participant declared that she “know[s] where to go and what to do, know[s] who to ask, and where data is housed...and how to use information effectively” because the cabinet is united. Others voiced support from a budgeting and planning perspective. In their view, because the health and social service programs serve many of the same populations in the state, a single cabinet can more successfully plan budgets and carry out policies by taking a broad perspective on Kentucky’s needs. Regardless of organizational structure, however, state and local agencies face the ongoing challenge of “how to balance what we have done with what we need to do.”

Some state officials explained how they promote individual choice and leverage expertise outside the public sector in order to progress toward health goals for the population. For example, one official pointed out that “the state doesn’t tell clients whom to pick” for providing adult day care or other voucher-based caregiving services. Because beneficiaries can choose their service provider, she explained, “quality [is] driving the market.” An official from another state expounded on how bidding on contracts can be used to enhance the quality of services. From his perspective, contracting with a private-sector service provider (rather than delivering a service in-house) can lead to better service quality when the private sector has more expertise than the public agency. Several site visit participants also observed that their states have gained experience in contracting and working with private-sector entities from their Medicaid agencies’ oversight of managed care organizations. In these discussions, stakeholders supported the use of market forces both to control the cost of care and to improve the quality of service.

We don’t believe in providing services that can be better provided by the private sector, so we contract out [for those].

Strategy Three: Using Evidence to Support Decision Making

Marshaling the data to evaluate the performance of interventions in achieving their goals was described as essential to winning support for policies that align financial incentives to improve the population’s health. Meaningful evidence was described as a clear indication that the policy or program in question had demonstrated value, which could gain support for scaling up and sustaining the policy or program. Performance assessments of holistic or coordinated service provision were deemed particularly important if stakeholders were skeptical that nonmedical services could improve health. Participants mentioned the usefulness of regularly evaluating performance to demonstrate value and gain the support of doubtful stakeholders. For example, stakeholders in Vermont initially had difficulty getting support from the federal government to fund Support and Services at Home (SASH), a program coordinating health care, housing, and

Do some work first, then evaluate, then roll out.

case management services for older adults. At first, CMS did not recognize how the program could reduce costs or lead to health benefits. State officials appealed to CMS, however, by sharing results of a pilot program evaluation that demonstrated cost savings, health benefits, and client satisfaction. Because of these promising pilot results, CMS approved funding for the program statewide as one of Medicare's Multi-Payer Advanced Primary Care Practices demonstration projects.

In addition to being important for monitoring success, performance data were also viewed as essential to assessing current conditions and needs of populations in the states. Participants in all sites talked about efforts to integrate data systems so that clients could be tracked more efficiently and decision makers could have a clearer picture of service utilization and client needs. Comprehensive assessments in the states have involved the aggregation of data sets from a number of service administrators and providers. For example, in San Diego County, officials conducted a massive data collection project to assess the built environment. Stakeholders in transportation, public health, urban planning, human services, and others joined to create an atlas that illustrates the geographical variations of several measures including active transit options (e.g., bicycle ways, sidewalks), safe routes to schools, barriers to physical activity, conditions of parks and recreational spaces, air quality, fast-food restaurant density, and access to supermarkets and other fresh-food facilities. Thus far, public health entities have used the atlas to assess health disparities; academic institutions have used it to conduct studies of physical activity in the population; and transportation and city planners have used it to guide investments and projects.

Although officials acknowledged a desire to make evidence-based decisions, the site visits revealed two major challenges to gathering and acting on collected information. First, participants described data collection difficulties as related to the reluctance of departments (or individuals) to share the data with others. As one official explained, personnel may be wary of disclosing their organization's information if they had been penalized for poor performance in the past. Participants also commented that clients may have concerns about sharing personal data. Moreover, participants cautioned that the adoption of interoperable technology alone is not sufficient for sharing information or coordinating services. According to one participant, "If you only add new technology, you just get more silo[s] [in the] organization. You [only] organize chaos." He explained that technology does not inherently offset mistrust; staff may still feel protective of their client/program data despite being able to share it. Communication from the leadership and careful planning for data governance were noted as important to successfully integrating systems.

[It's about] balancing actionable evidence with confidentiality.

