



**FUNDERS FORUM**  
on Accountable Health



# AHC of Maricopa County Case Study

Maricopa County, AZ  
2018

# THE FUNDERS FORUM ON ACCOUNTABLE HEALTH

The Funders Forum on Accountable Health is a collaborative at George Washington University's Milken Institute School of Public Health that works to advance accountable communities for health (ACH) models by promoting dialogue and catalyzing change among public and private funders of ACH efforts across the country.

The Forum is a common table for funders of ACH efforts to share ideas and experiences, explore potential collaborations, support common assessment approaches, and build a community of practice.

Visit our website at [accountablehealth.gwu.edu](http://accountablehealth.gwu.edu) to learn more!

## Acknowledgements

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# FUNDERS FORUM CASE STUDIES

**The Funders Forum on Accountable Health conducted ten case studies of different accountable health models to better understand the key implementation challenges and opportunities they face.**

Accountable Communities for Health (ACH) are community-based partnerships formed across sectors to focus on a shared vision and responsibility for the health of the community. They pursue an integrated approach to health that focuses not only on the clinical setting, but also on how the broader community can support health care's "Triple Aim"<sup>1</sup> of better care for individuals, better health for populations, and lower health care costs.

The Funders Forum interviewed leadership from ten ACH sites in order to better understand the various approaches to governance structure, portfolio of interventions, investments in technology, funding sustainability strategies, and anticipated short- and long-term outcomes of their ACH efforts.

The purpose of this report is to provide an in-depth overview of the Accountable Health Community of Maricopa County in Arizona. We wish to thank all the participants in this case study.

Reports on all ten case studies are available on our website at [accountablehealth@gwu.edu](mailto:accountablehealth@gwu.edu).

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1. Berwick, D. M., T. W. Nolan, and J. Whittington. 2008. "The Triple Aim: Care, Health, and Cost." *Health Affairs* 27(3).

# AHC of Maricopa County

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### What is the Accountable Health Community of Maricopa County?

In 2017, Dignity Health St. Joseph’s Hospital and Medical Center, in partnership with a number of clinical and social service partners that have a long history of collaborating together to address community level health challenges, was selected to participate in the Centers for Medicare and Medicaid Innovation’s (CMMI) Accountable Health Communities (AHC) demonstration project. Under this demonstration, these partners are launching a new program, called 2MATCH (To Match and Align Through Community Hubs),<sup>1</sup> that is focused on identifying and addressing unmet social service needs of patients via a uniform screening and referral platform shared across partnering clinical care sites. It is specifically targeting addressing service needs related to food insecurity, utilities, exposure to violence, transportation, and housing. Partners are building on their earlier efforts and creating stronger linkages between the health care and social service sector. To this end, projects emphasize an assets-based approach to collaboration, grounded in recognizing and drawing on the expertise and strengths of partners outside the health care sector, in order to most effectively make positive change.

### Origins of the Accountable Health Community of Maricopa County

The current network of partnerships within Maricopa County is built upon years of cross sector collaboration between local health systems, government agencies, and broader community stakeholders. Following the passage of the Children’s Health Insurance Plan (CHIP), St. Joseph Hospital’s and Medical Center’s community health and benefits department began engaging on a deeper level with community partners utilizing the elements of collective impact to address social needs such as housing, transportation, and other social service areas in an effort to reach lower-income uninsured children and help enroll them in health coverage. The hospital’s community health and community benefits department also began to invest in projects aimed at integrating care delivery within the community, through initiatives like school-based health centers, and mobile clinics. However, St. Joseph’s staff soon realized that solely focusing on health care delivery could only affect health outcomes so much. As a result, its community health and community benefits department began shifting its focus towards collaborating with community partners to address larger community-level factors affecting patients’ health and well-being. One of the first issues St. Joseph’s community health and community benefits department chose to address was environmental health risk factors in the region. It convened an affinity group of local stakeholders from diverse sectors, including government, schools, and public health organizations to resolve environmental health problems through both policy action and changes to local environments.

In 2012, this affinity group model of collaboration grew into what is now the Arizona Community of Care Network (ACCN). Over the years, the ACCN has involved over 80 local stakeholders, including safety net providers, behavioral health providers, hospitals, housing and social service providers, government agencies, businesses, insurers, nonprofit organizations, and community members. This network is focused on driving aligned agendas, through collaborative goal setting processes,



*“I think long is the day that we could say it’s my funding, and it’s my organization, and it’s my patients...We’ve got to start working together. There’s too much to be done.”*

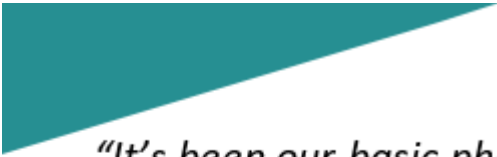
**Marisue Garganta**  
**Director of Community Health Integration**  
**St. Joseph’s Hospital and Medical Center**

1. The 2MATCH Project is an Accountable Health Communities Model supported by Funding Opportunity Number CMS- 1P1CMS331609-01-00 from the U.S. Department of Health & Human Services (HHS), Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.

and supporting multi-sector partnerships to address pressing community-level health challenges.

