S4A
Systems for Action

Strategies to Achieve Alignment, Collaboration, and Synergy Across Delivery and Financing Systems

Integrating Health and Social Services through a Novel Independent Practice Association

Research In Progress Webinar
December 10th, 2025
12:00-1:00 pm ET/9:00-10:00 am PT

colorado school of public health

Agenda

Welcome: Carrington Lott, MPH, Program Manager at S4A

Presenters: Elena Rosenbaum, MD from Healthy Alliance, New York

Jonathan G. Shaw, MD, MS, from Stanford University School of Medicine

Q&A: Carrington Lott, MPH, Program Manager at S4A

Presenter

Jonathan G. Shaw, MD MS
Medical Director
Evaluation Sciences Unit
Stanford University

Jonathan co-leads Stanford's Evaluation Sciences Unit a multidisciplinary team focused on implementation science. He is a health services researcher and a practicing family physician in community-based primary care. For the past decade, his clinical practice has been at Ravenswood Family Health Center, an FQHC serving the primarily immigrant communities of East Palo Alto.

Presenter

Elena Rosenbaum, MD
Medical Director
Healthy Alliance

Elena is the Medical Director at Healthy Alliance, an upstate NY social care network, focused on coordinating social, behavioral, and clinical services to enable people to lead healthy lives.

Acknowledgments

- Funding from RWJF, starting Nov 2021.

Robert Wood Johnson Foundation

Systems for Action (S4A) is a national program of the Robert Wood Johnson Foundation (RWJF) that aims to discover and apply new evidence about ways of aligning the delivery and financing systems that support a Culture of Health

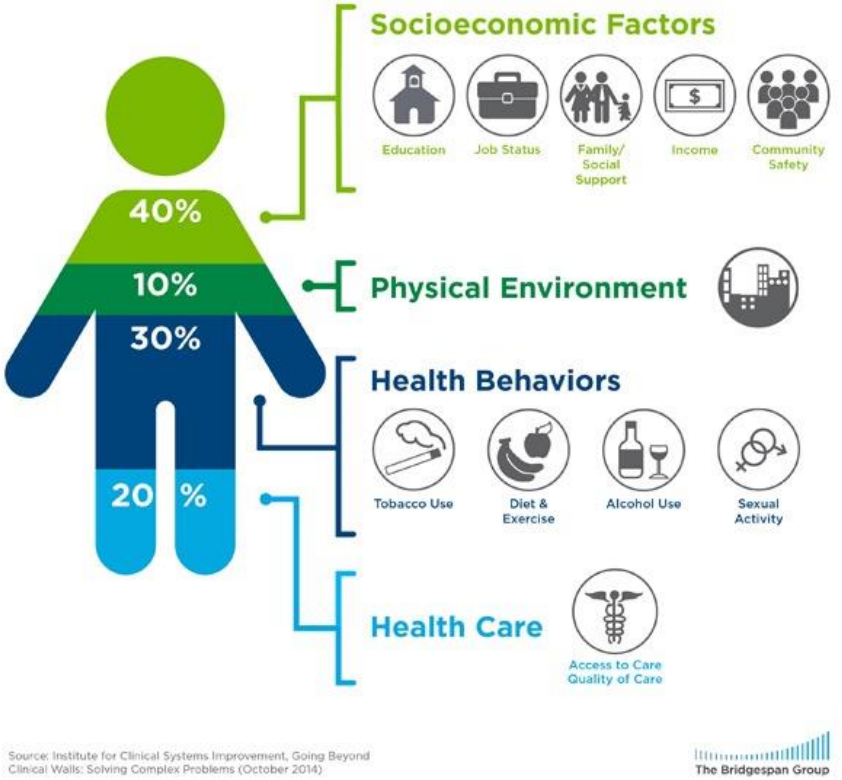
Systems for Action is coordinated by the Colorado School of Public Health, University of Colorado.

- No conflicts of interest.

