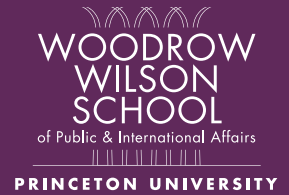




# Shared Measurement and Joint Accountability Across Health Care and Non-Health Care Sectors: *State Opportunities to Address Population Health Goals*

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## IN THIS BRIEF

- ✓ **Health care leaders are well-positioned to use cross-sector approaches to drive improvements in population health** in collaboration with state leaders.
- ✓ **Jointly employing measurement and accountability tools can help policymakers improve health outcomes** to an extent not possible through isolated, medical-centric efforts.
- ✓ **Success requires five pre-requisites:** (1) shared understanding, (2) goal alignment, (3) leadership support, (4) external stakeholder engagement, and (5) a clear decision making process among policymakers.
- ✓ **Oregon has best-practice experience forming cross-sector partnerships** and using jointly employed measurement and accountability tools to improve health outcomes and educational achievement since 2011.

## Introduction

In the context of growing health care costs in the United States, juxtaposed with poor overall health status, state agencies should jointly employ performance measurement and accountability tools to drive cross-sector activities that target meaningful improvements for population health. In this context, cross-sector refers to activities across health care and non-health care sectors related to health status.

Health status is largely influenced by factors outside the health care delivery system, particularly for low-income populations.<sup>1</sup> State efforts to improve health and reduce health disparities through the lens of medical care alone will have limited impact. Interventions that address the social determinants of health - the conditions in the places where people live, learn, work and play - such as employment, safe housing, access to healthy nutrition, and high quality education, have the greatest potential to improve health.<sup>2,3</sup> As more states expand their focus to address population health goals, they have the opportunity to employ a variety of health and other resources to meaningfully target these foundations of health.

Cross-sector collaboration has been increasingly recognized as an important approach for addressing population health goals. Federally Qualified Health Centers and other safety-net providers frequently link patients with social-service partners to address non-health care factors contributing to poor health. Additionally, strategic partnerships between health care and non-health care sectors are emerging, including targeted health system collaboration with public health, housing, community development and beyond.<sup>4</sup> Moreover, various states have begun to implement flexible services related to housing and other supports under the Medicaid benefit.<sup>5,6</sup> For example, California's Whole Person Care Pilots Program focuses on the coordination of health, behavioral health, and social services (such as housing) for vulnerable Medi-Cal beneficiaries.<sup>7</sup>

*“The commitment of a group of important actors from different sectors to a common goal will have far greater impact than isolated efforts of individual organizations.”*

Kania, J., Kramer, M. (Winter 2011).  
Collective Impact. *Stanford Social Innovation Review*, p. 36.

## Shared Measurement and Joint Accountability

This brief outlines how state agencies can employ *shared measurement* and *joint accountability* across sectors as tools for improving population health outcomes. States can use these tools to drive coordination of preventive efforts and broaden the boundaries of population health achievements that no sector, or isolated incentive, can achieve alone. For the purposes of this brief, shared measurement and joint accountability are defined as follows:

- › **Shared measurement:** an agreed-upon set of measures between two or more state agencies or sectors - including common specifications, data sources, benchmarks and reporting - that indicate performance towards a set of shared goals.
- › **Joint accountability:** the cross-sector employment of one or more performance accountability strategies, including but not limited to public reporting, contractual expectations, and financial incentives, to hold multiple sectors accountable for their respective contribution towards a shared goal(s) as monitored through a set of shared measures.

These cross-sector, shared measurement and joint accountability approaches can be employed by public agencies (e.g., state/local governmental housing and health agencies), alone and/or with contracted vendors (e.g., local housing authorities and Medicaid health plans).

This brief builds on Oregon’s health and education cross-sector model, including the use of shared measurement and performance-based accountability tools as described in the case study on page 8. Oregon established a shared governance structure that includes members of the state’s health and early learning policy committees. Members of the Child and Family Well-being (CFWB) Measures Workgroup collaborated to leverage the state’s experience with quality measurement and performance-based accountability to drive cross-sector activities targeting kindergarten readiness.

## Key System-Level Factors When Considering a Joint Accountability Approach

Joint accountability to improve population health can be realized by aligning goals, performance measurement, and accountability tools (i.e. incentives) across health care and non-health care sectors. However, inherent differences across sectors are often sizeable, creating potential challenges to implementing joint accountability. Beyond basic distinctions in scope and expertise, health care and non-health care systems often have major differences in planning, financing, and service delivery. Furthermore, varying experience with the application of performance-based accountability is likely across health care and non-health care sectors.