Through this network, St. Joseph’s Hospital and Medical Center works with community partners, including the Maricopa County Public Health Department, to build consensus on public health issues that partners agree to collectively prioritize based on the community health needs assessment. Under the ACCN, St. Joseph’s community health and benefit department provides grants to community partners to carry out multi-sector collaborative projects aimed at addressing identified gaps in services related to identified priorities. This network also continues to convene multiple affinity groups, including one focused on mental and behavioral health issues, and another group working on health and housing challenges among medically vulnerable patients. The ACCN has not only served as a vital source of funding for community partners to engage in collaborative efforts, it has fueled the development of trusting, working relationships between health care providers, community organizations, and social service providers in the area.

In addition to the infrastructure built by the ACCN, other partnering health care providers within the region have enriched collaborative efforts via their independent expertise addressing the social and health care needs of patients holistically. For example, Native American Connections (NAC), a longstanding mental health and substance use disorder service provider in the area, is also one of the largest local providers of permanent supportive housing and affordable housing in the area. As NAC moved into partnering with St. Joseph’s and other community stakeholders, NAC brought historical experience working on issues like access to food and transportation, housing stability, and assisting patients exiting the criminal justice system.



*“It’s been our basic philosophy, healthy mind, healthy body, and healthy spirit within that individual, their family, and the community. I’ve been here 40 years. That’s what we were talking about 40 years ago and we’ve just expanded that going forward.”*

**Dede Devine**  
**Native American Connections**

Building off these existing working relationships and community expertise, St. Joseph’s Hospital and Medical Center, alongside several clinical and community partners already engaged in the ACCN, decided to pursue becoming an

Accountable Health Community (AHC) under the federal CMMI Accountable Health Community demonstration project. Under this project, partners are now in the early stages of implementing the 2MATCH program, which is piloting a virtual screening and referral platform that all partner sites will use to assess patients’ social service needs and communicate with one another to help address those needs in a coordinated and streamlined manner.


## Governance Structure

St. Joseph’s Hospital and Medical Center serves as the backbone support hub for all program activities and manages grant funding for key demonstration specific activities and navigator staffing across partner sites. An advisory board made up of leadership from clinical and community partner organizations, as well as state and local government representatives, and some health-focused foundations meets quarterly and is in charge of guiding key program decisions. A larger consortium of partners meets monthly to develop recommendations for this advisory board and develop community-informed strategies for successfully implementing program activities. St. Joseph’s has been able to provide small stipends to community partners to participate in this consortium and the advisory board, in order to ensure that key partner perspectives are not lost due to limited

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resources.

The 2MATCH oversight structure is similar to other cross-sector collaborative efforts in the community. St. Joseph's Hospital and Medical Center also convenes a Community Health Integration Network, a committee of St. Joseph's Board of Directors, composed of hospital board members, state and local government agencies, insurers, safety-net providers, local nonprofits, and community members. This separate network is the main community advisory body that develops recommendations regarding community-level priorities that the hospital should address, including through the ACCN and its community benefit program. These recommendations are reviewed and approved by both hospital leadership, and ultimately the hospital's community board. St. Joseph's decision to apply to participate in CMMI's AHC demonstration project was ultimately reviewed by this Community Health Integration Network before being approved by hospital leadership. The Community Health Integration Network also played a key role in providing recommendations regarding community partners that should be included within the application to participate in the CMMI AHC demonstration project.




*"They had the chance to come together and hear from different community partners that either opened their eyes to new resources they didn't even know existed or forged relationships that have strengthened their ability to coordinate across resources...now they have a face to put with the organization."*

Kurt Shephard  
CEO  
Valle Del Sol

## Policies, Funder Priorities Helped Build Momentum for Collective Action

In interviews, partners highlighted policy changes at the local and state level, as well as key stakeholder agendas that have helped build a culture of collaboration in Maricopa. In the health care sector, the increasing shift towards value-based payment has built interest across health care systems, and behavioral health care providers to work more closely with community partners to address the needs of high utilizers. While many local safety-net providers have always engaged in such work, driven by their organizational mission, these policy changes have made effective collaboration a greater business imperative for these stakeholders. Additionally, having county, city and state representatives on the advisory board leads to a greater focus on bills that support increased alignment of community resources to address social determinants of health, such as enabling a match with SNAP benefits to better address food insecurity. Government agencies in other sectors have



