Systems for Action
National Coordinating Center
Systems and Services Research to Build a Culture of Health

New Studies Aim to Save Lives and Money by Connecting Health and Social Systems

Researchers will study strategies for aligning systems that support health care, public health, and social services to improve health and well-being for vulnerable populations

For Immediate Release

LEXINGTON, KY —Systems for Action is proud to announce the funding of eleven new studies. With $1.85 million in funding support from the Robert Wood Johnson Foundation, these new studies will help medical care providers, social services agencies, and public health organizations find new ways of working together to improve health and well-being within U.S. communities.

Each research team will test an innovative approach for improving health by integrating the delivery of medical care with other social and community services, such as housing, transportation, food and nutrition, child and family services, education, and employment support. By rigorously documenting the health outcomes and costs that result, these studies will set new standards for how health and social services should be delivered and financed across the U.S.

Systems for Action (S4A) is a national program of the Robert Wood Johnson Foundation that builds a Culture of Health by discovering powerful ways of connecting the nation's fragmented medical, social, and public health systems. The Systems for Action National Coordinating Center, based at the University of Kentucky College of Public Health, coordinates these studies as part of its national portfolio of research focused on systems and services research.

"Delivery systems for health and social services are often disconnected, allowing far too many people fall through the cracks," said Dr. Glen Mays, director of the S4A Coordinating Center. "These studies will discover new avenues for coordination that save lives and reduce disparities in health outcomes."

The eleven projects and teams are:

Optimizing Governmental Health and Social Spending Interactions
Johns Hopkins University collaborating with representatives from public finance, public health, and social and community service sectors

The United States spends more money on healthcare than other developed countries while experiencing significantly worse health outcomes, indicating a need to explore health drivers other than healthcare spending. While nonmedical barriers such as lack of adequate housing, education, and transportation are known to influence well-being, how spending that addresses these social needs affects health outcomes is less clear. This study will examine total government spending across both medical care and social service sectors to characterize the impact of such spending on health outcomes and disparities. The research team will create a novel longitudinal dataset that merges medical, public health, social services, and community service governmental spending with population health outcomes. Based on U.S. Census of State and Local Governmental Finance data, this new dataset will allow researchers to examine public

spending across medical, public health, social and community service sectors at both the state and county levels. Study findings will engage cross-sector stakeholders in conversations about aligning public spending to achieve better health and reduce health disparities.

Testing a Shared Decision-making Model for Health and Social Service Delivery in East Harlem
The Fund for Public Health in New York City and its program partner New York City Department of Health and Mental Hygiene collaborating with clinical and non-clinical partners, faith and community-based organizations, and community residents

Lack of coordination among health and community services organizations can result in individual agencies working in isolation, ultimately contributing to wasted resources and poor outcomes for the most vulnerable. A promising method for addressing this lack of coordination is the adoption of a place-based system integration. Using such a model, providers of services collaborate to improve the health and well-being of the populations they serve. This study will test a model, which aligns a city health department with cross-sector community stakeholders to improve health and reduce inequities across neighborhoods. Specifically, the research team will examine the East Harlem Neighborhood Health Action Center; which encompasses the city health department, clinical and non-clinical partners, faith- and community-based organizations, and community health workers. The research team will investigate how the Center's shared decision model affects coordination, effectiveness, and efficiency across these sectors. Using qualitative & quantitative methods, the research team will assess the community's health outcomes, satisfaction, success in linking clients to needed services, and success in coordinating systems to improve health and health equity in the neighborhood. Lessons learned from this study will inform best practices for replicating this model in other neighborhoods in New York City and across the U.S.

Linking Medical Homes to Social Service Systems for Medicaid Populations
National Committee on Quality Assurance (NCQA) collaborating with Medical Home Network and Cook County Health and Hospitals System

Low socioeconomic status and other social risk factors are linked to poor health outcomes and increased emergency department (ED) visits, while also impacting health care quality, cost, and use. Thus, assessing and addressing these social risk factors can help improve patient outcomes. Unfortunately, connecting social services organizations that address these risk factors with organizations providing medical services can be very challenging, due in part to systems that do not "talk" to each other. In this study, researchers will evaluate how linking electronic data between patient-centered medical homes and social service providers affects the health and well-being of Medicaid patients. The research team will investigate if the use of a web-based communication and care management platform that digitally connects medical homes and social service providers improves the identification and delivery of services to address social risks, quality of care, and unnecessary ED utilization. Findings from this study will contribute to best practices and guidance for other communities.