**States should assess the following system-level, readiness factors before deciding whether joint accountability is feasible in a specific situation:**

### SHARED UNDERSTANDING OF HEALTH CARE AND NON-HEALTH CARE CONTRIBUTIONS TO HEALTH STATUS

- › State entities considering the use of a cross-sector, joint accountability approach must have a clear understanding of how each sector contributes to population health. Research continues to expand our understanding of the origins of health, such as the social determinants, epigenetics and beyond. A clear, evidenced-based link between non-health care sector actions and population health goals must exist to ensure face validity of any joint accountability approach.
  - ›› When a shared understanding of cross-sector contributions to health status does not already exist, states should consider engaging public health leaders (e.g., within government, academia or non-profit organizations) to provide support. Tools such as the creation of evidence reviews, convening a cross-sector forum, or providing ongoing, neutral facilitation can help states and other engaged entities garner the foundational and shared understanding needed to establish joint accountability.

## ALIGNED SYSTEM GOALS

- › Commitment and buy-in to a cross-sector, joint accountability approach necessitates that identified health targets are mutually beneficial to engaged entities and aligned with each sector-specific set of goals.
  - ›› For example, Oregon's shared kindergarten readiness goal is well positioned to have evidence-based, reciprocal impact on the state's individual goals for health and education outcomes.

## CROSS-SECTOR LEADERSHIP SUPPORT

- › Cross-sector efforts are time-intensive and require the engagement and buy-in of a diverse set of actors with differing expertise and power. State leaders must demonstrate firm leadership and authentic dedication to a shared population health agenda to generate the vision and sustained commitment necessary for success. Leaders must understand, value and articulate the shared contributions of each involved sector towards reaching the shared goal. Furthermore, participating leaders must have the decision-making authority to implement accountability structures in order to drive performance improvement.
  - ›› Throughout Oregon's health and education cross-sector efforts, state agency and local leaders have repeatedly called out the importance of shared action for improving population health goals. For example, regular and public acknowledgement by state and local leaders of the importance of kindergarten readiness in achieving health system goals helped to create broad buy-in for cross-sector joint accountability efforts across the state.

## DIVERSE STAKEHOLDER ENGAGEMENT

- › While states may have the authority to mandate joint accountability, external stakeholder involvement is important for buy-in and for ensuring meaningful and effective approaches to joint measurement and accountability. Cross-sector leaders must be ready to discuss and actualize a meaningful external stakeholder engagement strategy before implementing the tools of shared measurement and joint accountability. Due to the potential scope of multi-sector stakeholder engagement, thoughtful consideration of the diversity, size and overall engagement process is necessary at the outset. To start, leaders from each sector must identify their key stakeholder groups and make decisions on scope of engagement.

Oregon's health and early learning cross-sector effort utilized a public nomination process to solicit interest for participation in the Child and Family Well-being Measures Workgroup. Decision makers from Oregon's health and education agencies and respective policy bodies chose workgroup participants based on breadth of representation from key stakeholder groups, diversity (e.g., geographic, racial, ethnic, and beyond), and capacity to participate.

### States should consider representation and engagement from stakeholder groups such as:

- ›› Organizations/provider groups to be held accountable;
- ›› Key state and local leaders and decision makers;
- ›› Health care and non-health care service providers;
- ›› Measurement/performance accountability experts;
- ›› Advocacy organizations;
- ›› Culturally-specific organizations;
- ›› Unions, if applicable;
- ›› Health, public health and social service researchers, and
- ›› Inter-related agencies/fields.

## CLEAR DECISION-MAKING PROCESSES

- › The importance of clear decision-making processes is critical when considering a cross-sector approach to performance measurement and joint accountability. Leaders must agree and clearly express how decisions will be made. Consideration must be given to the additional time that may be needed to gain approval from more than one policy or leadership body. Furthermore, representatives of each sector who have appropriate authority and content knowledge must remain actively involved throughout the process. In order to do this, each sector must:
  - ›› Identify key individuals with necessary decision-making authority;
  - ›› Develop buy-in and support for the joint accountability approach by providing education regarding the opportunity to impact shared goals and population health outcomes; and
  - ›› Identify an appropriate process, timeline and level of inclusion for decision-makers during the development of the joint accountability approach (e.g., participation on workgroup, scheduled updates, pre-identification of decision points).