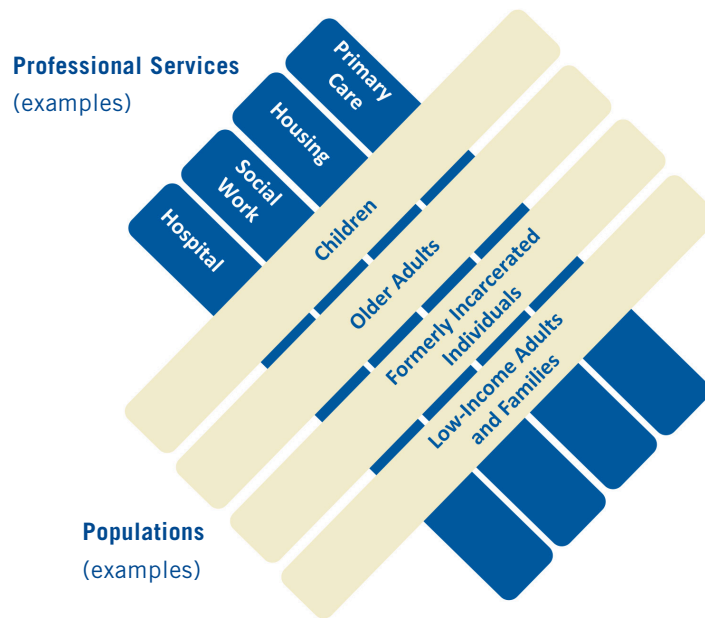
Second, data may not be suitable for decision making unless they are aligned with the state's health needs (i.e., unless the data are relevant to evidence-based decisions) and representative of state/local populations. Given the complexities of measuring health, however, decision makers may have difficulty deciding precisely which information to collect. Some officials noted that they may look to other states, typically their geographic neighbors, to guide their data decisions (e.g., what to measure, how to collect data), especially

when no precedent exists in the state. Others worried that following others was inappropriate because the local situations were different. One participant pointed out that federal agencies can facilitate states' learning from one another by standardizing IT systems for reporting or sharing data (e.g., CDC's National Electronic Diseases Surveillance System [NEDSS]). Federal agencies' input may be restrictive, however. For example, an official commented that the data-gathering priorities are often based on federal grant requisites rather than locally driven, area-specific needs. He explained that this can lead to misdirected investments if the state-level measures required by federal agencies are not detailed enough to detect local disparities. According to one state public health official, the usefulness of data is dependent on whether they are collected in a reliable, standardized way that includes diverse samples of the state's population. In addition, several stakeholders observed that service costs frequently overshadow health outcomes as the primary goals of state-level interventions because financial results are less complicated to measure. These officials warned that the ease of data gathering, rather than the importance of the measures, may determine which data points are collected. They were concerned that important information may therefore be overlooked in the decision-making process. Although many officials described difficulties in measurement and data collection, they noted the importance of using evidence to assess needs, demonstrate performance, and guide decisions for improving health.

Strategy Four: Targeting Populations with High Medical and Social Needs

Discussions with officials revealed that the leading edge in state health improvement is service coordination for those populations³² with high medical and social needs. Because these individuals are associated with high financial cost of care and administration, they present the greatest opportunities to improve service delivery and align incentives.^{33–38} The groups that had multiple and diverse service needs were children, older adults, people with disabilities, individuals transitioning out of correctional facilities, and low-income families (i.e., people who are typically eligible for numerous assistance programs). This population-driven approach,³⁹ which delivers services based on a group's needs,⁴⁰ differs from a professionalized approach, which organizes care based on the service provider's expertise (Figure 4). In the population model, stakeholders come together from various disciplines to create a coalition that addresses numerous determinants of health.⁴¹ In contrast, the professional model emphasizes medical factors in health, functional expertise, limited coordination of providers, and strong professional identities.⁴² Although a professionalized model of service provision still is common in health care,²⁶ the study participants frequently described a population model when discussing current efforts to improve health in their states. They noted that their agencies are sometimes legislatively mandated to coordinate and budget for target populations. At other times, anticipated cost savings and efficiency gains were the drivers of coordinated care for those people with complex, ongoing medical and nonmedical needs. According to some participants, these examples of cross-sector collaboration for target groups offer starting points for more comprehensive coordinated efforts to improve the health of whole populations across the states.

