Integrating Health Care and Social Services: Moving from Concept to Practice

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IN THIS BRIEF

- ✓ Policymakers need to bridge the gap between social services and health care delivery because social factors – economic stability, housing, education, relationships, neighborhood, and other environmental influences – impact individual's health status.
- ✓ Efforts that stop with health care delivery miss opportunities to make significant improvements for individuals, particularly the most vulnerable, and their communities.
- ✓ There are practical approaches that state agencies might employ to better integrate social services and health care delivery. Practical approaches for state agencies to better integrate social services and health care delivery include six strategies ranging from shared governance structures to procurement efforts.
- ✓ California, Michigan, Minnesota, Oregon, Washington, Vermont, and Virginia all have lessons to share.

Introduction

Efforts to improve health care that typically stop at hospital, physician, or health plan responsibilities miss opportunities to make significant improvements in both individual and population health. Growing recognition of the role that social factors play in the health status of individuals[1] has heightened attention to the connection between health and social services, particularly for vulnerable populations. Social determinants of health (SDOH) may include factors such as an individual's economic stability, housing, education, relationships, neighborhood, and other environmental influences.[2]

Today, more state health care purchasers, health plans, and health care providers are seeking to establish strong partnerships with social service agencies in a concerted effort to integrate and enhance service delivery, reduce costs, and improve individual and population health. This brief examines practical approaches that state agencies might employ to better integrate social services and health care delivery.

While the scope and design of social services varies across states and localities, social services commonly address the following needs:

Economic supports to assist people in meeting basic needs such as housing and food, and to help individuals in obtaining and maintaining employment.

Early childhood development and learning programs.

Preventing, detecting, and addressing abuse and neglect of children and adults.

SIX POTENTIAL INTEGRATION STRATEGIES

- Shared Governance
- Financing and Payment Models
- Integrated Assessments and Care Teams
- Data Linkages
- Procurement and Grant Funding Efforts
- Performance and Quality Metrics

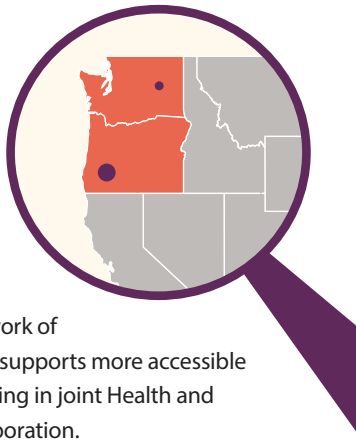
Social Services Integration Strategies

This brief describes the following **six potential integration strategies** that state agencies might employ to better integrate social services and health care delivery.

These integration strategies are not mutually exclusive. Many state approaches to integrate health care and social services employ more than one strategy.

STRATEGY 1 | Shared Governance

One integration strategy available to state purchasers is to **include both health care and social services organizations** in a shared governance approach. A shared governance structure with representation from a cross-section of decision makers and stakeholders can help bridge disparate policy and service delivery structures across state and local agencies – and between health and social service systems. Shared governance structures also offer a means of deepening relationships between state and regional organizations over time and of aligning state and local efforts to integrate the delivery of health and social services.



OREGON

- **Oregon has a Joint Subcommittee of members from the Oregon Health Policy Board and the state's Early Learning Council.** The Subcommittee's purpose is to develop a shared policy framework and a timeline to ensure integration of the State's health and early learning systems. The Subcommittee established a regional governance structure that aligns work of the state's Medicaid Coordinated Care Organizations (CCOs) with a network of regional Early Learning Hubs. The Hubs' goal is to make educational supports more accessible for underserved children and families. CCOs and Hubs are participating in joint Health and Early Learning Forums to identify and act on opportunities for collaboration.

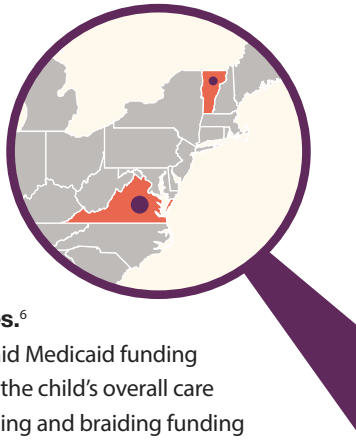
WASHINGTON STATE

- **Washington State provides financial support and technical assistance to nine regional Accountable Communities of Health (ACHs), which are multi-sector coalitions that aim to improve the health of their regions.** A key component of the ACH model is balanced engagement from community partners, including health care, public health, and social service providers. The state has tasked ACHs with assessing community population health needs, setting regional goals, and creating closer linkages between health and community-based social services providers to achieve regional aims. All nine ACHs include social services or human services organizations as members, alongside representation from health systems providers. Some ACHs have designated seats for housing, others for food systems and transportation representatives; many ACHs include local Area Agency on Aging representatives, and others include first responders. Early on the state spelled out its expectation that state Medicaid managed care organizations would serve as members on ACH governing boards, and, in fact, all ACHs include such representation on their boards.[3]