# Identifying Population Health Goals for Shared Measurement and Joint Accountability

Before employing the tools of shared measurement and joint accountability, participants must identify health improvement targets that are amenable to actions across the multiple involved sectors and for which adequate evidence exists.

## Evidence Basis and Realm of Influence

To successfully drive improvements in population health through shared measurement and joint accountability, identified targets must reflect each sector's individual realm of influence. Effective interventions - which can be employed by each sector independently or through an integrated approach - must be established. For example, evidence-based approaches to improve early childhood development have been established for multiple sectors, including Reach out and Read™ (primary care), Nurse Family Partnership<sup>9</sup> (public health) and high quality child care<sup>10</sup> (early learning and education). Emerging and established evidence for effective, multi-sector interventions targeting housing security, food insecurity, and tobacco use lend these issues as additional targets for applying the tools of shared measurement and joint accountability. The following table outlines potential, collaborative efforts between health care and non-health care sectors amenable to shared measurement and joint accountability.

Table 1: Potential Collaborative Efforts Amenable to Shared Measurement and Joint Accountability

Cross-Sector Effort	Population Health Goal	Potential Agencies Involved		Example Interventions		
		Health Care	Non-Health Care Sector	Health Care	Non-Health Care Sector	Shared
<ul style="list-style-type: none"> <li>Housing and health care</li> </ul>	<ul style="list-style-type: none"> <li>Reduce chronic homelessness</li> </ul>	Medicaid agency; Medicaid health plans	State housing agency; local housing authorities	Screen for homelessness; targeted, intensive case management (e.g., for high utilizers); utilization of community health workers; improve care for complex health needs; link to housing assistance <sup>11</sup>	Assessment; intensive case management; connect high risk individuals with housing navigators; support coordinated entry system; inform policy on permanent, supportive housing solutions	Develop coordinated approach (assessment, prioritization); share data; apply trauma-informed approach; improve hand-offs between service providers
<ul style="list-style-type: none"> <li>Education and health care</li> </ul>	<ul style="list-style-type: none"> <li>Increase high school graduation rates</li> </ul>	Medicaid agency; state public employee benefits purchaser; Medicaid health plans; Qualified Health Plans; commercial plans; school-based health programs	State education agency; regional education school districts or local school districts	Adolescent SBIRT <sup>12</sup> and depression screening; chronic absenteeism identification <sup>13</sup> ; oral health assessment; coordination with school-based health clinics; institute One Key Question <sup>14</sup>	Increase capacity to identify high-risk students; implement or expand mentoring programs, credit recovery programs and/or alternative education options. <sup>15</sup>	Identify opportunities for data sharing, timely intervention, and improved coordination; employ trauma-informed care; create joint plan to address chronic absenteeism <sup>16</sup>
<ul style="list-style-type: none"> <li>Public health and health care</li> </ul>	<ul style="list-style-type: none"> <li>Reduce smoking prevalence</li> </ul>	Medicaid agency; state public employee benefits purchaser; Medicaid health plans; Qualified Health Plans; commercial plans	State public health agency; local or regional public health agencies	Identification of individuals who use tobacco; link patients to cessation support services; expand cessation benefits and eliminate barriers; adopt tobacco-free campus policies <sup>17</sup>	Support or offer cessation support services (e.g., quit line); support policies that increase: the price of tobacco, number of tobacco-free environments, or protections from second-hand smoke <sup>18</sup>	Create a cross-sector advisory committee to identify local or regional opportunities to improve tobacco cessation

# Design and Implementation of Joint Accountability

## Unique Factors for Shared Measurement

When considering the development of a shared measure set, states may wish to review a prior State Health and Value Strategies (SHVS) brief, [Considerations for State Development of Performance Measure Sets](#)<sup>19</sup> as well as the [Buying Value Measure Selection Toolkit](#)<sup>20</sup> which was recently updated with support of SHVS and the Robert Wood Johnson Foundation.

During the development of a *shared measure set* for a cross-sector, joint accountability approach to drive improvements towards a common goal, state entities should consider the following seven questions:

### 1 | Whose performance will be measured?

It is critical to be clear on exactly whose performance is being targeted at the outset of any joint accountability approach. For example, performance can be held accountable at either the organizational level (e.g., accountable care organizations), or at the provider level, or both. When applying performance-based accountability to cross-sector work, it will be necessary to consider the opportunity for how these entities can work in collaboration to improve pre-determined shared goals. Clarity on whose performance will be measured is key for informing decisions related to stakeholder participation, data sources, unit(s) of measurement and beyond.