Figure 4: Population and Professionalized Approaches to Care



Children. One state official described the family resource and youth services centers (FRYSCs) that are operated in schools to reduce (nongenerative) barriers to children’s learning. In order to target those children and families most in need of services, the centers are placed in school districts in which at least 20% of students receive free or reduced-price school meals. FRYSCs provide health screenings, referrals to medical and nonmedical services, child care programs, counseling, and literacy services. According to participants, by housing the FRYSCs in school buildings, the state can maintain a direct connection between the families and the numerous child-centered health and social services.

In another example from the facilitated session, an official described an early childhood intervention to prevent entry into the foster care system (excluding cases of abuse or neglect). The evidence suggests that children in foster care have worse health and social outcomes than other children do.^{43,44} Accordingly, based on data from the state’s Medicaid agency and department of human services, officials conducted an assessment that identified those families who were at high risk of having a child enter foster care. The participant explained that this collaborative endeavor has helped state officials direct preemptive services to high-risk families as an approach to “bending the cost curve” in health care and social services.

Older Adults and People with Disabilities. Participants in San Diego County described a coordinated care initiative targeting dually eligible Medicare beneficiaries (low-income seniors eligible for both Medicare and Medicaid) and individuals with disabilities, which integrates the delivery of medical, behavioral, and long-term care services in order to reduce costs and promote independent living. As part of this initiative, the division of Aging and Independence Services (AIS) coordinates with private health plans (contracted by Medicaid) to assess the beneficiaries’ needs and connect clients with services, including in-home care

assistance. To better serve the senior population, participants noted that the department also collaborates with entities like the local VA medical center, the Department of Housing and Community Development, and transportation providers to link older adults to a spectrum of medical and nonmedical services. AIS also educates service providers themselves on successful collaboration by providing training in creating “virtual teams” of medical and social service professionals.

Formerly Incarcerated Individuals. Rhode Island participants described its Transition from Prison to Community (TPC) project, which brings together services and leadership from a multitude of state departments, including health, mental health, human services, corrections, labor and training, children and families, transit, and education, in addition to service providers in the communities. A variety of committees across these departments meet regularly to develop innovative ways to coordinate services for offenders in order to promote their well-being, encourage their transition into society, and reduce recidivism.

San Diego County has established the Corrections Transition Center (CTC) where offenders can go immediately after being released from prison to be assessed for an array of social (including housing), behavioral, and medical needs. Many of the services are provided on-site. The center is adjacent to a substance abuse treatment facility, which can provide ongoing treatment and counseling as well as immediate detoxification services if needed. This setup is helpful, according to one of the participants, since a majority of offenders coming to the CTC are battling drug addiction. According to officials, ongoing case management is a core service of the CTC; employees receive comprehensive training on the local services available to CTC clients and the processes by which clients may be linked to appropriate programs. Although the unpredictable and long-term nature of offenders’ needs creates challenges for coordination, to best serve their clients, the center’s staff maintains direct communication with law enforcement and many health and social service providers in the area.

Low-Income Individuals and Families with Complex Health and Social Needs. One population noted across the site visits is the cross-cutting group that is eligible for multiple publicly funded programs, such as Medicaid, Supplemental Nutrition Assistance Program (SNAP), housing assistance, foster care, and Supplemental Security Income (SSI). For these individuals, state officials generally emphasized coordinating the application process in order to increase the relevant agencies’ administrative efficiency and to decrease the burden on applicants. For example, some participants referred to the computer kiosks located in state or county offices where applicants can input their information in person to check their eligibility and sign up for several programs at one time. Others added that online submission processes are integrated to allow easier application from home. During several site visits, new state-based health insurance exchanges were cited as the key vehicle to incorporate processing for numerous services into one online portal. In one state, beneficiaries are given a single identification number for multiple services that makes tracking financial data and service usage easier. Several participants also acknowledged a “no wrong door” approach to eligibility services, in that potential beneficiaries may apply

for a variety of cash assistance or other categorical programs, regardless of their entry point into the application system.

