Public Health Solutions
40 Worth Street, 5th Floor
New York, NY 10013-2988
646-619-6400

INTEGRATING HUMAN SERVICES AND CLINICAL SERVICES WITH CLIENTS AT THE CENTER

A Three-Part Symposium Series Hosted by Public Health Solutions (PHS)

Part One Summary

On November 13, 2020, more than 50 leading experts from community-based organizations, government, healthcare, health systems and corporations convened for Public Health Solutions' Symposium **Integrating Human Services and Clinical Services with Clients at the Center** to inform the design of a new framework, including core components of a client-centered infrastructure, to effectively address social determinants of health towards achieving health equity in New York City. The Symposium is the first in a three-part series. Following is a summary of the issues and key discussion outcomes from the symposium's breakout sessions

Introduction

Over the past several years, the health care industry has been buzzing about social determinants of health (SDOH) – the conditions in which people are born, grow, live, work and age – that have a major impact on health outcomes, care quality, and medical costs. It has been widely understood that better coordination and investment in these non-clinical drivers of health can improve health and decrease health care costs.

Hospitals are increasingly incentivized to lower costs by reducing hospital visits, and a healthier population can help accomplish this goal. However, despite potential savings and improved health results, the industry is still in the early stages of meaningfully addressing SDOH due to a host of complex challenges.

When New York City became the epicenter of the COVID-19 pandemic in the United States, it upended everyone's lives. In the aftermath of the pandemic, both the health care system and the landscape of social services in the United States have been permanently changed.

This is a crossroad moment for change. With deepening food insecurity, increasing housing instability, slow job recovery, and the replacement of many in-person health services with telehealth services, the need for a truly collaborative solution is more urgent than ever. New York needs a solution that provides a sustainable and coordinated approach to delivering care, bridges communities and systems of care, and centers around a person's holistic needs.

Public Health Solutions
40 Worth Street, 5th Floor
New York, NY 10013-2988
646-619-6400

Problems

Although there has been significant progress in recognizing and addressing SDOH, many challenges remain:

1. **Closed Loop Referrals:** In the absence of a perfect world where all our systems work seamlessly together, the ability to close referral loops becomes an integral part of a SDOH solution and is currently one of our biggest problems. A truly closed-loop referral means that a service provider is able to assess and identify the most appropriate resource from multiple options, ensure that the patient is in agreement, schedule the engagement, ensure that the referral happens, and have some form of response back to show that the engagement happened and indicate whether or not the person's unmet needs were resolved. Closed-loop referrals offer an often-overlooked capability for the referral process to originate in a health care setting but shift to a community-based organization or collaborative for ongoing support, with the care team being able to follow the referral through the process and other redirects that may occur. Without this capability, the person is likely to have to return to the heath care setting for resolution. Closed-loop referrals are more than a one-way, one-and-done process. Successful implementation depends on the successful engagement of organizations that will be part of the system.

2. **Fragmented and Siloed Care Coordination:** Silos between health and social service organizations prevent the exchange of information and data about available services, and unmet needs and costs, leading to fragmented care system that is difficult to navigate. Over the years, both health and social service organizations have developed a greater understanding of the implications of a fragmented care system. For patients, it poses significant risks to their health, while for health organizations, it results in higher costs. Successful SDOH programs require relationships between health and social service organizations. The ability to refer patients to nonclinical services and to share data between those organizations is a critical part of addressing non-medical needs, but many providers have few or no formal partnerships in place. A coordinated system of care would mean that health and social service organizations are all working together and maintaining clear channels of communication to deliver appropriate and consistent care.

3. **Lack of Connections Across Multiple Data Systems:** Community-based organizations often enter data across multiple systems to satisfy funder requirements and conform to the limitation of their own and funders' systems. This means that excess time is spent on administrative tasks and data is fragmented at both client and organization levels. With multiple organizations meeting many different mandates across myriad systems, it's that much more challenging to connect across organizations to share individual and

Public Health Solutions
40 Worth Street, 5th Floor
New York, NY 10013-2988
646-619-6400

community needs which could be better addressed by another organization or ones that could be shared collectively.

4. **Lack of Standardization in Data Collection:** The type of data collected varies widely as well. Today there are a diverse array of definitions and terms for the various categories and metrics of SDOH data. The differences in how providers collect data, however, could include different definitions, metadata, and measurement. Also, a wide variety of screening tools are currently used in clinical settings to capture SDOH data. Without a standardized screening tool, this data lacks an interoperable set of fields leading to data sharing challenges. Many providers even lack the time and resources to draw meaningful, actionable conclusions from SDOH data they have.

5. **Poor Data Sharing and Completeness:** There are data gaps at each phase of the data collection lifecycle, from population level data that does not include key SDOH variables, to a community-based organization (CBO) that cannot report the outputs and impact of a key social intervention. All stakeholders face major challenges in accessing rich, complete data to build out deeper applications and subsequent interventions. Health Information Exchanges have provided opportunities for health systems to track patients across a care continuum with other participating providers; but their uptake has been limited due to competing IT demands and limited resources. The concept of the Community Information Exchange has gained momentum in recent years as a promising way forward to paint a more complete picture of patient circumstances. However, a lack of standardization and interoperability issues remain hurdles to overcome.

6. **Lack of Financial Alignment:** Despite the growth and ability to gather SDOH data, there is still little financial alignment across the health care sector. While some SDOH data may be included in a patient's electronic health records, much of this data is not included due to inconsistencies around medical billing codes, payer models, and the lack of follow-up with CBOs. The growth of value-based care has been a promising start to increase the use of SDOH data, but there is still more needed to be done.