### 2 | Who will participate in the shared measures selection process?

A combination of the necessary decision-making authority, topical and process expertise, and external stakeholders are needed to produce a set of shared measures that are effective and meaningful for joint accountability. Given the potentially large workgroup size when including such cross-sector representation, thoughtful consideration of structure and process is important. Utilization of subgroups, cross-sector staffing, and consultants should be considered to streamline and effectively implement the measurement selection process.

### 3 | What are appropriate measures for inclusion in the measure set?

A set of selection criteria should be adopted to assist in determining appropriate measures for inclusion. Care should be taken to consider previously adopted measure selection criteria, when available, to improve alignment. Example criteria commonly adopted in a measure selection process include, but are not limited to: measures are valid and reliable; measures represent opportunity for performance improvement; a national body has endorsed the measures; measures have relevant benchmarks; and measures are focused on outcomes.

### 4 | What data sources will be used?

Preferred data sources and associated technical knowledge will inevitably differ across sectors and among measure selection participants. During the development of a shared measure set, care must be taken to familiarize workgroup members with each of the key data sources and to ensure adequate expertise and knowledge are present among participants or through consultation. Measure options may be constrained by the availability or timeliness of desired data sources. Attention must be given to variations between data sources (e.g., data collection methodology, frequency, population, size) and the associated implications for use with performance measurement. Data sources that allow for stratification by race, ethnicity, gender, language and/or geography should be prioritized to allow for the identification of sub-population disparities where feasible.

## 5 | What is the appropriate unit of measurement?

For a shared measure set, unit of measurement choices may be complicated by variation in how delivery systems are organized (e.g., geographically and/or contractually). Potential trade-offs regarding unit of measurement decisions must be carefully considered, including the ability of measure(s) to reflect performance differences attributable to performance improvement, as well as ability to compare performance differences across a group, region or sector.

## 6 | What is the proper size of the shared measure set?

The potential for a particularly cumbersome data set resulting from a cross-sector process is high. Trade-offs between measure inclusivity (e.g., to meet the priorities of different stakeholders, to be representative of priority performance dimensions, etc.) and administrative or provider burden must be considered when determining measure set size. Alignment with existing, sector-specific measure sets helps streamline overall performance measurement for state agencies and providers. Balancing measures across pre-identified domains simplifies measure vetting. Ultimately, measure gaps will likely exist, as not all priority target areas will have readily available, validated measures and/or data sources. Moreover, many measures supportive of population health have a long lag-time and may not be amenable to joint accountability. Participants will need to weigh the desire for developing new and innovative measures against the constraints of time, capacity and data availability.

## 7 | Who will be responsible for analysis and reporting?

Consider the following questions when reporting performance data in a multi-sector approach:

- » Does each state entity have adequate expertise, resources and capacity to share responsibility for data analysis and performance reporting? If not, how will the work be divided and supported?
- » How will the frequency and timing of reporting be determined and aligned?
- » Is there sensitivity related to reporting any of the chosen performance measures (e.g., timing, media attention, particular policy priority)? If so, how will the sensitivities be addressed?

### Joint Accountability Considerations

Joint accountability can take various forms and will be influenced by each sector's experience with implementing performance-based accountability. While the use of performance measurement tied to financial incentives (including shared risk) is quickly becoming normative in the health care sector, such applications are less common in social services and education.

Beyond varying experience, additional factors can create challenges to buy-in for a joint accountability approach. Individuals and organizations dislike being held accountable for something for which they feel a lack of control. A state must commit resources towards facilitating collaboration amongst cross-sector entities for which joint accountability is being extended in order to develop trust, working relationships, and a means to collaboratively succeed in a joint accountability effort.

Furthermore, state leaders must decide whether performance-based accountability will be applied consistently within each sector, or whether application will differ according to the environment. If implementation varies, leaders will have to consider potential impacts on effectiveness in driving performance improvement as well as basic perceptions of fairness.<sup>21</sup> Finally, attention must be given to likely cross-sector differences in budgeting, financing and flexibility pertaining to incentive distribution. The following is a brief description of commonly used performance-based accountability tools and unique considerations for a *joint accountability* approach:

#### PUBLIC REPORTING

- » Cross-sector leadership may employ public reporting on performance measures as a tool for driving performance improvement. This tool can stimulate competition in performance among contracted providers within and across sectors, provide information for consumer-driven decision-making, and inform decisions by policy makers.