In addition to integrated application processes, some participants also described collaborative needs assessments for low-income, high-needs groups. For example, San Diego's Regional Continuum of Care Council (RCCC) oversees a coordinated assessment of the local homeless population's diverse service needs. The RCCC brings together stakeholders from San Diego's HHSA, Department of Housing and Community Development, county law enforcement, other local agencies and private-sector organizations, as well as philanthropic groups to connect homeless individuals to housing assistance and other health and social services. The RCCC's Taskforce on the Homeless also administers the region's Homeless Management Information System, an integrated data repository service that providers can use for needs assessment, program planning, and client management.

Site visit discussions illustrated how collaborative efforts serving groups with complex and extensive needs can bring together personnel from many health and social service areas. As a result, these targeted interventions may provide lessons for—and perhaps facilitate—future coordination for the state population as a whole.

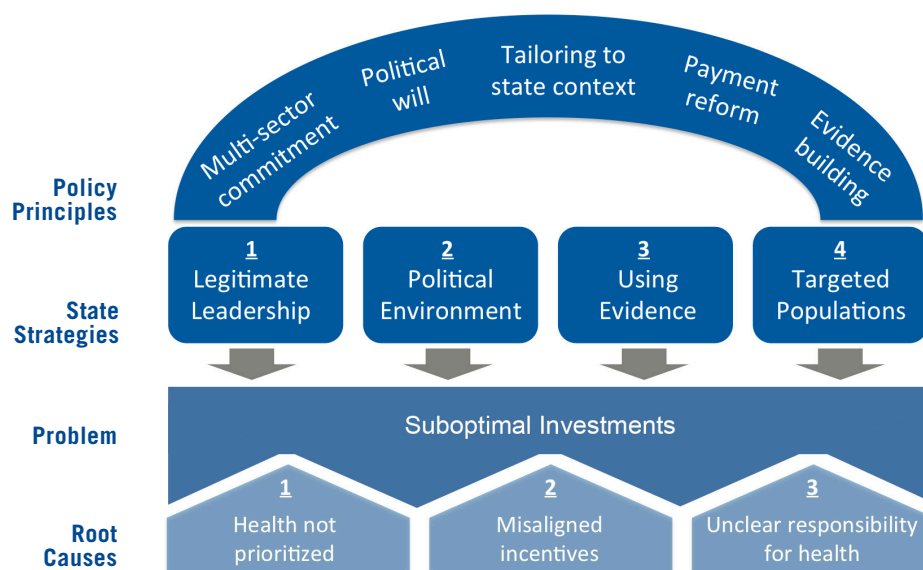
Principles for Moving Upstream

For many states, improving the population's health has remained an elusive but persistent goal. Even though officials seek to optimize health in their states, policy decisions and investments do not necessarily align with the evidence regarding promising approaches. Specifically, state interventions do not regularly “move upstream”—that is, social services to promote health are not consistently being used before expensive health care services (“downstream”)—even though research strongly suggests that more attention to nonmedical determinants can benefit health outcomes for the population. This study offers insights into this apparent contradiction from the perspectives of state officials, as well as the current efforts by some states to incorporate both social and health services in their health improvement activities. The root cause analysis emphasizes that a focus on the fundamental sources of suboptimal investments in the states can steer officials toward developing the most productive activities for improving the state's health.

Given the obstacles described by state officials, we sought to identify the steps currently being taken to improve the state's health. Although each state is different, discussions with government officials and community partners revealed several common experiences nationwide. Our findings suggest that despite the challenges in decision making, the states' efforts—in leadership, political action, data utilization, and targeted programming—demonstrate both the willingness and the capacity for state-level actors to enhance the health of their populations.

The strategies described here are hardly comprehensive or likely to be universally successful. Local leaders working to improve their population's health will encounter different financial and political environments, service provider resources and skills, and population needs. While we acknowledge that each environment will determine the particular strategies, certain values and approaches may be the same. Based on our observations of state and county efforts, we identified five policy principles to continue moving states toward improved health of their populations. Each addresses root causes of suboptimal investments, builds on existing progress in the states discussed in this report, and reflects the needs of state and county officials to make effective decisions (see Figure 5).