SHARED GOVERNANCE OPPORTUNITY IN ACTION

In October 2016, CMS sent Washington a letter outlining their agreement in principle on the proposed 1115 demonstration waiver for up to $1.125 billion for Delivery System Reform Incentive Payment (DSRIP) projects, and giving ACHs a key role in developing and implementing these projects. ACHs and their partners will be eligible for incentive payments if they meet milestones and achieve outcomes envisioned for the DSRIP projects. [4]

STRATEGY 2 | Financing and Payment Models



Traditional funding silos at the federal, state and local levels have constrained integration of financing for health care and social service initiatives. **Several financing approaches can help states achieve greater integration of health and social services.** Blended and braided funding are two financing strategies that enable states to drive integration of physical health services delivery with social services available from local community organizations. Blended funding merges individual sources into a single funding stream whereby costs do not need to be tracked by funding source. Braided funding coordinates separate funding streams, but maintains separate accountability for each stream.[5]

VIRGINIA

- **Under the Children's Services Act (CSA), Virginia has over 20 years' experience blending funding streams from Departments of Social Services, Juvenile Justice, Education and Mental Health to better meet health-related social needs of low-income and at-risk children and families.**[6] In addition, local Family Assessment and Planning Teams (FAPT) "braid Medicaid funding for eligible children with other available funding sources to support the child's overall care plan."[7] A recent NASHP brief examined Virginia's experience in blending and braiding funding streams as a potential template for other states.

VERMONT

- **Vermont's Integrated Family Services (IFS) initiative pools state funding for children's mental health services to support high-need children and their families by giving local agencies in two regions flexibility to deliver a holistic set of services – including non-medical services that influence health status.** The IFS model gives local authorities control over children's mental health funding streams that were previously disbursed separately by nearly a dozen divisions within five departments at the state's Agency of Human Services.[8] The pooling of mental health dollars under the IFS initiative is supplying ideas and encouragement as the agency considers a similar approach for additional programs.

SOCIAL SERVICES INTEGRATION: CASE STUDY

Vermont's Integrating Family Services Initiative

In 2010, Vermont launched an Integrating Family Services (IFS) initiative to pool funding streams for children's mental health services.[i] The model is being piloted in two regions (Addison County and Franklin/Grand Isle Counties) and allows for more flexible use of funds for children's mental health services that previously had been disbursed across five departments and over eleven different divisions of the Vermont Agency of Human Services (AHS). The IFS initiative uses a blended funding model to ensure holistic and accountable planning and service delivery at the local level. In 2014, AHS estimated that funding (exclusive of medical services) available for the initiative was approximately $145 million.

Under the IFS initiative, AHS provides a case rate payment to the two regions, which essentially operates as an aggregate annual cap or budget for the program. The aggregate annual cap is set based on historical caseload. Within that budget, the two regions must make decisions regarding the allocation of resources, balancing when and where to disburse funds against competing priorities, including early intervention and prevention services, services for families with high needs, and services required by statute. The two regions also have flexibility to deliver community-based social services and non-medical services that influence health status.[ii] "The focus is now on outcomes and quality of services instead of how many services are provided," explains AHS' Susan Bartlett.[iii]

AHS has put into place agreements with the two regions, which serve to both streamline previous reporting requirements, and to specify quality monitoring and oversight expectations. At the local level, the two regions have developed their own agreements that specify collaborative leadership and decision making, the roles of providers, and service priorities for the regions. While a formal evaluation of the program has not been completed, the state has anecdotal evidence of children and family receiving services to which they did not previously have access – including creative use of community-based social services, reduced administrative burden on local service agencies, and improved provider satisfaction at the local level.

