Partnership
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A National Learning
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Meeting the Administration's Call-to-Action: *Leading Practices to Address Health-Related Social Needs in Communities Across the Nation*

February 27, 2024 | Noon-1:00 p.m. ET

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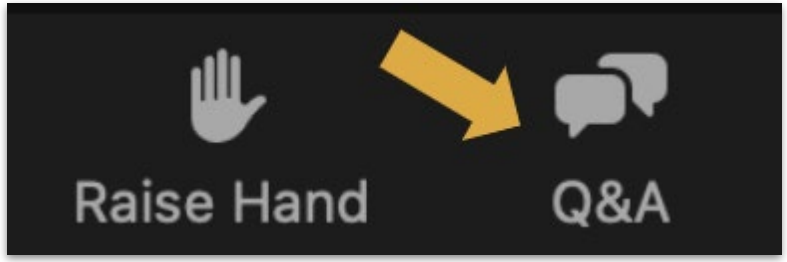
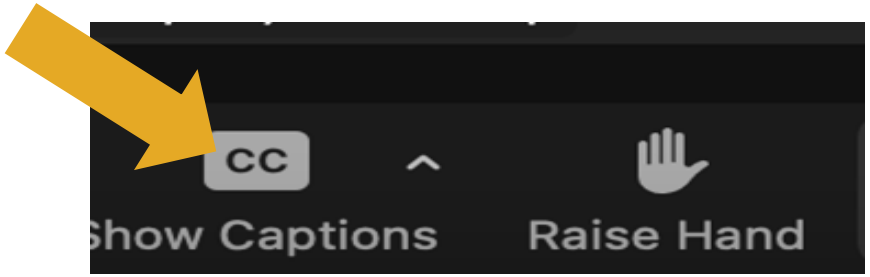
Administrative Notes

- ✓ This webinar is being recorded. The recording, slides, and follow-up material will be shared with all registrants
- ✓ Please use the Q&A tab at the bottom of your screen and we'll try address a couple of questions at the end of the presentation. We will also send a survey to capture questions.
- ✓ Closed captions are provided for this session, can also click "Show Captions" to display automated captions





Meeting the Administration's Call-to-Action:

Leading Practices to Address Health-Related Social Needs in Communities Across the Nation

Moderated by Partnership Co-Chairs:

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President & CEO,
Partners in Care Foundation

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Mission:

To enable successful **partnerships** and contracts **between health care and community care networks** to **create** efficient and sustainable **ecosystems** needed to provide **individuals with holistic, person-centered social care** that demonstrates cultural humility.

Vision:

A **sustainably resourced, community-centered social care delivery system** that is **inclusive** of all populations and **empowered by shared governance** and financing, multistakeholder accountability, and federal/state/local policy levers.

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Implementing Co-Designed Social Care Delivery System Changes

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A View From the Administration

Nancy DeLew

Associate Deputy Assistant Secretary for Health Policy, HHS Office of the Assistant Secretary for Planning & Evaluation (ASPE)

Dr. Aditi Mallick

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Leading Practices to Address Health Related Social Needs in Communities Across the Nation

HHS Call to Action

February 27, 2024

U.S. Department of Health and Human Services

What are SDOH and HRSNs?