Figure 5: Policy Principles for Improving the Health of Populations in the States



Multisector Involvement and Commitment

Involvement by and commitment from stakeholders across a broad range of sectors are essential to improving a state's health. For public-sector officials tackling the central problem we have identified—that states do not make overall budget and policy decisions that optimize the health of their populations—engaging a range of stakeholders at the onset of new initiatives (e.g., planning programs, identifying measures) is necessary for building relationships, optimizing resources, and ultimately achieving the states' health goals. This broad-based commitment may stem from political directives, shared accountability, or metrics that span multiple sectors. Concerted efforts may also emerge in response to an external challenge or stimulus, such as a state or federal legislation or a significant funding opportunity. For example, CMS Innovation Center initiatives (e.g., the Accountable Health Communities model), which are federally supported under the Affordable Care Act, may generate innovations that promote the integration of social services and health care to target specific health goals of communities. Nongovernmental actors such as philanthropic or private organizations can also initiate multisector involvement by convening diverse

partners, identifying common objectives, and motivating collaboration. Although some collaborative work may be largely propelled by a single actor, numerous partners across sectors may participate proactively. For example, the “megacommunity” is a growing approach in public health and other fields, in which key individuals from government, private organizations, civil society, and other entities “deliberately join together around a compelling issue of mutual importance.”⁴⁵

The relationship between a catalyzing actor or event and a sustained multi-sector effort is complex. The literature on “collective impact”^{46,47} further illuminates how such collaboration can be sustained and successful. According to the participants, external stimuli and leadership are important but not sufficient for success. And while informal coordination may be valuable for temporary efforts, they noted more formal partnerships—or even contractual agreements—as crucial to longer-term endeavors.

Public officials agreed that they “have enormous opportunity in [their] roles” to stimulate, encourage, and help sustain these diverse coalitions that work toward improving the health of their states’ populations. Multi-sector commitment is a strong support in efforts to

We have enormous opportunity in our roles.

achieve health goals. As such, it permeates all the root causes and state strategies discussed in this report. Because health at the population level is influenced by the dynamic and complex intersec-

tions of numerous actors, building bridges across sectors and encouraging collaboration are essential elements for any efforts to make progress in state health.

Gaining Political Will

During the session and site visit discussions, officials described the necessity of gaining the political will of executive and legislative policymakers to achieve state objectives and pursue endeavors to improve their populations’ health. The support of political actors is critical to resolving any of the three root causes identified by the participants and to build on any of the four state strategies revealed in the site visits. Political will is so important to improving a state’s health that one participant warned that without it, any efforts to make the state healthier would be stifled, despite having a “culture of health.” Unlike most of the other policy principles, the need for political will may transcend state boundaries. As a result, in addition to rallying the support of state government officials, state-level actors must account for the perspectives of both federal and local decision makers. One way to increase political support is to use a “galvanizing issue” or rallying call to which policymakers can direct investments. Although the issue may be complex, simple messaging (about a new initiative, health need, etc.) is essential to build widespread agreement on the policy agenda or approaches to improve the state’s health. In general, the participants underscored the importance of translating evidence in ways that are straightforward and meaningful for decision makers. As one official explained, “[You need to] draw a map to the things they care about.”

Flexibility in Tailoring Programs to a State's Context

Tailoring policies and programs that are unique to a state's population needs may be more effective than standardized interventions because they fill specific, local gaps.⁴⁸⁻⁵⁰ Although some federal program funding is categorical, where opportunities do exist to redirect funds (e.g., via Medicaid waivers), some state agencies already modify their investments in accordance with their specific context and population needs.^{51,52} State-specific programs may encourage health issues to rise on the policy agenda (addressing root cause 1) by making the state's health more salient to residents and officials and adhering to their local norms and values (root cause 3). (Some states make this explicit by [re]titling prominent programs. For example, Medicaid is known as Medi-Cal in California, SoonerCare in Oklahoma, and Green Mountain Care in Vermont.) Tailoring health improvement efforts to the state may also promote data collection and evaluation (state strategy 3) because the states can try out interventions as pilot programs and accordingly build their evidence base to support implementing successful programs statewide or terminating ineffective interventions. Stakeholders may also be more accepting of data sharing for a state or local effort to which they feel allegiance. Finally, state-specific programs can help stakeholders design programs for sub-populations in the state identified as high-needs groups (state strategy 4).