- » In Oregon, transparency regarding health system quality was identified as an important aspect of health care delivery system reform during formative community input sessions. Oregon's health system quality measurement design includes [public reporting of Coordinated Care Organizations' performance](#) against a set of state, quality metrics on a regular interval, including side-by-side comparisons across all 16 CCOs.

#### CONTRACTUAL TERMS

- › State purchasers of health and non-health services can incorporate aligned or similar expectations for performance improvement into contracts with applicable entities. Performance against these measures can be used for contract negotiation, renewal decisions, and beyond, including financial incentives and penalties.

#### FINANCIAL INCENTIVES

- › The power of economic incentives to facilitate change is well known, and state purchasers of health and non-health services can structure financial incentives in various ways. *Pay for performance* is a well-positioned model for incentivizing performance improvement in a joint accountability effort. In this approach, providers receive a bonus or "incentive" payment for performance that meets a defined target for one or more performance measures. Other models that can be adapted from use in the health care system include cross-sector *bundled payments* for health improvement activities and *shared savings* or other risk-sharing models.<sup>22</sup> For more information on considerations related to financial incentives, see the Appendix for financing questions in the Joint Accountability Toolkit.

Regardless of the chosen joint accountability approach and level of alignment, state leaders across sectors must ensure close coordination and frequent reassessment to evaluate impact and unintended consequences of the selected accountability approach or approaches. Ongoing attention to resources, capacity, communication and flexibility across engaged state entities and contractors is critical for success.

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## Conclusion

With recognition that medical services contribute a small fraction to population health outcomes - and the imperative to reduce our nation's unparalleled health care expenditures and improve health status - states need newer, better methodologies for targeting the foundations of health.

The health sector is well positioned to expand its leadership in performance-based accountability and states can thoughtfully deploy resources to drive cross-sector approaches for achieving population health goals. With clear evidence regarding the significant role of social determinants in driving health outcomes, states should expand performance measurement and accountability beyond factors controlled solely by the health care delivery system and connect with actions by non-health care sectors. Specifically, state health leaders should engage in opportunities to implement collaborative, joint accountability approaches with non-health care sectors that target meaningful, shared goals in education, housing, nutrition, and beyond.

Ultimately, state leaders must demonstrate strong political will to strategically step out of their respective silos and commit the necessary resources for cross-sector collaboration in order to collectively and positively impact population health status and health care expenditures to an extent not possible through isolated, medical-centric efforts alone.



# Appendix 1: Case Study

## Oregon's Health and Education Cross-Sector Collaboration

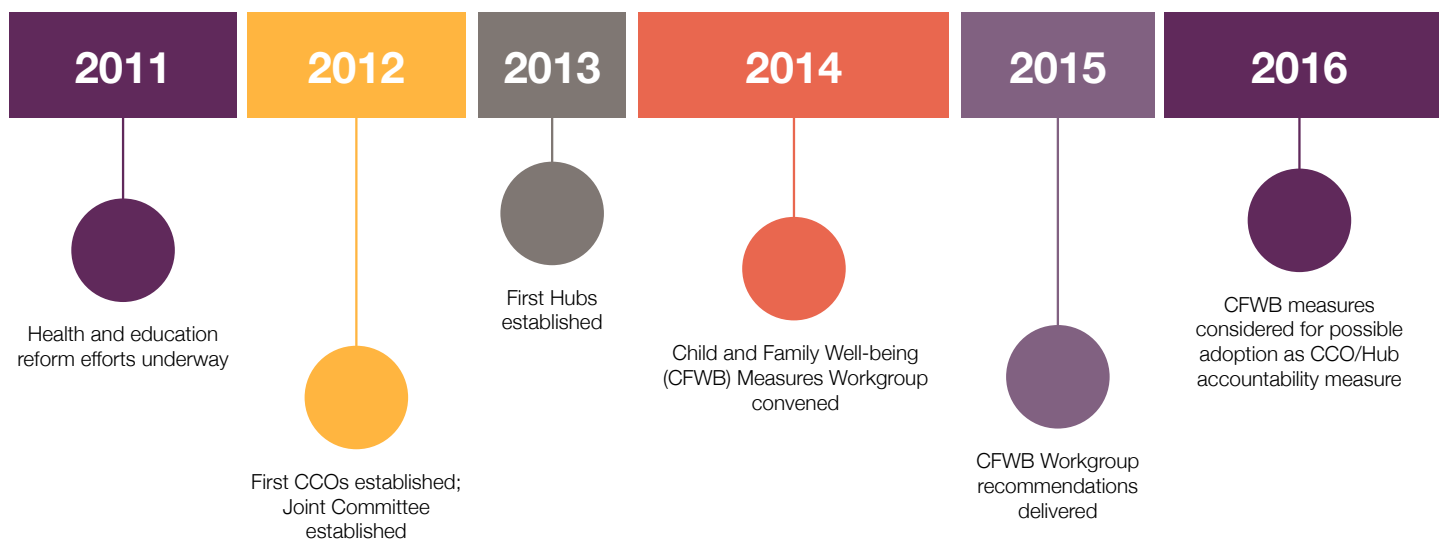
In the last five years, Oregon has undergone concurrent transformation of its health care and education systems spurred by a common history of escalating costs and inadequate outcomes. With executive and legislative support, plus federal approval of Oregon's Section 1115 Waiver Medicaid Demonstration, Oregon made significant reforms to its health care delivery system in 2012 guided by the Triple Aim<sup>23</sup> goals: better health, better care, and lower costs. An overlapping period of education reform has focused on improving Oregon's outcomes across the education spectrum from early learning to higher education.