The pooling of mental health dollars under the IFS initiative is supplying ideas and encouragement as the agency considers a similar approach for additional programs.

i. Click here to access the Vermont Agency of Human Services website for more information on the IFS initiative.
ii. Integrated Family Services Prenatal to 22 years old: Redesign Concept, Agency of Human Services, January 2014.
iii. Bailit Health interview with Susan Bartlett, Vermont Green Mountain Care Board, May 3, 2016.

STRATEGY 3 | Integrated Assessments and Care Teams

Health care providers and social service agencies are implementing strategies to bring their systems together to provide a more comprehensive assessment of patients' health and social service needs, develop shared or aligned service plans to address patients' needs, and utilize multi-agency care teams to manage patients' care. The Virginia CSA example described on page three specifically incorporates integrated assessments and care teams that address both health and social service needs in a coordinated manner. Similarly, the Vermont IFS initiative to pool funding for high-need children includes integrated assessments for multiple types of health care and social service programs from different departments within the state's Agency of Human Services.

A number of county, local health plans, and other programs are also implementing tools and approaches to better integrate assessments and care teams related to health and social services for individuals and families at risk:

MINNESOTA

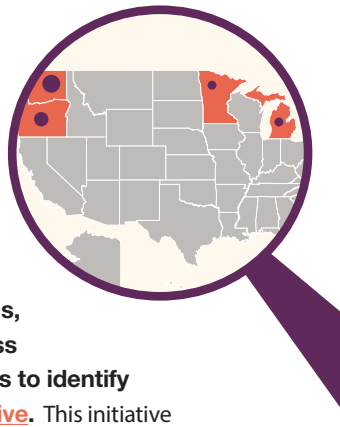
- **Hennepin Health routinely uses a screening tool that addresses social issues alongside medical screens.** The LifeStyle Overview screening tool helps the care management team better understand patients' needs, and informs the provision of housing and social services. The tool guides the patient's care plan and goal setting as well as informs new programs and services. A single accountable care coordinator works with a larger team of health, behavioral health and social service providers to coordinate the care of each high-risk patient.[9]

OREGON

- **The CCO and Early Learning Hub in Willamette Valley, Oregon partnered to create a portal that allows the area's early learning providers to share developmental screening results obtained in schools, homes or other community settings with health care providers who are able to access the information from their office.**[10,11]

STRATEGY 4 | Data Linkages

Public agencies at the state and local levels are pursuing more sophisticated collection and use of data to support and enhance health care and social services integration. In some cases, state agencies with responsibility to maintain information systems are mining data to match individuals across multiple systems, providing a broader view of their needs, utilization patterns, and opportunities to intervene. In other cases, states are both enabling health plan access to more data and requiring Medicaid plans to use SDOH data in their complex care management programs.



WASHINGTON

- **As part of its Health and Human Services Transformation Plan, King County, Washington matched individual's demographics and service utilization across multiple systems, including Medicaid, behavioral health, jail bookings, homeless services, emergency medical services and therapeutic courts to identify individuals who qualify for the county's Familiar Faces Initiative.** This initiative identifies high utilizers of the jail (defined as having been booked four or more times in a 12-month period) who also have a mental health and/or substance abuse condition.[12] An intensive, community-based care management team provides comprehensive services to adults identified under the program. These services include mental health and substance abuse services integrated with primary health care, as well as life skills training. The initiative launched in June 2016 with a target population of 60 adults.[13]

MICHIGAN

- **The Michigan Department of Health and Human Services (DHHS) incorporated the collection and use of data on social determinants of health as a responsibility of its Medicaid health plans in the 2016 contract.**[14] Plans must "develop a multi-year plan to incorporate social determinants of health into their process for analyzing data to support population health management." DHHS also requires contractors to develop a "core set of social determinants of health" as part of their provider performance measure reports. DHHS' new Medicaid health plan requirements helped spur development of initiatives such as the UnitedHealthcare's myConnections™ pilot program in Detroit; this pilot established a regional hub to co-locate and coordinate the delivery of health and social services as well as collect SDOH data to inform more holistic care management for members.

Michigan Department of Health and Human Services Contract Requirements Spur Integration of Social and Health Care Services in Detroit

In 2015, the Michigan Department of Health and Human Services (DHHS) incorporated into its Medicaid managed care procurement health plan responsibility for collecting – and using – information on social determinants of health. The Michigan DHHS' contract also required that health plans participate in initiatives to improve population health in the region. The DHHS' proactive approach has led to innovations at the community level, including UnitedHealthcare's implementation of a pilot program in the Detroit area to assist low-income individuals and families in accessing social, medical and behavioral services that can have a significant impact on health and quality of life. UnitedHealthcare's Detroit initiative is part of its recently launched national myConnections™ program.

