

The National Summit on Health Care and Social Service Integration: Executive Summary

Introduction

Health care providers, payers, and systems are increasingly interested in approaches that address both medical needs and social determinants of health (SDOH). As the health care sector transitions to value-based payment models, demand has grown to reduce health care costs while promoting quality of life and improving health outcomes. Integrated models of care allow individuals to receive service in community settings that can help manage chronic conditions, reduce food insecurity, provide transportation, support employment, and reduce social isolation. Integrating these services into health care delivery requires robust planning and assessment; knowing how to navigate complicated social service systems; case management; and accountability for service delivery and outcomes. Health care payers and providers must decide whether to “build” their internal capacity to manage and deliver services to address social needs or “buy” additional capacity from existing community providers. For many organizations, the more cost-effective strategy will be to partner with existing community networks that have existing linkages to community services. These essential services are shown to [improve health outcomes and reduce the cost of care](#). This is particularly true for “[high-need, high-cost](#)” people who have complex health conditions and social risk factors and who often have significant functional limitations.

When networks of community-based organizations (CBOs) partner with providers, payers, and health systems, the resulting integrated care system can lead to better outcomes and lower costs, especially if those partnerships emphasize values of trust, shared leadership, accountability, sustainability, and innovation. Successful plans for integration must draw on the expertise of stakeholders nationwide, including CBOs and their networks; state and federal health and human services agencies; health plans and health system; and experts in SDOH financing and health information technology (IT).

Interviews, Focus Groups, Working Groups, and In-Person Meetings

Starting in the fall of 2019, the Administration for Community Living (ACL) undertook a series of activities to engage these stakeholders. As of spring 2020, these activities have included:

- Interviews with stakeholders and experts in CBO business acumen in October and November of 2019;
- A Roundtable of more than 25 CBO stakeholders in Washington, DC, in December of 2019;
- Semi-monthly calls and presentations with a workgroup drawn from the December Roundtable; and

- A National Summit in Washington, DC, in March of 2020, attended by more than 150 participants, including federal and state staff, thought leaders, CBO network experts, health plan and health system decision-makers, and national associations and foundations.

A summary of key themes and ideas generated from these stakeholder meetings can be found in the full *National Summit on Health Care and Social Service Integration* summary report.

National Summit on Health Care and Social Service Integration

The National Summit took place in March of 2020 in Washington, DC. More than 150 people attended; they were affiliated with federal and state agencies, health plans, health systems, national associations, Area Agencies on Aging, Aging and Disability Resource Centers, Centers for Independent Living, universities, philanthropies, and advocacy groups. The Summit had three (3) primary goals:

1. Develop a shared approach for integrating medical and social care;
2. Highlight integrated models that have demonstrated significant success; and
3. Develop strategies to replicate and scale effective CBO-health care partnerships.

The Summit highlighted HHS leadership's vision for addressing social determinants of health through value-based care and leveraging existing community-based organizations as partners to health care organizations. Health care executives, community leaders and thought leaders had a robust exchange on the vision and challenges for achieving integration of health care and social services for older adults and people with disabilities recognizing the need to strengthen community assets overtime through sustainable financing strategies across sectors and stakeholders. ACL solicited feedback from Summit participants on a set of shared goals and principles around person-centered approaches to integrating health care and social services. Summit participants agreed that CBO networks could be built at the local, regional, and statewide levels and that strong Network Lead Entities would ensure quality, standardization, and enforcement of adequate contracting. The Summit also included a series of breakout sessions in four (4) key areas:

1. Financing social care services;
2. Scaling CBO networks;
3. Data and technology barriers and opportunities, especially around interoperability; and
4. The role of state and federal governments to facilitate integration through health care and CBO partnerships.

Input from Summit participants helped inform a series of action items in each area; these actions are listed later in this Executive Summary.