Commitment to Payment Reforms to Align Incentives with Broader Health Goals

Officials expressed a desire for provider payment reforms within the health-care sector to reflect more holistic health goals for state populations. They emphasized the strength of financial incentives in medical service provision and were encouraged by the aims of accountable care organizations (ACOs) to improve care coordination and broaden the scope of provider responsibility. Participants were particularly supportive of approaches that move away from volume-based payment structures. While health care payment reform directly addresses misaligned incentives (root cause 2), it may also make responsibility for some health outcomes more explicit (root cause 3) if financial rewards are associated with stipulated results. Moreover, payment schemes can create incentives to enhance services and/or coordinate with groups that have great medical and nonmedical needs (state strategy 4). Some Medicaid ACOs, for example, have already implemented shared savings models to encourage service integration for their beneficiaries.⁵³ Because health care is heavily monetized, state officials emphasized the importance of improving and reinforcing financial incentive structures within the health system as a step toward better health for state populations.

Participants also endorsed the importance of aligning financial incentives across health care and social-sector agencies to meet state health goals. One state official suggested integrating the rewards associated with both social and health outcomes as a way to steer the efforts of separate agencies in the same direction. This vision of shared accountability for a broader set of outcomes has recently attracted more interest from the federal government as well. Beginning this year, the Center for Medicare and Medicaid Innovation (CMMI) will

provide grant funding to a range of health care and social service entities to implement an Accountable Health Communities (AHC) model of service delivery.⁵⁴ In the AHCs, medical and nonmedical stakeholders collaborate to meet the community's health and social needs. The model currently focuses on referral, navigation, and alignment between health and community services. While performance measures and rewards are not yet determined, this model may offer a way forward for aligning financial incentives across sectors.

Evidence to Initiate and Sustain Programs

Evidence plays important roles in decision making to improve the health of a state's populations. Findings from research studies and local assessments can demonstrate health needs in the state, offer recommendations for intervention designs, and provide reasons for sustaining—or expanding—initiatives that work and terminating those that do not. State officials explained that they rely on data experts and researchers to develop a credible and reliable evidence base for their decision making. Specifically, in order to widen the scope of health interventions to include nonmedical services, evidence is needed to determine which social service investments have the greatest return in regard to health improvements or health care cost reductions. To be sure, assessing the relationships between nonmedical services and health outcomes requires enhanced data collection and management by agencies in both sectors. While developing the interoperable infrastructure to link social program and health care databases may require substantial time and resources, state officials underscored such investments as a foundation for strategic coordination in the future. Expanding resources for rigorous research may not only signal that health is being prioritized in the state but also sustain health as a priority by demonstrating needs (or progress) in the community (root cause 1). In practice, because shortcomings in data collection and measurement can stifle evidence use (state strategy 3), state government officials may benefit from partnering with researchers, service providers, professional groups, and other governmental agencies to determine key measures, data points, and procedures for sharing information. A focus on evidence may also reveal the extent of social and medical needs of various populations in the state, which can guide policy action for targeted groups (state strategy 4).

Conclusion

Although improving the health of populations in the states is a central goal of state officials, and evidence is emerging about the importance of investing upstream in social services to improve state health downstream, acting on this evidence to optimize health is a complex, challenging task. Given the objective evidence pointing to the ability of other countries' health systems to generate better population-level health outcomes for lower costs, one policy option is to call for wholesale changes in the way we finance, pay for, and organize our medical care and social services.

Such shifts in political priorities, however, may not be in the immediate offing, and there are considerable lessons to be learned closer to home. Research indicates that variations

in health outcomes in the United States are attributable to policy decisions relating to social services investments made by state officials. In this study, we sought to identify the underlying root causes for why states do not invest more in services that improve the health of populations. We also aimed to understand the states' experiences in overcoming these challenges and to identify the strategies and the contextual factors that influence decision making to make states healthier.