Public Health Solutions
40 Worth Street, 5th Floor
New York, NY 10013-2988
646-619-6400

Breakout Sessions

The Symposium hosted three breakout sessions to gain insights on pertinent topics. Here are some key discussion points and takeaways:

Session 1: "Building Integrated Human Services Infrastructure: CBO Capacity, Gaps in Human and Clinical Services Integration, and Accountability"

- Funding is not getting to where it is most needed. Funding for addressing SDOH often lands in the hands of the health care sector and not the nonprofit service sector. While the COVID-19 pandemic had a disproportionately higher impact on medically and socially at-risk populations and the need among under resourced communities increased, community-based organizations faced dwindling funds and resources – to the point where many have struggled to survive. Meanwhile, there is a growing demand for funders to award less-restrictive funds to CBOs in the future to help CBOs stay flexible and functional for the months moving forward. While examples such as the CARES Act authorized funding to provide loans to aid small business, it lacked specific guidance for nonprofits that have unique financial and operational needs. Future federal packages must consider other ways to better support the non-profit service sector longer-term. Adequate funding mechanisms and collaborative strategies would allow for more services to be delivered at a time when the demand is critically high.

- Government needs to be at the center of the SDOH conversations. The federal government can and should play an important role in educating and closing the gaps when addressing social determinants of health in this community. Governmental agencies are needed to coordinate and align the various sectors and organizations in the pursuit of establishing a long-term infrastructure and model. By facilitating participation in these conversations, policymakers can make tackling health equity a priority and ensure its inclusion in future policy changes and funding allocations.

Session 2: "Reaching High-Need Populations: Innovations, Partnerships, and Community Driven Solutions"

- COVID-19 introduced new opportunities for CBOs to expand their scope of service delivery options and develop new ways of identifying client's needs. The COVID-19 pandemic has demonstrated stark social and economic inequalities, with vulnerable and marginalized groups being disproportionately affected. As state and local governments assembled COVID-19 response and recovery plans, CBOs have used this time to leverage their existing partners and diversify their methods of reaching New York City's most vulnerable populations. In anticipation of the next COVID-19 peak, it is important to consider how

Public Health Solutions
40 Worth Street, 5th Floor
New York, NY 10013-2988
646-619-6400

these organizations can continue to expand their own capacity. CBOs may want to identify community partners with whom they can work closely and track additional ways to address the needs of their target populations and communities.

- Technology has created innovative ways of reaching high-need populations. However, there are still gaps that exist as many individuals in need do not have adequate access to technology services. The COVID-19 pandemic upended the traditional face-to-face interaction between a provider and patient. Digital technologies are being harnessed to support public-health response to COVID-19 in New York City. Innovations like telehealth services have magnified the ability to treat patients remotely and improve disease management through remote monitoring programs. Virtual instruction and distance learning have allowed students across the city to compensate for logistical challenges and health concerns. Information sharing with other CBOs has helped these entities more easily reach their clients and understand their range of needs. As New York City continues to navigate its way through the pandemic, there are still risks that must be considered for virtual services to be a vital and sustainable component of health care service delivery. Access to telemedicine may be particularly difficult for low-income and homeless individuals who may have limited access to internet services or other technology platforms. As such, these individuals are at risk for inadequate or poor care delivery services. Without creating solutions to these gaps, low-income individuals will continue to be systematically disenfranchised by the health care sector and encounter further challenges in the upcoming months.

- Stakeholders and organizations must have a continued commitment to reaching high-need populations. There is growing recognition that truly creating a sustainable public health infrastructure requires partnership and breaking down silos amongst health care, social services, and public health sectors. Amid ongoing multisector work at the state and local level, continuing to have similar "virtual" conversations is extremely important moving forward. This necessary action creates additional opportunity to collaborate, create awareness, and strategize ways to reach high-need populations.

Session 3: "Technology's Role in Creating an Integrated Public Health Infrastructure: Challenges and Opportunities"

- While there is a common understanding that the federal government sector must be a part of these conversations, knowing where the initiation of change comes from first is still a bit unclear. To date, successful alignment of human and health services has been achieved through human capital-intensive approaches to data analytics, involving unstructured and inconsistent information exchange between the two domains. The information technology systems are marked by an absence of interoperability that has significantly impacted CBOs' ability to adequately address SDOH. Policymakers must develop standards and systems that will facilitate improved information sharing and interoperability. By identifying and

Public Health Solutions
40 Worth Street, 5th Floor
New York, NY 10013-2988
646-619-6400

deploying polices and resources, CBOs and healthcare systems can work simultaneously to build a stronger base that will support the integration of this data.

- Large investments of federal resources and funding have already spurred the digitization of healthcare. However, the social services sector has not benefitted from the same resources or budget allocations which leave them behind in this digital age. CBOs are currently dealing with more than 5 different systems and hospitals that demand the usage of their own information systems, which CBOs do not necessarily have the bandwidth for. To overcome these challenges, achieving a fully integrated public health infrastructure requires the coordination of information, people and services across organizations and sectors. With this said, the value of advanced analytic approaches in driving efficient social resource delivery will depend on the quality and comprehensiveness of the already available data. Leveraging entities like RHIOs may be a good place to start in order to ensure secure and vital access to patient's health information across the two domains.

- Two models that leaders of the social sector and health sector must look towards as a model for change are the Oregon models and North Carolina models. The Oregon coordinated care model, follows a bottom-up approach, and was first implemented in coordinated care organizations. These organizations work together in their communities to serve people under one budget and hold accountability for population health outcomes. In comparison, North Carolina follows a top-down approach and is currently implementing unique steps to make major shifts towards a value-based healthcare payment model. This effort will be driven by the federal government in order to supplement programs and initiatives that address social risk factors and poor health outcomes. While both models have their own respective risk and benefits, New York can use these as examples for sustainable deployment of their own healthcare services.