Developing Community Integrated Health Networks

CBOs that form networks can more easily contract with larger health plans and health systems. They can facilitate various health and social care services that will streamline the care individuals receive, leading to improved quality of life, improved health outcomes, and lower costs. Each CIHN is led by a Network Lead Entity (NLE), an organization that assumes responsibility for directing the development and design of a network structure, facilitates services, and provides administrative oversight and governance. More information about the composition and makeup of CIHNs and NLEs can be found in this [Business Acumen Roundtable Workgroup paper](#). A significant advantage of NLE-led CIHNs is their capacity to provide services at different geographic scales. The figure below illustrates how an NLE can coordinate CBOs within a CIHN to partner with health systems and health plans to integrate social services for individuals.

Figure 1: Potential CIHN Structure



CIHNs improve health outcomes and quality of life, and reduce costs, by offering:

- A broader array of services through partnerships;
- A framework to reach more of the population by achieving a more extensive geographic reach;
- The opportunity to serve as a one-stop, coordinated system to link individuals to services;
- The mechanism for developing a more robust administrative structure;
- Opportunities to improve overall care management; and
- The chance to develop strong collaborations with health systems and health plans.

CIHNs face challenges on the four fronts of financing social care, data technology and interoperability, state leadership, and scaling.

Financing

The most feasible model for funding social service delivery and ensuring long-term sustainability is a multi-payer system, which can support the collective business goal of integrating social and medical services into one network. However, multi-payer systems face several challenges:

- In the domain of billing, there is frequently a mismatch in the language used to describe services, and that mismatch impacts how organizations perceive billing to Medicaid.
- CBOs are often not at the table when Medicaid waiver programs are being developed or operationalized. Consequently, agreements with health plans are implemented two to three years before a Request for Proposals (RFP) is released, leaving CBOs at a disadvantage when it comes time to respond; with earlier planning, CBOs can partner with MCOs in preparing responses to these RFPs. CBOs must understand the value of attending public events and providing public comments early in the process to promote as much integration as possible between social and health care services.
- Because CIHNs can identify individuals with specific health conditions or social risk factors unaddressed by medical providers, partnerships between CIHNs and Medicare Advantage plans can promote service innovation. But CIHNs must participate in early Medicare Advantage conversations held among the state, health systems, and health plans.

Data and Technology Interoperability

CIHNs depend on technology to support the successful integration of social services and health care. Poor service coordination can leave individuals at increased risk of poor health outcomes, including increased risk of needing institutionalization. Data and technology problems are exacerbated by:

- Difficulties navigating and aligning federal legal requirements, state-specific regulations, and data sharing policies across partners;
- Data infrastructure capabilities;
- Inconsistent definitions of data elements and technical specifications;
- Frequent updates and the risk of obsolescence;
- Insufficient training; and
- Outdated data sharing policies.

To mitigate these challenges and help ensure that they can provide accurate, up-to-date information at the right time, CIHNs must establish a data infrastructure that enables:

- Closed-loop referrals;
- Data standards, policy, and governance;
- Informed consent and data security/privacy; and
- Transmitting and receiving information to and from payers.

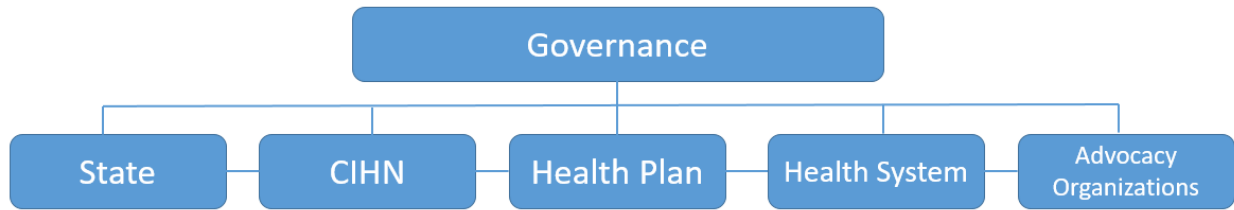
Existing and evolving technical standards such as those from the HL7 Gravity Project and IEEE can help minimize technological complexity and address the challenges listed above.