We began our work with a session with officials from diverse states, at which we facilitated the development of an agreed-upon problem statement: "States do not make overall budget and policy decisions that optimize health of the population in the state." Further analysis uncovered three root causes of the problem: the health of the state population is not prioritized; incentives are misaligned; and responsibility for health is not clear. From the facilitated session and additional site visits in several states, we also characterized state experiences with improving health across four thematic strategies: legitimate leadership, political environment, evidence to support decision making, and target populations. Finally, we identified five principles that policymakers and their partners could use to encourage and nurture these strategies: encouraging and maintaining multi-sector involvement and commitment, gaining political will, tailoring programs to the state's context, committing to payment reforms that align incentives with broader health goals, and building evidence to initiate and sustain programs that improve the states' health.

This work demonstrates that while great challenges face leadership, great opportunities abound as well. By discovering and following the paths that lead upstream, state officials can make policy decisions that enhance service delivery, maximize the impact of existing resources, and improve the health of their populations.

Appendices

Site Visit Discussion Guide

Investing for State Health

State Site Visit Discussion Guide

Milbank Memorial Fund and Yale University

The purpose of this site visit is to learn about state approaches for producing greater state population health for health care and social service investments. A subset of the following questions will be posed to state officials based on their current roles and earlier experiences.

Current Programs and Policies

1. Are there any current programs or initiatives in the state that work to improve both medical and nonmedical determinants of health?
 - What is being done that you think is truly innovative?
 - What elements are driving the success?
 - What has been done that you know does not work?
2. Who are (or would be) the stakeholders involved in coordinating social and health services?
 - Are there formal structures in place for coordinating?
 - What might facilitate or prevent coordination?
3. In general, how are the budgets developed for social and health services and programs in the state? How are the spending priorities determined?
4. How are social and health care services evaluated at the state level?
5. Which populations in the state are most in need of integrative social and health services? How are they addressed?

Historical Context

1. What events have taken place to make the current program or policy come to be?
2. How have current efforts otherwise been shaped by prior events or context?

Looking Ahead

1. Thinking longer term (~5 to 10 years in the future), what are your state's plans to improve the health of the population?
 - What do you see as the biggest challenges facing population health improvement in your state?
2. Are there any common metrics that may be acceptable for both health and social sectors to share? What might shared accountability across these sectors look like?
3. In an ideal situation, what sort of information would you like to have in order to make decisions about allocating resources, implementing programs, or evaluating programs across health and social services?

Output from Root Cause Brainstorm

1. The health of the state population is not a priority (i.e., state officials may not think about health as much as other issues).
2. People do not see the link between social services and health (lack of belief/insufficient evidence of social investments linking to health).
3. State officials have other goals to achieve (e.g., economics, jobs).
4. There are powerful constituencies/interest groups (e.g., pressure from lobbies).
5. There is intent to optimize health, but implementation is complicated.
6. It is difficult to know what the "health goal" is.
7. There are challenges related to the gravity of the situation, changing status quo, addressing inertia.
8. There is a lack of disseminated goal.
9. Funding is in silos (investments in one place bring about savings/benefits "somewhere else").
10. It is unclear who has agency/responsibility for health.
11. Incentives are misaligned.
12. There are political and economic barriers.
13. Language can be polarizing (social vs. health...).
14. There is no common definition of "health" (vs. wellness?).

15. There is inherent controversy over social services investments (decisions can be based on values rather than objective criteria).
16. Measurement of health is poor and there is limited data on program effectiveness to improve health.

Notes

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31. When financial resources are “braided,” monies are brought together from separate funding streams to pay for services, with expenditures from each stream monitored and reported to funders. In contrast, when resources are “blended,” monies are combined into a single funding pool and allocated without tracking the original funding source. Many factors go into decisions about whether to braid or blend funds. Even though we used braiding in this example, it is not meant to be a recommendation but rather a reflection of one locality’s experience.
32. “Population” is used here to refer to a group that shares a particular characteristic. This characteristic could be a geographic location, such as a state population, or a demographic (e.g., children), shared condition or experience (e.g., people living with diabetes, individuals who have been incarcerated), or collective need (e.g., individuals who do not have permanent housing).
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