

Session

Aligning Delivery and Financing Systems to Improve Health Equity: Addressing Social Determinants of Health through Cross-Sector, Collaborative Partnerships

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APHA 2022 Annual Meeting and Expo

Abstract

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Evidence demonstrates that personal, social, economic, and environmental conditions strongly influence health and health equity. Social services and programs designed to improve these conditions are often disconnected from the medical services and public health programs tasked with improving health. When these systems operate in isolation of one another, it can hinder innovations aimed at improving conditions -- like housing, transportation, economic assistance, education, etc. Rigorous testing of novel approaches for aligning delivery and financing systems using cross-sector approaches is essential to finding successful, sustainable and scalable approaches. The goal of system coordination is to advance health equity and population health, creating healthier communities.

Systems for Action (S4A) is a national research program of the Robert Wood Johnson Foundation that studies ways of aligning the delivery and financing systems that support medical, social, and public health services. This panel highlights findings from five S4A studies underway:

- (1) a national longitudinal study of Nurse Family Partnership sites measuring the effectiveness of multi-sector financing and delivery strategies
- (2) a mixed-methods study to understand the effectiveness of a global all-payer payment model combined with multi-sector community health teams
- (3) a mixed-methods approach to evaluate the effectiveness of multi-sector Partnerships for Early Childhood Development in maintaining social needs screening, referral, and service delivery for children during the COVID-19 pandemic
- (4) a mixed methods study estimating the impact of mobility enhancements on access to care, diabetes progression, healthcare utilization and costs in a group of low-income, chronically ill patients
- (5) a quasi-experimental research study investigating the impact of a novel independent practice associations (IPAs) formed among community-based social service organizations (CBOs) to address social determinants of health among residents of upstate New York, specifically focused on outcomes experienced by racial and ethnic minority populations.

Collectively, these abstracts provide key evidence and implications that inform discussions around existing policies, proposals, emerging trends, and their potential impacts on health equity and population health.

Panelists include the principal investigators of each study, from the University of Colorado- Denver, University of Vermont, New York University, Georgia State University, and the Stanford University School of Medicine. The panel will be moderated by Glen Mays, PhD - Director of the S4A National Program Office (based at the University of Colorado-Denver).

Abstract

Integrating health and social services through a novel independent practice association: lessons learned from healthy alliance New York

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Addressing social determinants of health is critical to achieving equitable access to health care. Healthy Alliance, originally funded by NYS DOH through MediCaid waiver funding, developed a novel social care IPA (Independent Practice Association) which curates a social determinants of health network (SDHN) as a regional strategy to provide health-critical social services in upstate NY. Methods: We describe implementation of a novel SDHN and how it functionally breaks down silos between social care, health care and other sectors. We map out services provided through the network and describe the structure and key elements of Healthy Alliance's management of the SDHN network, which moves beyond adoption of a technological referral platform (Unite Us) to active curation, organization and collective contracting. Results: After 3 years of implementation, Healthy Alliance manages 22 counties across NY. Healthy Alliance services include 20 service types, over 100 service subtypes (e.g. housing), 520 partner organizations, 36,000 requests for connections, and 18,000 unique community members served; over 70% of all service requests result in connection to services. Since inception, Healthy Alliance has secured seven contracts with three managed care organizations (MCO) for its services. Discussion: Establishing a successful SDHN requires more than the technological referral platform infrastructure to connect health systems to social service providers in a community. Healthy Alliance's experience has validated the need for performance management, setting benchmarks for quality of services, assisting partners with data reporting and security, and providing support through a referral coordination center that helps navigate referrals. Healthy Alliance has learned about the challenges associated with implementing social needs screening and barriers with collecting data. As an example, organizations have struggled with capturing important demographic information such as race and ethnicity that are key in demonstrating impact on health equity. Making the financial case for sustained funding and contracting is a work in progress, as MCOs and other entities remain reluctant to spend money on SDH other than what comes from philanthropy. A rigorous multi-year evaluation of economic and health outcomes impact of the model has just been initiated (<https://systemsforaction.org/>).

Abstract

Partnerships for Early Childhood Development: The impact of social needs screening and referral in pediatric primary care clinics on caregivers

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Background: There has been a surge of interest among pediatric primary care providers to screen for social risk factors in clinical settings and refer families with needs to local resources. The United Hospital Fund developed the Partnerships for Early Childhood Development (PECD) initiative to foster community partnerships and social needs screening and referral programs among seven NYC-based pediatric primary care clinics. Each clinic partnered with a local community-based organization to which caregivers with social need(s) were referred for services. Our research group at NYU Grossman School of Medicine conducted an outcome evaluation of the PECD initiative.