Strengthening the Carry Capacity of Local Health and Social Service Agencies to Absorb Increased Hospital and Clinical Referrals
Trailhead Institute and collaborators from University of Colorado, Denver, University of Kentucky, The Nonprofits Centers Network, Serve Denton, and The Glasser

Schoenbaum Human Services Center

As hospitals and clinics increase screenings for social determinants of health (SDOH), referrals to agencies that provide services to address these needs also will increase. However, questions remain about the ability of nonprofits and other "community resources" to absorb these increased referrals for services. Using secondary data analysis, a review of existing capacity assessment models, and case studies of human service centers in Florida and Texas, researchers will develop and implement an approach for assessing the capacity of community social services organizations and their partners to absorb and meet the needs of referred clients. Findings will lead to improvements in understanding the nonprofit sector's ability to respond to growing demand, ultimately contributing to the long-term goal of strengthening cross-sector partnerships and integration of services and systems to improve health outcomes.

Testing an Integrated Delivery and Financing System for Older Adults with Health and Social Needs
New York University collaborating with the New York Academy of Medicine, Lifespan of Greater Rochester, and Rochester RHIO

Addressing the social determinants of health is vital to improving individual and population health and advancing health equity. Research indicates that integrating health and social services is both necessary and cost-effective. This is especially true for the growing number of older adults who face increasing risk of multiple chronic health conditions, cognitive decline, and disability. The Community Care Connections program integrates care navigators and health care coordinators into the workflow and referral systems in health care delivery settings. These coordinators connect patients to resources, guide them across healthcare settings, and serve as their patient care advocates. The study utilizes a mixed-methods approach to conduct a rigorous assessment of the health, social, and economic impact of this program and examines these novel inter-organizational partnerships between social services and healthcare sectors. Findings will help strengthen existing programs and provide important information about components critical for successful implementation.

Community-Based Decision-making and Engagement with the Cheyenne River Sioux Tribe's Public Health Plan: Weaving the Tasina Luta
Texas A&M University collaborating with the Cheyenne River Sioux Tribal Health Council

Native American communities experience many obstacles to health and well-being due to adverse social, economic, and environmental conditions. Few tribal public health programs are financed adequately to surmount these obstacles. Fewer still are locally financed and managed. This study will elicit the values and preferences of Cheyenne River Sioux Tribe (CRST) members in order to enhance the implementation of the CRST's first autonomous public health program, the Tasina Luta (Red Blanket). Through a series of focus groups and interviews with Tribal members and local service experts, this research will inform the efficient integration of the Tribe's resources to better engage community members and achieve a larger collective impact. This one-year developmental study will explore effective mechanisms for public health program diffusion within the CRST community, positioning the project for future quantitative work evaluating the impact of the identified implementation strategies.

Linking Education and Health Data to Improve Adolescent Health in Los Angeles
University of California Los Angeles collaborating with the Los Angeles Unified School District

Declines in academic performance often precede declines in health and health behaviors, particularly among minority youth living in economically distressed communities. The social and economic burdens imposed on communities with high rates of mental illness could be alleviated if patients were diagnosed and treated in adolescence rather than adulthood. Many adolescents with behavioral health needs fail to seek early treatment due to lack of access to care, finances, or knowledge of available resources. School performance may be a valuable early indicator of children in need of critical health services, particularly behavioral health services. Currently, the ability to use academic data as a population health and surveillance tool is limited by a poor understanding of which measures are the most meaningful indicators of behavioral health needs. This one-year developmental study will support the creation of a novel risk indicator tool that links academic performance and health data to identify academic indicators of such behavioral health needs as post-traumatic stress disorder, depression, and substance abuse. The research team will facilitate system alignment as they collaborate with leaders from the education, health, and social services sectors to design a tool that could be implemented within the school district. Findings will contribute to early prevention strategies and foster cross-sector collaborations between education and health providers to help improve adolescent behavioral health services equity in under-resourced communities.

Integrating Health and Social Services for Veterans by Empowering Family Caregivers
Durham Veterans Administration Medical Center collaborating with the VA Caregiver Support Program

Injured war veterans face substantial barriers to maintaining employment, high levels of family strain, homelessness, and extensive unmet physical and mental health needs. The Department of Veterans Affairs (VA) offers a range of medical, public health, and social services to eligible veterans; however, these services reside within distinct bureaus leading to service fragmentation, poor alignment with veteran needs, and variability in access across medical centers. Federal funding was approved in 2010 to establish a national program to provide veterans' caregivers with training on how to navigate the VA system, function as a care team member, and improve clinical skills. Evidence from the initial group of enrollees showed that veterans whose family caregivers participated in the program utilized more primary, specialty, and mental health services than did those whose caregivers did not participate. While use of *health services* increased, data regarding the influence of family caregivers on veterans' use of *social services* is still needed. Using quantitative and qualitative methods, this one-year developmental study specifically investigates the effect of institutional support for family caregivers on veterans' use of vocational rehabilitation and educational social services. Study findings will elucidate key contextual and scalable features of institutional support for family caregivers that can reduce system inefficiencies through improved services coordination.