In Detroit, UnitedHealthcare is leasing a recreation center to serve as a hub for coordinating the delivery of health and social services, and developing a social service referral network. The community center offers residents an array of medical services alongside a network of social service providers with staff at the location. For example, the center offers a food pantry for people with diabetes – stocked with produce and other items supplied by local growers. The community center also offers women, infant and children (WIC) services, transportation services, job training, and other services. Most services are open to all community residents, but some resources, such as the food pantry meals for persons with diabetes, are specifically aimed at UnitedHealthcare members.

Part of UnitedHealthcare's myConnections™ program is data collection and information sharing software related to social determinants of health. The myData platform is used to compile and analyze social and economic data on members – and the community at large – so that the plan and its partners can tailor interventions to address specific social determinants of health needs that may adversely affect the health of its members.[i]

Table 1 summarizes relevant excerpts from the Michigan Medicaid health plan contract, which the state executed with participating plans on January 1, 2016, and a link to which is found in the sources section below.[ii] For example, the state's requirement that health plans "develop and submit to [the state]…a multi-year plan to incorporate social determinants of health into their process for analyzing data to support population health management," finds its response in UnitedHealthcare's use of its myData platform to support population health management at its Detroit community center location.

Table 1: Michigan Integration Strategies in Action: Excerpts from the Medicaid Health Plan Contract

Population Health Management – Data Aggregation and Analysis	• Contractor must develop and submit to [the state]…a multi-year plan to incorporate social determinants of health into their process for analyzing data to support population health management…(page 47) • Contractor must participate in initiatives to develop a core set of social determinants of health, community-based support service provision, utilization, and health outcomes that providers will submit to for inclusion in performance measure reports, including agreement on how the data must be submitted by providers in order to minimize the administrative burden. (page 48)
Community Collaboration Project	• Contractor must participate with a community-led initiative to improve population health in each region the Contractor serves. (page 49) • Contractors may propose the development of their own community collaboration initiative to improve population health if such initiatives do not exist in a particular region. (page 49)
Services Provided by Community-Based Organizations	• Contractor must, to the extent applicable, enter into agreement with community-based organizations to coordinate population health improvement strategies in the Contractor's region which address the socioeconomic, environmental, and policy domains as well as provide services such as care coordination and intensive care management…(page 49) • Contractor must, to the extent applicable, support the design and implementation of Community Health Worker interventions delivered by community-based organizations which address social determinants of health and promote prevention and health education…(page 50) • Contractor must provide or arrange for the provision of community health worker (CHW) or peer-support specialist services to Enrollees who have significant behavioral health issues and complex physical co-morbidities. Examples of CHW/peer-support services include but are not limited to: 1) conduct home visits to assess barriers to healthy living and accessing health care; …8) arrange for social services and surrounding support services. (page 42-43)

i. Bailit Health interview with Michael Roaldi, UnitedHealthcare, April 22, 2016.
ii. Click here to access the Michigan contract.

STRATEGY 5 | Procurement and Grant Funding Efforts

Procurement vehicles, a powerful tool for state agencies, provide opportunities for purchasing agencies to incorporate requirements for integration of social services and health care services at the outset of a contractual relationship. For example, state purchasers can leverage their managed care contracts to compel health plans to address social service needs by facilitating successful referrals and directly coordinating care with social service programs and agencies.

State purchasers can also define eligibility for state grant funding opportunities to include requirements that health care providers jointly apply with entities and approaches designed to address social service needs and integrate health care with social services for targeted populations.

MICHIGAN

- **The Michigan DHHS Medicaid health plan requirements described in the preceding example were originally part of a procurement that required successful bidders to develop data analytics to identify and tailor interventions addressing defined social needs of a target population.** This procurement also included new requirements for plans "to provide or arrange for the provision of community health worker (CHW) or peer-support specialist services to enrollees who have significant behavioral health issues and complex physical co-morbidities."

MEDICAID HEALTH PLAN SUPPORTED CHW SERVICES FOR THESE HIGH-NEED INDIVIDUALS MUST INCLUDE:

- Conducting home visits to assess barriers to healthy living and accessing health care;
- Arranging for social services (such as housing and heating assistance) and surrounding support services; and
- Serving as a key knowledge source for services and information needed for clients to have healthier, more stable lives.