Governance and State Leadership

To succeed, a CIHN needs strong leadership by a governing body that oversees the CIHN; gathers and incorporates input from stakeholders; and guides the network toward a streamlined, person-centered, accessible, and cost-effective technological framework infrastructure. Robust governance can improve the network's chances to scale up, sustainably finance services, and successfully share data. State agencies – especially state units on aging (SUAs) – can convene these meetings and facilitate conversations among NLEs, CBOs, health plans, and health systems. States can influence policies that support the integration of health and social services. States can support CBO activities such as developing business operations and refining business acumen skills and capabilities. States can also strategically align state Medicaid policies (such as managed LTSS) with the infrastructure of CIHNs in the state. To support states in advancing the integration of health care and social services for older adults and people with disabilities, ACL developed a [*Strategic Framework for Action: State Opportunities to Integrate Services and Improve Outcomes for Older Adults and People with Disabilities*](#).

A potential structure of a governing body or governing arrangement appears in Figure 2.

Figure 2: Governance Partners



Scaling

To scale up, CIHNs must establish consistency of services, adhere to access standards, ensure the quality of care, and enable data sharing, all to calculate ROI for prospective payers. Creating CIHNs from existing CBOs and health partners allows those CBOs to begin integrating social services and existing health care systems, without having to assume the considerable risk of building an entirely new system. CIHNs can also turn to experts to support the development of data or IT infrastructure.

As CIHNs scale up and attract more partners, consistency will assume increasing importance. Building this consistency into contracts, quality certifications, and data sharing makes it easier for networks to establish new partnerships. Moreover, to develop and scale CIHNs, all stakeholders must coordinate their strategies for workforce development. Providing access to services is only beneficial if the network has the workforce needed to deliver those services.

Action Items

Working with leaders in the field, ACL has identified action items in each of the four key areas that CIHNs must focus on. The figure below lists those action items.

Table 1: Action Items

Financing Social Care	Governance & State Leadership
<ul style="list-style-type: none"> ▪ Develop provider-agnostic care delivery systems of SDOH sustained through reimbursement from multiple payers ▪ Outline how to establish CIHNs as best-practice partnerships that support the alignment of funding and services ▪ Work with CBOs to market their value; ▪ Position CBOs as collaborators, not competitors ▪ Share best practices with critical partners 	<ul style="list-style-type: none"> ▪ Outline and clarify roles for funding, regulation, oversight, and policy development through collaborative efforts ▪ Seek clarification from federal partners to identify funding sources and provide guidance and support ▪ Determine how best to maximize revenue and funding at the state and local levels ▪ Ensure accountability with funds and adherence to regulations ▪ Support CIHN development and data integration efforts ▪ Share best practices with key partners.

Technology	Scaling
<ul style="list-style-type: none"> Continuously acquire data, aggregate data, analyze data, and act on the findings (4As) Build infrastructure to support data integration and interoperability Create a standardized means to make referrals and ensure that those referrals are closed-loop Catalog best practices and share with key partners, including state and federal partners 	<ul style="list-style-type: none"> Expand CIHN development, as well as data integration and interoperability at all levels Establish CBO network credentialing processes Establish a shared process for developing partnerships Establish quality monitoring guidelines; Lead or join to form CIHNs; and Share best practices with key partners

To make progress on these action items, CIHNs will have to address several pressing problems:

1. Determine a network’s value proposition and ROI for prospective partners;
2. Shift financing to value-based payments or similar risk- and outcomes-based models;
3. Prepare to partner with health plans and health systems; and
4. Clarify the role of federal and state partners.

Shared Principles and Goals

Building on the work of the Roundtable Workgroup and working with input from participants at the National Summit, ACL has identified a set of shared principles and goals for developing a network of CIHNs. These are displayed in the table below.

Table 2: Shared Principles and Goals

Overarching Principle: Use a person-centered approach to integrate health care and social services.

Principle	Description
Trust	Uphold and preserve the confidence and respect of individuals.
Leadership	Co-lead and coordinate holistic services.
Accountability	Create a culture of performance and data-driven quality improvement among all stakeholders.
Sustainability	Advance equitable shared financing of social care and shift to risk-based payment overtime.
Innovation	Evaluate and evolve interventions to improve service delivery, efficiency, and outcomes.

For more information including video sessions, please visit [ACL’s National Summit on Health Care and Social Service Integration Summit website](#) or reach out to Kristie Kulinski at kristie.kulinski@acl.hhs.gov.