Both transformation efforts have focused on extending flexibility and leadership to new, regional entities, while holding them accountable for expected outcomes. Within the health sector, 16 [Coordinated Care Organizations](#) (CCOs) were established by 2013 to manage the care of Medicaid beneficiaries.<sup>24</sup> CCO performance is measured against a set of quality metrics, and financial rewards are distributed for performance that meets specified targets. As part of education reform, 16 [Early Learning Hubs](#) (Hubs) were established by 2015 and are responsible for coordinating regional early learning services for children and families. Hubs are contractually responsible for generating improvement against a set of early learning state metrics. At the outset, each sector adopted an overlapping measure for developmental screening of young children<sup>25</sup> as part of their performance measure set.

With growing recognition of the impacts of early experiences on long-term health and education outcomes at the time of Oregon's reform efforts, state leaders committed support for a cross-sector, collaborative effort focused on improving kindergarten readiness. In 2012, a [Joint Committee](#) was formed including members from each of the Governor-appointed policy bodies overseeing the health and education sectors. This Joint Committee has recognized the importance of aligning measurement and accountability approaches for emerging CCOs and Hubs to drive performance improvement for actions that contribute to kindergarten readiness. In 2014, the Joint Committee convened the Child and Family Well-being Measures Workgroup to develop a shared measurement strategy that informs program planning, policy decisions, and allocations of resources.



Figure 1: Timeline of health and education reform in Oregon





## Child and Family Well-being Measures Workgroup

The [Child and Family Well-being Measures \(CFWB\) Workgroup](#)<sup>26</sup> - chosen through a joint application and nomination process - included diverse, cross-sector representation with expertise in health care, early learning, education, human services, public health and analytics. Staff who had strong experience in Oregon's cross-sector coordination efforts and performance measurement supported the workgroup. In addition, Michael Bailit and Michael Joseph of Bailit Health Purchasing, LLC, provided critical consultative support and expertise on measure set development throughout the process. Finally, well-respected community leaders within the health and early learning systems were selected to co-chair the workgroup. The CFWB Workgroup met monthly from September 2014 through September 2015.

### Setting the Foundation

Initial meetings of the CFWB workgroup focused on clarifying purpose and establishing an understanding of the workgroup's charge. The workgroup agreed on a definition of child and family well-being, adopted measure selection criteria, and isolated a set of six domains for child and family well-being to help organize their work. During these first meetings, workgroup members expanded their understanding of the shared and contrasting priorities, values and delivery system organization across each sector.

### Developing a Shared Measurement Set

Workgroup participants researched, identified and compiled potential measures of child and family well-being into a measure repository. Accountability measures already existing in state health and early learning measure sets were included to promote alignment. Workgroup members reviewed candidate measures individually to determine appropriate fit for the measure set. State staff and consultants subsequently applied measure selection criteria to determine how well candidate measures aligned. When finalizing the measure set, workgroup members took into consideration potential unit(s) of measurement, performance time period, data availability and national benchmarks for each measure.

### Final Product

The CFWB workgroup identified a total of 67 prioritized measures arranged into a readily accessible [Measure Library](#).<sup>27</sup> This library was further organized into distinct measure sets, including a *Monitoring Measure Set* of 51 measures positioned to assess and track factors that indicate or contribute to child and family well-being. In addition, three separate accountability measure sets were created to assess the performance of specific entities and hold them accountable for progress in various areas of child and family well-being. The *CCO Accountability Measure Set* includes 14 measures, the *Hub Accountability Measure Set* includes 12 measures, and the *Joint (CCO/Hub) Accountability Measure Set* includes seven measures. The majority of workgroup members articulated their belief that adoption of the joint accountability measures is the best opportunity for improving kindergarten readiness through collective action across health care and education sectors.