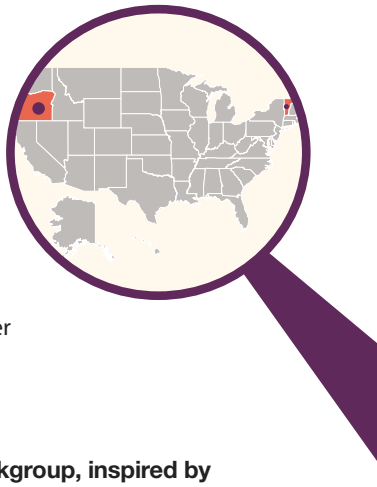
CALIFORNIA

- **California's Whole Person Care (WPC) Pilots seek to integrate care for a vulnerable group of Medi-Cal beneficiaries with poor health outcomes and identified as high users of multiple systems.**[15] The WPC pilots are funded as part of California's recently approved 1115 waiver and will entail coordination of health, behavioral health, and social services in a patient-centered manner with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources.[16] If selected, a county, a city and county, a health or hospital authority, or a consortium of any of the above entities must have collaborative leadership and systematic coordination among public and private entities, identify target populations, share data between systems, coordinate care in real time, and evaluate individual and population progress.

Responding to federal grant solicitations offers opportunities for states to strengthen partnerships between health care and social service providers. Federal funding, such as the Accountable Health Communities Model (AHCM), creates opportunities for states and local entities to support holistic approaches to improving population health. The Centers for Medicare and Medicaid Services (CMS) is focused on interventions that identify health-related social needs of Medicare and Medicaid beneficiaries, and then promote clinical-community collaboration to address those needs whether related to: 1) housing instability[17] and quality; 2) food insecurity; 3) utility needs; 4) interpersonal violence; or 5) transportation. CMS has modified the first of three tracks that it intends to test under the AHC Model and re-opened the funding opportunity earlier this fall.[18]

Many State Innovation Models (SIM) Initiatives feature integration approaches across medical care, behavioral health and social service providers, and are intended to drive service delivery and payment models towards improving population health. Similarly, under new Medicaid Delivery System Reform Incentive Program (DSRIP) initiatives in multiple states, social service providers are eligible to receive incentive payments related to process measures and population health improvement goals as DSRIP program participants.[19]

STRATEGY 6 | Performance and Quality Metrics



Quality measures for monitoring, reporting – and ultimately, payment purposes – are a key lever for states to encourage provider organizations and health care organizations to forge stronger links to integrate social services and health care. **Leading state purchasers are identifying quality metrics associated with social determinants of health and requiring reporting of such measures, with the future intent of rewarding health care organization performance on such measures in their contracts and coordination agreements.**[20]

VERMONT

- **Vermont's ACO shared savings pilot program reports statewide data on school completion and unemployment rates.** While these measures are not included in the ACOs' shared savings calculations, collecting and reporting this information lays the groundwork for the state to push stronger social and health service integration in the future.

OREGON

- **The Oregon's Child and Family Well-being Measures Workgroup, inspired by research that "connects the dots" between early childhood experiences and long-term well-being, developed a set of child and family well-being measures.** The workgroup – an advisory committee to the Oregon Health Policy Board and Early Learning Council – developed a 67-item measure library, and recommended 15 high priority 'dashboard' measures for monitoring purposes.[21] Included is a set of 'joint accountability measures' designed to improve kindergarten readiness by means of collective action across the state's health care and education sectors.[22]

Conclusion

Low-income, at-risk populations served by state health care purchasers often need – and may be eligible for – assistance with social services and supports to improve or maintain their health status. The strategies and levers discussed in this issue brief offer a broad menu of options for state purchasers to encourage meaningful linkages and integration between health care and social service providers. No single strategy or lever will suffice in forging these linkages, but working together, disparate public and private entities can design reimbursement and delivery systems better positioned to effectively address health-related social service needs and improve overall population health. As the examples in this paper attest, many state and local agencies and their partners are on their way to doing just that – testing and investing in a variety of integration approaches to better address social determinants of health – and offering a road map for others to follow.