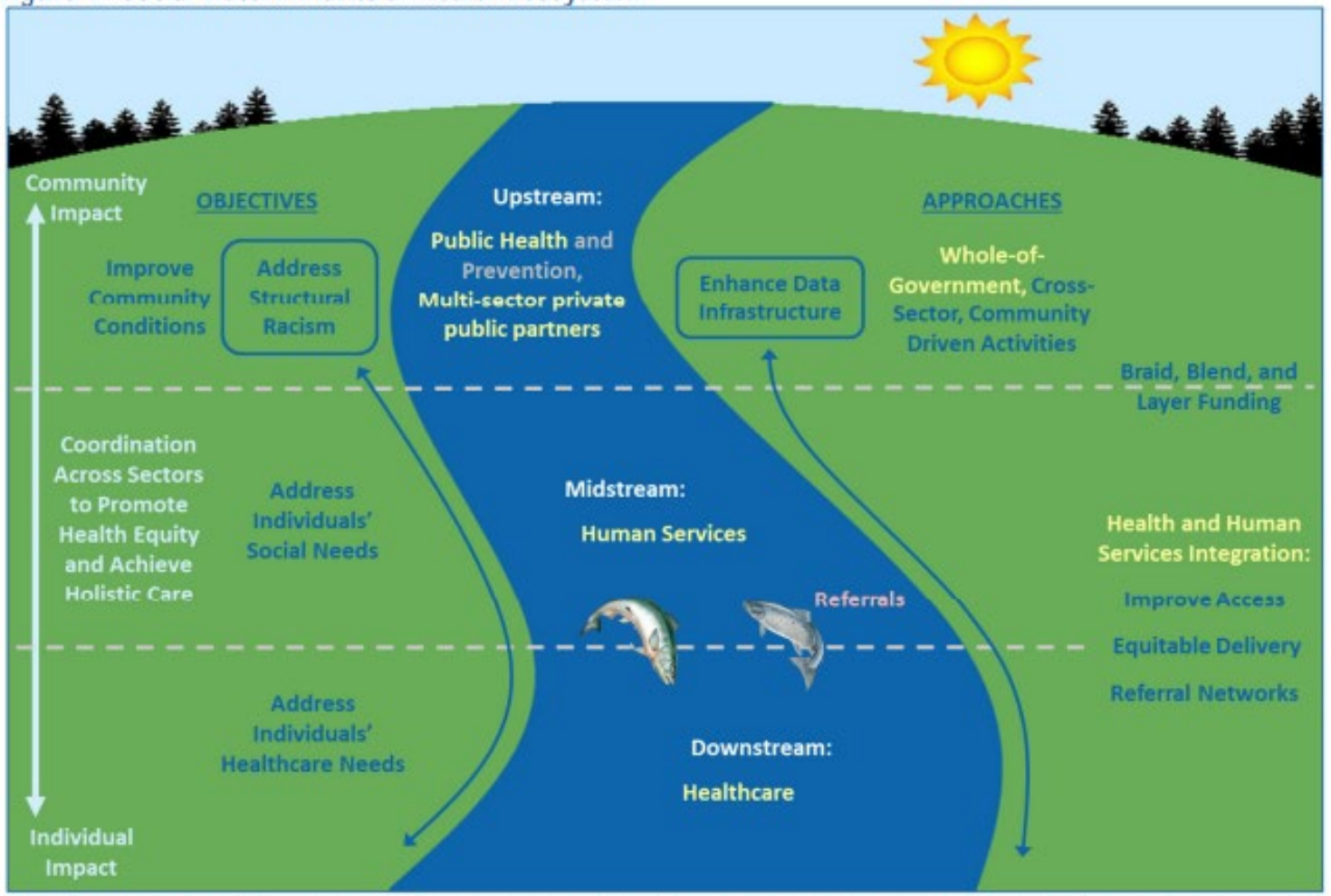
HHS defines SDOH as:
"…the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."

These community-level social factors influence a variety of individual health-related social needs (HRSNs) such as:

- Financial strain
- Housing stability
- Food security
- Access to transportation
- Educational opportunities

Social Determinants of Health Ecosystem

Figure 1. Social Determinants of Health Ecosystem



Note: Adapted from Castrucci B, Auerbach J. Meeting Individual Social Needs Falls Short of Addressing Social Determinants of Health. Health Affairs Blog. January 16, 2019

U.S. Playbook to Address Social Determinants of Health

Purpose: Highlight a set of exemplary actions under three main pillars that federal agencies are undertaking to support health by improving the social circumstances of individuals and communities.

Pillar 1: Expand Data Gathering and Sharing. The Administration is advancing data collection and interoperability among health care, public health, social care services, and other data systems to better address SDOH with federal, state, local, tribal, and territorial support.

- **Pillar 2: Support Flexible Funding to Address Social Needs.** The Administration has been working to identify how flexible use of funds could align investments across sectors to finance community infrastructure, offer grants to empower communities to address HRSNs, and encourage coordinated use of resources to improve health outcomes.