Outline

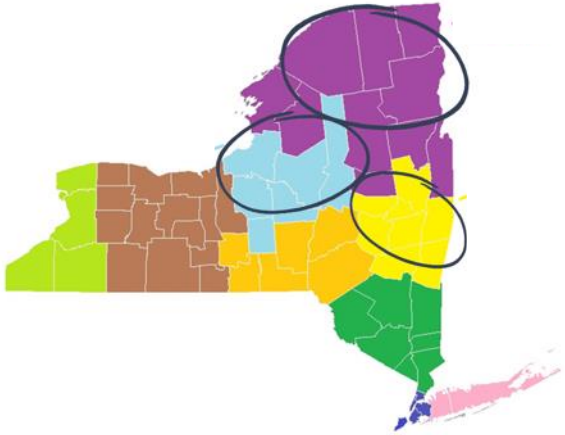
1. Context and History of Healthy Alliance
2. Quantitative Study Aims and Relevance
3. Quantitative Data Access and Prelim Analysis: A 4-year Odyssey
4. Programmatic and Policy Evolution and Lessons Learned
5. Next Phase: Qualitative evaluation (QI)

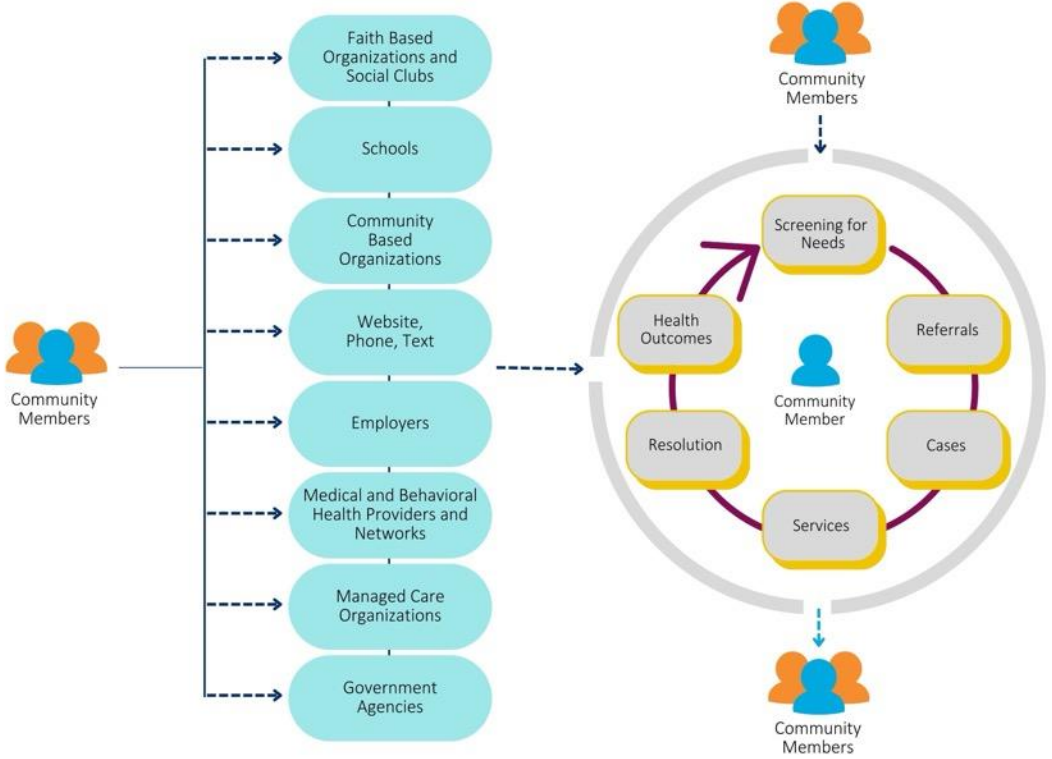
REDEFINING HEALTH



“No Wrong Door” to Services

S4A
Systems for Action





healthy alliance

www.healthyalliance.org

Key Features of a SCN

S4A
Systems for Action

NEJM Catalyst | Innovations in Care Delivery

CASE STUDY

Breaking Down the Barriers Between Health and Social Care Services: Implementing a Social Determinants of Health Network

Elena Rosenbaum, MD, Jonathan G. Shaw, MD, MS, Todd H. Wagner, PhD, Stacie Vilendrer, MD, MBA, MS, Marcy Winget, PhD, MHS, Coretta Killikelly, MSN, RN, Lynne Olney, MBA, Erica Coletti, MBA, Michele Horan, RN, Michele Kelly, CPA, Steven M. Asch, MD, MPH

Vol. 4 No. 6 | June 2023

DOI: 10.1056/CAT.22.0286

Most determinants of health are social and not directly amenable to medical treatment. To improve equity, the medical delivery system must partner with social care services,

Table 1. Key Solutions Contributing to Beneficiary–Service Connections Through Healthy Alliance's Network