Endnotes

1. A recent study found that states with a higher ratio of social to health spending (calculated as the sum of social service spending and public health spending divided by the sum of Medicare spending and Medicaid spending) had significantly better subsequent health outcomes for seven measures. See Bradley EH et al. "Variation In Health Outcomes: The Role Of Spending On Social Services, Public Health, And Health Care, 2000–09" *Health Affairs* May 2016 vol. 35 no. 5 760-768.
2. Tricia Brooks, "Measuring and Improving Health Care Quality for Children in Medicaid and CHIP: A Primer for Child Health Stakeholders," Georgetown University Health Policy Institute, Center for Children and Families, Robert Wood Johnson Foundation, March 2016. Click here to access.
3. Information on representation on ACH governing bodies may be found in the first year evaluation of Washington's Accountable Communities of Health (page 15). Click here to access.
4. See CMS letter to Washington here.
5. Amy Clary and Trish Riley, "Braiding and Blending Funding Streams to Meet the Health-Related Social Needs of Low-Income Persons: Considerations for State Health Policymakers," National Academy for State Health Policy, February 2016. Click here to access.
6. Amy Clark and Trish Riley, "Pooling and Braiding Funds for Health-Related Social Needs: Lessons from Virginia's Children's Services Act," National Academy for State Health Policy, June 2016. Click here to access.
7. Ibid.
8. Integrated Family Services Prenatal to 22 years old: Redesign Concept, Agency of Human Services, January 2014.
9. Click here and here to learn more about Hennepin Health's assessment tool.
10. Click here for more information.
11. Click here for more information about Oregon's Early Learning Hubs.
12. A cross-sector design team recently used this analysis to create a future vision of how the various systems that serve "familiar faces" could improve health and social outcomes for this population.
13. For more information about King County's Familiar Faces Intensive Care Management Team, click here.
14. Click here to access the Michigan Department of Health and Human Services 2016 Medicaid health plan contract.
15. Generally, whole-person care includes the coordination of health, behavioral health, and social services in a patient-centered manner with the goals of improved health outcomes and more efficient and effective use of resources.
16. Click here for more information about California's Whole Person Care Pilots.
17. Since housing instability is a broad issue and addressed by other publications, it is not specifically addressed in this issue brief. Click here to access the September 2015 SHVS issue brief, "Improving Care for Medicaid Beneficiaries Experiencing Homelessness," by Carol Wilkins. Additional resources on this topic include the following:
    - Wilkins, C., Burt, M. R., & Locke, G. (2014). A Primer on Using Medicaid for People Experiencing Chronic Homelessness and Tenants in Permanent Supportive Housing. Washington, DC: Assistant Secretary for Planning and Evaluation, Department of Health and Human Services. Click here to access.
    - Burt, M. R., Wilkins, C., & Locke, G. (2014). Medicaid and Permanent Supportive Housing for Chronically Homeless Individuals: Emerging Practices from the Field. Washington, DC: Assistant Secretary for Planning and Evaluation, Department of Health and Human Services. Click here to access.

18. CMS' original AHC model funding announcement requested applications from community-based organizations, health care practices, hospitals and health systems, institutions of higher education, local government entities, and tribal organizations. CMS' goal is to test a three-track approach to interventions that link beneficiaries with community services.

    - Track 1: increase beneficiary awareness of community services.
    - Track 2: offer community service navigation services to help high-risk beneficiaries access services.
    - Track 3: Promote partner alignment so that community services are available to meet the needs of beneficiaries.

    CMS has modified Track 1 so as to reduce the number of beneficiaries that successful applicants must screen from 75,000 to 53,000 per year. In addition, the maximum amount per award recipient has increased from $1 million to $1.17 million. A recent CMS blog posting about this re-issued funding opportunity may be found here.

19. Jocelyn Guyer, at al. "Key Themes from Delivery System Reform Incentive Payment (DSRIP) Waivers in 4 States," Kaiser Family Foundation, April 2015, and author knowledge of DSRIP programs in New Hampshire and New York. Click here to access Kaiser Family Foundation issue brief.

20. Crawford and Houston, "State Payment and Financing Models to Promote Health and Social Service Integration," Center for Health Care Strategies, February 2015. Click here to access.

21. "Child & Family Well-Being Measures Workgroup, Final Report and Recommendations," Joint Subcommittee of the Early Learning Council and the Oregon Health Policy Board, September 11, 2015. Click here to access.

22. A future SHVS issue brief will include more information on Shared Measures and Joint Accountability.

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