- **Pillar 3: Support Community Backbone Organizations.** The Administration is supporting the development of community backbone organizations and other infrastructure to link health care systems to community-based organizations. The Administration will distribute new grants to enhance emerging and existing backbone organizations and continue ongoing programs that bolster entities providing housing assistance, food access, free or low-cost legal resources, environmental justice resources, and more.

HHS Call to Action

- **Motivation**
  - Given research showing SDOH accounts for about half of variation in health outcomes, HHS is moving with urgency to advance a series of new policies, as well as funding and training opportunities, to address SDOH and HRSNs.
- **Vision**
  - We envision a future in which everyone, regardless of their social circumstances, has access to aligned health and social care systems that achieve equitable outcomes through high-quality, affordable, person-centered care.
- **Purpose**
  - Call to Action intended to catalyze cross-sector partnerships to facilitate enhanced coordination between health and social care providers through shared decision making and by leveraging community resources.

HHS Call to Action:

Addressing Health-Related Social Needs in Communities Across the Nation

Example Actions

- **Community-Based Organizations:** Develop and/or expand capacity to serve as a Community Care Hub and/or participate as a partner organization in a CBO network led by a Hub organization.
- **Health Systems and Clinicians:** Engage community partners on needs assessments and in shared decision making, enlist the expertise of backbone organizations such as Community Care Hubs, and consistently identify patients with HRSNs and connect them with community resources.
- **Payers:** Consider covering and paying for allowable services, incentivize health care providers to screen and refer patients for HRSNs, and establish partnerships with backbone organizations.
- **Public Health Departments:** Leverage community health assessments and multi-sector partnerships, forge relationships with backbone organizations, and support the health care sector's work on SDOH and HRSNs through public health's population health expertise.
- **Health Information Technology:** Partner with other sectors in planning and implementing interoperable, community- and person-centric approaches to electronic social care referrals and care coordination, and adopt and advance the use of open data standards.

Community Care Hub Conceptual Model*

Funding Sources

Including federal, state, local, philanthropic, and private funds

Community health workers may serve an important role in making connections between the various steps in this diagram.

Health IT is an enabling tool for the functions outlined in this visual model that should be used in a coordinated and equitable manner.

Community Care Hub

Community Care Hub coordinates administration functions, funding, and operational infrastructure, including enabling health care contracting on behalf of a wider network of community-based organizations (CBOs) to align care and track outcomes to inform quality improvement and contractual requirements.

1. Presentation

Individual engages a health care provider, school, CBO, or public health or other government agency.

2. Screening

Individual is screened for social and/or medical needs and social and/or medical needs information is collected.

3. Connection

Individual is connected to social or medical service provider.

4. Service Provision

Referred provider engages individual, identifies applicable funding sources, and provides relevant services.

5. Referral Feedback

Referred provider communicates to referring entity to create a feedback loop.

6. Tracking Outcomes

Providers track outcomes and share them with hub to improve service delivery.

*Conceptual model is evolving and may differ between communities. In practice, individuals may not move through this model in a linear fashion.

Recent CMS Actions To Address Health-Related Social Needs

Pillar 2: Support Flexible Funding to Address Social Needs

- Community Health Integration and Principal Illness Navigation services
- Social determinants of health risk assessments add-on payment
- Telehealth flexibilities for health and well-being coaching services (temporary) and SDOH Risk Assessment (permanent)
- Medicaid flexibilities to address HRSN:
  - Section 1115 demonstrations in certain states (Arizona, Arkansas, California, Massachusetts, New Jersey, New York, Oregon, Washington)
  - Medicaid managed care programs through "in lieu of" services
  - Housing and nutrition supports provided under home and community-based services (HCBS) authorities
- Medicare Shared Savings Program Advance Investment Payments to build infrastructure and capacity to address SDOH, particularly in underserved and rural areas.

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Panel Discussion

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How to Get Involved in the Partnership…

- Sign up for our email list: https://www.partnership2asc.org/sign-up/

- Follow the Partnership on social media:

www.linkedin.com/company/partnership-to-align-social-care

@partnership2asc

- Reach out directly to:
  - ✓ *Support the Partnership*
  - ✓ *Ask about getting involved in leadership/workgroup activities*
  - ✓ *Share your expertise/experiences*

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