*"I think that people are truly invested. The partners that I've interacted with at the consortium meetings or even on the phone calls are really compassionate and dedicated, connected to the work, wanting to make it happen. Everybody's putting the time in that they need to in order to make it successful and it, I think, will be a true partnership in terms of being able to rely on different people's area of expertise so that you don't have to provide everything yourself."*

Alyssa Paone  
Native American Connections



also placed a greater emphasis on cross sector collaboration. For example, Arizona’s housing department has a low income housing tax credit program to build permanent supportive housing using the housing first model with requirements for wrap around support services as part of the application. The local jails have also instituted initiatives to work with housing and behavioral health service providers to connect high utilizers of jails to needed services. In addition to these government activities, in recent years, local foundations have focused more on funding activities aimed at addressing social determinants of health. In total, these actions have helped generate momentum for collaborative action, and have created aligned interest in working on addressing unmet social service needs.

## **2MATCH Program Leverages Data to Support Effective Collaboration**

While partners emphasized that community stakeholders have long worked collaboratively to address social determinants of health, they characterized the new 2MATCH program as an exciting shift in the way in which community partners will work together toward this goal. The backbone infrastructure of the 2MATCH program is Healthify, a new virtual platform shared by clinical and social service providers, that will be used to screen patients for social service needs and, in real time, refer patients to needed resources. Data will also be integrated with a health information exchange called Health Current and available for all health providers to access.

According to interviews, this new tool offers immense promise in enabling partners to leverage data to work more effectively and efficiently together. Using this new technology, partner clinical sites will screen patients for unmet social service needs across the program’s five priority areas. The results of patients’ screening will be automatically uploaded into the state’s health information exchange and be accessible to any other health care provider via patients’ electronic medical records. Patients identified as high risk based on having substantial unmet social service needs will work with a clinic’s onsite navigator, a new staff member whose sole responsibility is to help these high-risk patients obtain needed social services and supports. Using the virtual platform, navigators will facilitate warm referrals of their patients’ to needed social services. Rather than just provide patients with contact information for outside resources, navigators will be able to directly communicate with community partners about what patients need and can ensure that those organizations have the capacity to serve their clients. Community partners will also have greater context about incoming clients, as they will be able to see the results of patients’ social service screening and will know what care team referred the patient to them. Ultimately, partners hope that this shared system will break down siloes, even siloes that exist between disparate collaborative efforts to coordinate patients’ health and social service needs.

In addition to streamlining linkages and communications between the social service and health care sector, community partners highlight other expected advantages of the new 2MATCH platform. Having a shared screening and referral platform has created a new data source that, for the first time, will allow partners to systematically measure the health effects of addressing these social determinants. By validating what partners already intuitively know about the effectiveness of this work, such data could be helpful for health care providers in value-based purchasing arrangements and could help secure additional outside funding for community-based organizations. This data could also be leveraged to optimize implementation of the 2MATCH program, by assessing what care sites need greater navigation staff capacity based on the proportion of their patient population that is higher risk.

## **Benefits of Diversified Collaborative Activities and Interventions**

Separate from the 2MATCH program, the ACCN has implemented a diverse array of collaborative programs aimed at addressing upstream drivers of poor health in the community. St. Joseph’s earliest efforts to engage community partners in addressing environmental health concerns offer an example of the wide-ranging activities that these partnerships have produced. In partnership with other community stakeholders, St.

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Joseph's implemented home visits to evaluate and address environmental asthma triggers, removed outdoor environmental triggers from school grounds, like high allergen trees, engaged in advocacy to establish smoking bans in public areas, and partnered with government agencies to limit the environmental effects of living near airports.

Over the years, another core focus of ACCN programming has been integrating community organizations into clinical care teams, to help better address patients' social service needs and develop transition plans. The goal of these so called "in-reach" strategies is to leverage the expertise of community partners most attuned to the needs of specific patient populations, such as refugees or mothers with substance use disorders, and actually have these partners collaborate with health care teams to best address patients' needs holistically. One such project funded Native American Connections, the Phoenix Indian Center, and a federally qualified health center to collaboratively serve as navigators for housing, social services and primary care services for Native American homeless patients with substance use disorders and who were high utilizers within St. Joseph's emergency department. In this role, these partners helped patients address long-term housing needs, provided short-term rental assistance to maintain stable housing, and set patients up with primary care through the health center. These partners would even pick patients up from the hospital, as a "hot hand-off," to ensure they were connected to needed resources.

Community partners cite these collaborative efforts to coordinate the provision of health and social service needs across sectors as key to building the working relationships necessary to support implementation of the 2MATCH program. Over the course of interviews, stakeholders noted that the 2MATCH program felt like an "organic" outgrowth of these earlier efforts, and a way to develop a systematic structure for collaborative work that had already become integral to their operations.