Figure 2: Organization of the CFWB Measure Library



Table 2: Recommended Joint CCO and Early Learning Hub Accountability Measures

1. Oregon Kindergarten Assessment: average score by domain
2. Kindergarten attendance rate
3. Rate of follow-up to Early Intervention after referral
4. Percentage of children less than 4 years of age on Medicaid who received preventive dental services from a dental provider in the year
5. Percentage of children ages 3 to 6 who had one or more well-child visits with a primary care provider (PCP) during the year
6. Percentage of children who received developmental screening by 36 months
7. Among children and youth with special health care needs (CYSHCN) who needed specialized services, the percentage who received all needed care

## Lessons Learned: Oregon’s Joint Accountability Pursuit

Oregon’s CFWB workgroup experience confirmed that cross-sector measure set development is complex and time-consuming, but yields an important opportunity for impact. Rectifying differences in language, technical expertise, and delivery system nuances were easily managed. Most challenging to the CFWB work was the lack of available, valid measures for all of the prioritized targets within child and family well-being. The workgroup grappled with the desire to create innovative and transformative measures while noting the urgency of implementation and limited resources for new measure development.

State-level implementation of joint accountability for CFWB measures has been impacted by multiple factors, including but not limited to: changing leadership, urgency of new priorities, agency work capacity, and limited infrastructure for sustaining cross-sector collaboration. Additional implementation challenges related to joint accountability have resulted from differing organizational structures and resources across Hubs and CCOs, as well as differing capabilities related to data collection and data sharing. While the Joint Committee ultimately endorsed the CFWB workgroup recommendations, the intended application of the shared measures through joint accountability has not yet been fully realized.

Despite these challenges, the CFWB measures library continues to provide an active resource for state and local decision-making regarding child and family well-being measurement. Furthermore, workgroup members - and watchful stakeholders - have remained committed to the importance of addressing kindergarten readiness through coordinated efforts. Momentum gained by these activities continues to echo throughout state and local level activities, and consideration of the CFWB joint accountability measures by the Metrics and Scoring Committee and the 2017 Health Plan Quality Metrics Committee<sup>28</sup> is expected.

The achievement of joint accountability to drive cross-sector performance towards a common goal is hard and slow going, but the opportunity for significant pay-off is great. Start with efforts to jointly measure results, supported by cross-sector dialogue to reach a common understanding of definitions, terms and priority targets. Ultimately, this type of collaborative process will pave the way for meaningful execution of joint accountability that achieves population health outcomes not attainable through isolated performance measurement efforts alone.

# Appendix 2: Shared Measurement and Joint Accountability Toolkit

## How to Use this Toolkit

This document - including key questions and customizable templates - is provided as a guide to help states 1) assess readiness and 2) develop a shared measurement and joint accountability approach across health care and non-health care sectors. Health agency leaders and their partner agencies will need to answer these questions through a collaborative process in order to identify opportunities for realizing shared goals.

### SECTION 1 | Assessing readiness for joint accountability

#### Landscape

WHICH SECTORS ARE BEST POSITIONED TO ENGAGE IN A CROSS-SECTOR, JOINT ACCOUNTABILITY APPROACH IN ORDER TO IMPROVE POPULATION HEALTH OUTCOMES?

- Is there a clear and shared understanding of how each sector contributes to an identified, shared goal?
- Do each sector’s overall goals align in such a way that joint accountability tools can produce mutually beneficial results?
- Do the leaders and decision-makers within each sector demonstrate understanding and support for a joint accountability agenda?

#### Planning

HAVE KEY DECISION-MAKERS AND STAKEHOLDERS BEEN APPROPRIATELY ENGAGED DURING THE DEVELOPMENT OF THE JOINT ACCOUNTABILITY APPROACH?

- Have the key stakeholders across each sector been identified and engaged for soliciting input and buy-in for a joint accountability approach?
- Has agreement been reached regarding how decisions will be made? Has the decision-making process been clearly articulated?
- Is there a plan for how decision makers will remain involved in developing the joint accountability approach?

This table can help to identify potential stakeholders to engage when planning a joint accountability approach.