Testing a New Terminology System for Health and Social Services Integration
Columbia University collaborating with federal agencies, corporations, insurance providers, and professional associations

Current payment methods do not reflect the contemporary need for effective chronic disease prevention, nor do they address the social determinants of health. Historically, common payment standards intended to link private healthcare providers with payers did not factor in coding or language to cover services provided by nonmedical personnel. Nonmedical personnel, specifically those in the social services sector, remain at a financial disadvantage relative to their peers in healthcare due in part to hours of uncompensated care they provide to the nation's population. Payment structures and coding systems are not neutral administrative directories but reflect the social and political environment in which they were produced. The inclusion or exclusion of covered services in the standard coding language has multiple downstream consequences and can lead to health inequities. This one-year developmental study will evaluate a novel mechanism for incorporating social services into existing health billing codes, thereby allowing both social and healthcare services to be reimbursed within one system. Review of regulations governing coding methodologies, insurance agency payer plans, and feedback from stakeholder interviews will inform recommendations to existing policy that would codify social services and potentially improve access to services that address the social determinants of health.

Financing Integrated Health and Social Services for Populations with Mental Illness
Weill Cornell Medical College collaborating with OnTrackNY, OnTrackUSA

Adolescents and young adults often experience their first episode of psychosis as they are preparing to enter high school, college, or the workforce. The long-term implications of neglecting a future generation's mental health can range from an overburdened welfare system to overcrowding in correctional facilities. Implementing an intervention for first episode psychosis via Coordinated Specialty Care (CSC), the OnTrackNY program aims to help patients maximize recovery, improve social function, and manage their psychiatric symptoms. While coordinated care services are currently covered by public and private funding, little guidance is provided to payers on how to structure payments to CSC providers. This one-year developmental study will develop a flexible, multi-part payment system comprised of a bundled case-rate, a per-service, and a pay-for-outcome component. The resulting payment designs would then inform a decision support tool for payers of CSC and other multi-disciplinary, team-based interventions across the medical, social, and public health sectors. This project will address the barriers to adoption of payment innovations that can be accomplished by combining economics and health information technology to significantly improve population mental health.

Integrating Cross-Sectoral Health and Social Services for the Homeless
University of Utah and University of North Texas collaborating with Salt Lake County (Utah) and Metro Dallas Homeless Alliance (Texas)

Members of the homeless population bear greater risk than other populations for many preventable diseases but are less likely to access healthcare systems. These individuals need to be engaged by multiple systems to access services and support related not only

to stable housing but also to reliable transportation, employment opportunities, and a healthy family environment. This one-year developmental study will evaluate the US Department of Housing and Urban Development's initiative, the Continuum of Care (CoC) system, which addresses homelessness through cross-sector collaboration. Specifically, investigators will use a mixed-methods approach to test whether CoCs that are under resource constraints in terms of funding availability, less than optimal diversity in their partner organizations, and poor quality partnerships, experience greater challenges in addressing the full spectrum of health needs of their homeless populations. The study will generate evidence of the degree to which coordinated community services and resources are effective in improving health and equity, and will capture the key factors in successful cross-sector collaborations for the homeless. Study findings will identify effective models of CoC networks and thereby advance knowledge on building a culture of health in communities with highly vulnerable homeless populations.

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About the *Systems for Action* National Coordinating Center: The *Systems for Action* (S4A) National Coordinating Center conducts and supports rigorous research on ways of aligning the delivery and financing systems that support a Culture of Health. Building on a foundation of scientific progress from both health services research (HSR) and public health services and systems research (PHSSR), S4A seeks to identify system-level strategies for improving the reach, quality, efficiency, and equity of services and supports that promote health and well-being on a population-wide basis. S4A uses a wide research lens that includes and extends beyond medical care and public health systems to incorporate sectors such as housing, transportation, social services, community services and supports, education, criminal and juvenile justice, and economic and community development. The Center is supported by the Robert Wood Johnson Foundation and based at the University of Kentucky College of Public Health. For more information, visit **www.systemsforaction.org.**