Methods: 129 caregivers of pediatric patients who identified at least one social need during screening were surveyed at baseline and six months later (46% and 62% response rates respectively) to assess outcomes including social needs, food insecurity, caregiver depression, caregiver stress and clinic satisfaction.

Results: Caregivers were on average 32 years old, 98% were female, 61% identified as Hispanic or Latino, 40% spoke Spanish primarily, and 78% had Medicaid. Results showed statistically significant decreases in average number of reported needs (3.2 to 2.4; $p=0.009$), food insecurity, and depression as measured by the PHQ9. Caregiver stress declined but this change was not statistically significant. Caregivers reported high clinic satisfaction during both survey administrations.

Conclusions: The PECD initiative shows promise in addressing social needs and improving caregiver well-being. More rigorous studies with strong comparison groups are needed to better understand the impact of social needs screening and referral programs on families in pediatric clinical settings.

Abstract

Cross-Sector Collaboration between Nurse Home Visitors and Community Providers in the US: A Longitudinal Survey Analysis

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Background: Evidence-based home visiting programs improve the health of families experiencing adversities. Cross-sector collaboration across public health, health care and social services is essential to achieve positive home visiting outcomes. This study assessed changes in collaboration between Nurse-Family Partnership (NFP) home visitors and community providers in the US.

Methods: We conducted an internet survey of all NFP nursing supervisors in 2018, 2020 and 2021. The survey included the validated 7-item Relational Coordination Scale and 4 items adapted from the Interagency Collaboration Activities Scale on shared resources with 10 provider types. Data were analyzed with descriptive statistics; responses over time were compared using paired t-tests and one-way ANOVAs. We also used one-way ANOVAs to assess differences in collaboration by type of implementing site.

Results: The response rate was 71% (263/370) in 2018, 83% (316/383) in 2020, and 74% (307/414) in 2021. Relational coordination scores ranged from 1-5, while integration scores ranged from 1-20; where higher scores indicated stronger collaboration. Coordination with women's care increased from 2018 to 2020 (M=3.39 vs. 3.57; $p<0.00$); while coordination (M=3.23 vs. 3.01; $p<0.05$) and integration (M=6.5 vs. 5.28 vs. 5.43; $p<0.01$) with parenting programs decreased. Coordination with women's care was higher in healthcare entities (M=3.78) vs. Community-Based Organizations (CBO; M=3.41; $p<0.00$), while coordination with WIC was higher in government agencies (M=3.93) compared to all other site types ($p<0.00$). Integration with women's and pediatrics care were higher in health care (sum=8.23, 6.97 respectively) vs. government agencies (sum=6.01, 5.2; $p<0.05$) and CBOs (sum=5.72, 5.22; $p<0.05$). Integration with WIC was higher in government agencies (sum=9.74) than all other site types ($p<0.00$).

Conclusions: There is variation in the degree of cross-sector collaboration across NFP sites, by provider type and by type of implementing site. There is opportunity to improve cross-sector collaboration in NFP through targeted interventions to address family needs.

Abstract

COVID-19, mobility challenges, and healthcare utilization among vulnerable patients

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The absence of safe, timely, affordable transportation can be a major barrier for access to healthcare. The COVID-19 pandemic has added to the day-to-day mobility challenges faced by low-income, segregated and/or mobility constrained populations, including but not limited to service changes and shutdowns, increased travel costs, and greater risk of COVID transmission via public and shared transportation. These challenges often lead to disruptions in routine travel behaviors, healthcare utilization, and other health-related activities for vulnerable individuals, exacerbating barriers to healthcare and disparities in health outcomes.

We present the early results from a mixed methods study on the linkage between mobility and health in a group of low-income, chronically ill patients. Partnered with the safety-net healthcare provider in Atlanta, Georgia, Grady Health System, we surveyed and interviewed more than 200 low-income patients with uncontrolled diabetes or hypertension since August 2020. Originally designed prior to the pandemic, the study met unexpected delays and disruptions during the initial COVID-19 outbreaks and lockdowns. Nevertheless, it offered us a rare opportunity to study the pandemic-related changes in mobility, travel behavior, and healthcare utilization among this vulnerable population. The results will lend important insight into the various ways the COVID-19 pandemic could reshape social determinants of health and health disparities.