Example Stakeholder Groups	Health Care Sector	Non-Health Care Sector
<b>Organizations/providers groups to be held accountable</b>		
<b>Key state and local leaders and decision makers</b>		
Service providers		
<b>Measurement and performance accountability experts</b>		
Advocacy organizations		
<b>Culturally-specific organizations</b>		
Unions (if applicable)		
<b>Health, public health and social service researchers</b>		
Inter-related agencies and fields		

## Goal-Setting

CAN APPROPRIATE, CROSS-SECTOR IMPROVEMENT TARGETS FOR POPULATION HEALTH BE IDENTIFIED?

- Do the identified improvement targets reflect each sector's individual realm of influence?
- Do evidence-based interventions (e.g., sector-specific or cross-sector) exist that can be adopted or improved upon for addressing the identified improvement targets?

This table can help organize potential cross-sector targets for a joint accountability approach.

Sectors	Aligned Goals	Leadership Support (e.g., strong, weak, etc.)	Key Stakeholders (e.g., identification and buy-in)	Shared Population Health Targets	Realm of Influence (e.g., strong, weak, etc.)
Health Care					
Non-Health Care (e.g., housing)					

## SECTION 2 | Developing a shared measure set.

### Big Picture

- Whose performance will be measured?
- Who will participate in the shared measures selection process (e.g., staff, stakeholders, experts, decision makers)?
- How will the group be organized (e.g., chairpersons, subgroups)?
- What measure selection criteria will be used? How will decisions be made?
- What data sources will be used?
- What is the appropriate unit of measurement?
- What is the proper size of the shared measure set?
- How often will measurement occur?
- Who will be responsible for analysis and reporting?

### Organizing The Work

This table can be used for organizing potential measures and documenting appropriateness for joint accountability.

Measure	Data Source	Frequency of Measurement	Used By	Data Steward	Benchmark	Appropriate Level of Accountability		
						Health Care Sector	Non-Health Care Sector	Joint

For more information regarding the development of a shared measure set, states should review the prior State Health and Value Strategies brief, [Considerations for State Development of Performance Measure Sets](#).

### SECTION 3 | Defining the joint accountability approach.

Use this table to consider existing and potential applications of joint accountability and determine best approach.

Sector	Accountable Entity (e.g., public agency, MCO, provider, etc.)	Accountability Levers (e.g., reporting, contracting, financial incentives)	Expected Effect on Target Behavior	Areas of Alignment
Health Care	1.	A.	a.	
	2.	B.	b.	
	3.	C.	c.	
Non-Health Care	1.	A.	a.	
	2.	B.	b.	
	3.	C.	c.	

### SECTION 4 | Selecting a joint accountability strategy.

States can organize their chosen, joint accountability strategy to drive improvement in population health status using the following table.

#### Cross-Sector Goal

Shared Measures	Accountability Lever Applied		Financing*			
	Health Care Sector	Non-Health Care Sector	Unified	Sector-Specific	Blended	Braided
Performance measure 1:						
Performance measure 2:						
Performance measure 3:						

**\*Blended financing**<sup>29</sup> refers to the mixing of funds from different sources into one pool; costs do not have to be allocated and tracked by funding source. **Braided financing**<sup>30</sup> refers to the use of multiple funding sources for payment; tracking and accountability must be maintained at the administrative level.

STATES CAN UTILIZE THE FOLLOWING QUESTIONS TO DEVELOP AN APPROACH TO FINANCING AND THE USE OF INCENTIVES:

- How will incentives be financed?<sup>31</sup> Will there be separate, sector-specific sources, unified financing (i.e. state general fund specifically allocated for cross-sector work), or pooled financing (e.g., blended or braided)?
- If federal funding mechanisms are incorporated, how will associated regulations impact the approach?
- How will incentives be structured (i.e. how will funds be allocated)? Will they be structured the same or differently across sectors?
- If financial incentives are structured differently across sectors, how will this effect relationships and the intended collective action towards population health goals?

The development of a sustainable infrastructure to support ongoing, cross-sector collaboration is critical. Following implementation of a joint accountability approach, cross-sector state leaders and staff must ensure close coordination and frequent reassessment to evaluate impact and unintended consequences. Attention must be given to resources, capacity, communication and flexibility to ensure meaningful and sustainable impact on identified population health goals.

## Endnotes

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14. See <http://www.onekeyquestion.org>.
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21. In Oregon, differing accountability for improvement on a shared measure for developmental screening across the Medicaid system (where performance improvement is tied to financial incentives) and the early learning system (where performance improvement is contractually obligated but not tied directly to financial incentives) has created some provider frustration and negative impact on cross-sector relationships.
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