In addition, having the work of the ACCN continue in parallel to the 2MATCH program has enabled continued collaboration with a broader scope of partners than those actively involved in the 2MATCH program, including hospitals and other local health care providers not currently engaged in 2MATCH. It has also maintained a collaborative center for addressing pressing community challenges that fall outside of the narrow scope of work tied to this CMMI demonstration project.

## Funding

Across the ACCN and 2MATCH, financing projects has required braiding funding from a diversity of private and government sources. Historically, St. Joseph's Hospital and Medical Center has been a main funder for collaborative projects born from the ACCN, via community grants. Many of these projects have focused on providing patient navigation services, connecting patients to social services and primary care. Funding from CMMI has supported activities and staff specific to implementing the 2MATCH screening, referral, and navigation system, including developing the electronic screening technology and hiring navigators within clinical sites to manage screening and referrals. The 2MATCH program has also relied on private foundation support for its work, including securing joint funding for Arizona State University and St. Joseph's Hospital and Medical Center to conduct an evaluation of the impact of the 2MATCH program. Key foundations focused on social determinants of health have gone beyond providing financial support and now play an active role on the advisory board for the project.

Importantly, St. Joseph's community grants have not been a primary source of funding for providing social services, such as housing. AHC funding is not allowed to be used to provide any health or social services. In order to meet these needs, community partners continue to rely on funding from other government sources, such as the U.S. Department of Housing and Urban Development (HUD), Health Resources and Service Administration (HRSA), Medicaid, and workforce development programs. As such, partners cite limited government funding for these services and supports as an ongoing concern and a potential barrier to actually

resolving patients' unmet needs, even if they are successfully connected to service providers through the 2MATCH program. To address these concerns, St. Joseph's has attempted to hold funder forums to stimulate local foundation interest in funding additional activities within the 2MATCH project and address remaining gaps in service delivery. The hope is that initial implementation of program's core functions could help provide proof of concept to private funders and supply early data on the service gaps.

## Challenges


With implementation of the 2MATCH program, partners have observed new challenges related to federal requirements of CMMI not always aligning with the local needs of implementing organizations. For example, federal requirements dictated the questions that the 2MATCH program had to include in its screening tool. Partners noted that some of these screening questions are redundant to other screening activities that clinic sites are required to complete, and voiced frustration that they did not have flexibility to adjust screening language to minimize such duplication. Ultimately, partners worry that patient experience will suffer as a result of this duplication.

Integrating screening of social services into clinical workflows is also an anticipated challenge. Clinical partners in the 2MATCH program are in the process of training physicians and nurses in using the 2MATCH system and are developing optimal workflows for integrating patient screening into the care-delivery experience. However, one interviewee noted that considering social service needs is still a novel concept for some clinicians and outside of how they were initially trained. As such, proving the value of this work to clinicians over time will be critical to securing their long-term buy-in and collaboration.

Finally, stakeholders emphasized that limited funding for addressing patients social service needs is a persistent concern and challenge. Even with the strongest referral systems in place, community organizations will not be able to overcome challenges related to demand for affordable and supportive housing outstripping available local resources. In addition, community-based social service providers anticipate needing additional staff capacity in order to effectively manage increasing caseloads. Ultimately, the success of the 2MATCH program will hinge on whether government and private funders invest additional resources in social service provision and case management.

## Lessons Learned

Partners raised a number of lessons learned from these collaborative processes. Partners emphasized that building trust across stakeholders is one of the most important factors of successful collaboration. As the backbone organization of much of this work, St. Joseph's Hospital and Medical Center has attempted to build trust in a diversity of ways. They include hosting regular open calls with partners to listen to their reservations regarding projects and maintaining open communication channels to resolve problems on an ongoing basis. The hospital has also leveraged its role as trusted voice in the community to advocate on behalf of other community partners with funders.



*"Trust is the backbone of everything. I don't care what anybody says, you have to trust one another. It's almost like we're falling into each other's arms and we're hoping that the other one's going to catch each other."*

**Marisue Garganta**  
 Director of Community Health Integration  
 St. Joseph's Hospital and Medical Center

Interviewees also observed that

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building a shared system, like 2MATCH, that will be used across multiple organizations takes time, especially given the outside priorities every organization has to juggle. However, they viewed the process of preparing for implementation of this program as a valuable experience in and of itself. Partners noted that regularly convening with partners to develop this project has helped strengthen relationships, built trust and buy-in to the project, and even helped people better understand the scope of community resources provided by other partner organizations. In addition to having greater technological resources to facilitate referrals, they anticipate that this increased familiarity with partners will help strengthen coordination of service provision across sectors and ultimately improve their ability to serve patients.





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