Area	Feature of SDHN	Key Activitie
Technology	Closed-loop referral platform (i.e., tracks referral status over time, through fulfillment of meeting the need)	• Tracks referral information • Facilitates referrals among secto • Documents service connections • Provides data for identifying gap
User support	Training and implementation support	• Assistance with technology adop • Social needs screening best prac • Adoption and optimal use of He
User support	Referral center	• Assists agencies in directing refe that are best suited for the comr • Monitors all referral activity to e connections • Assigns Regional Referral Naviga
User support	Performance optimization	• Regionally based performance co partners with ongoing feedback to support network adoption
Quality	Network-wide service standards	• Ensures partners are receiving a referrals in a timely fashion • Ensures service connection succ
Data management	Policy- and process-related management	• Clarifies data privacy issues arou sharing • Assists with data management a
Financing	Contracting	• Healthy Alliance provides a singl MCO contracting with CBOs • Enables agencies not equipped t MCO to receive funding
Governance	Board and committees	• Leverage CBO expertise in local collaboration • Governing structure includes CB

Blending and Braiding

ALLIANCE FOR BETTER HEALTH, LLC

- Founding Members applied for DSRIP (2014) for 6 counties and receives funding from DOH forming the PPS.
- DOH prohibited PPS from contracting with an MCO (as payer) for CBO social care programs.
- Alliance for Better Health, LLC becomes managed services organization.

HEALTHY ALLIANCE IPA, LLC

- Formation of Healthy Alliance IPA in December 2018.
- Members authorized transfer of DSRIP funds to seed IPA. Dollars come with obligation to further DSRIP health objectives for Medicaid and uninsured.
- As a NYS recognized IPA, Healthy Alliance IPA is authorized to arrange for the provision of health and health related services to members of managed care organizations (MCOs), providing funding vehicle for CBOs focused on social care interventions.

HEALTHY ALLIANCE FOUNDATION INC.

- IPA Members authorized formation of the not-for-profit affiliate (Aug. 2021) for the purpose of soliciting grants and other funding restricted to non-profits.
- Healthy Alliance Inc. provides additional funding vehicle for CBO partners.
- Recipient of NYS DOH 1115 Waiver SCN Lead Entity Designation and grant (8/2024)

Financing Challenges: Hesitancy to Invest in SDOH

S4A
Systems for Action

1. Difficult for managed care organizations to estimate the full net benefit of their investments
2. Doubt whether social services can be delivered reliably and efficiently
    - Lack of familiarity with and trust in the local social services ecosystem
    - Common technical difficulties
3. Worry that they won't see return on investment due to membership churn

Nichols LM, Taylor LA. Social determinants as public goods: a new approach to financing key investments in healthy communities. Health Affairs. 2018 Aug 1;37(8):1223-30.

Healthy Alliance: A Social Care Network

S4A
Systems for Action

Innovation: Healthy Alliance formed a Social Care Network to

- Organize/curate a broad range (small & large) of regional social service agencies
- Effectively interface (negotiate, contract, closed loop referral) w/ health systems and insurers
- Originally 6 counties--> now covers 24 counties in NY State

Original Study Aim: by comparing Medicaid patients in counties with vs. without Healthy Alliance, evaluate its impact on:

1. Total cost of health care
2. Type of medical care received, and any shifts in use patterns
3. Social service care and health care use, by race and socio-demographics

Quantitative Data Analysis

- Two datasets
  - NY **SPARCs:** Cost and utilization data from the state-wide All Hospital Claims Database (2014 through 2023)
  - **Healthy Alliance's** member and services files (*Unite Us*).
    - Demographics (race/ethnicity, insurance, housing status)
    - SDOH screening from Health Leads Screening Toolkit,
    - Date of screen, client status (active, inactive), service type and subtype received, date of service, name of service program.
- Linkage: Probabilistic matching (name and DOB)
- Analysis: difference in difference methods, individual linked data

Our Experience - *"a Data Odyssey"*

S4A
Systems for Action

Data Woes…

- **The first steps can be the hardest…and most prolonged**

and

- **We encountered challenges every step of the way:**

1. Data **permissions/access**

2. Data **linkage:** between
   a. SPARCs (Health) and
   b. Healthy Alliance (Social Care) based on limited shared identifiers

3. Data/linkage **quality** issues

Our Experience - *"a Data Odyssey"*

Many organizations collecting data…

Some better/worse at capturing.

Selective missingness, e.g:

- **CBO's**: race/ethnicity data spotty
  - as we shared previously with this S4A group(*'24 RIP, '22 Think Tank*) tremendous variability in race/ethnicity data reporting, high missingness.

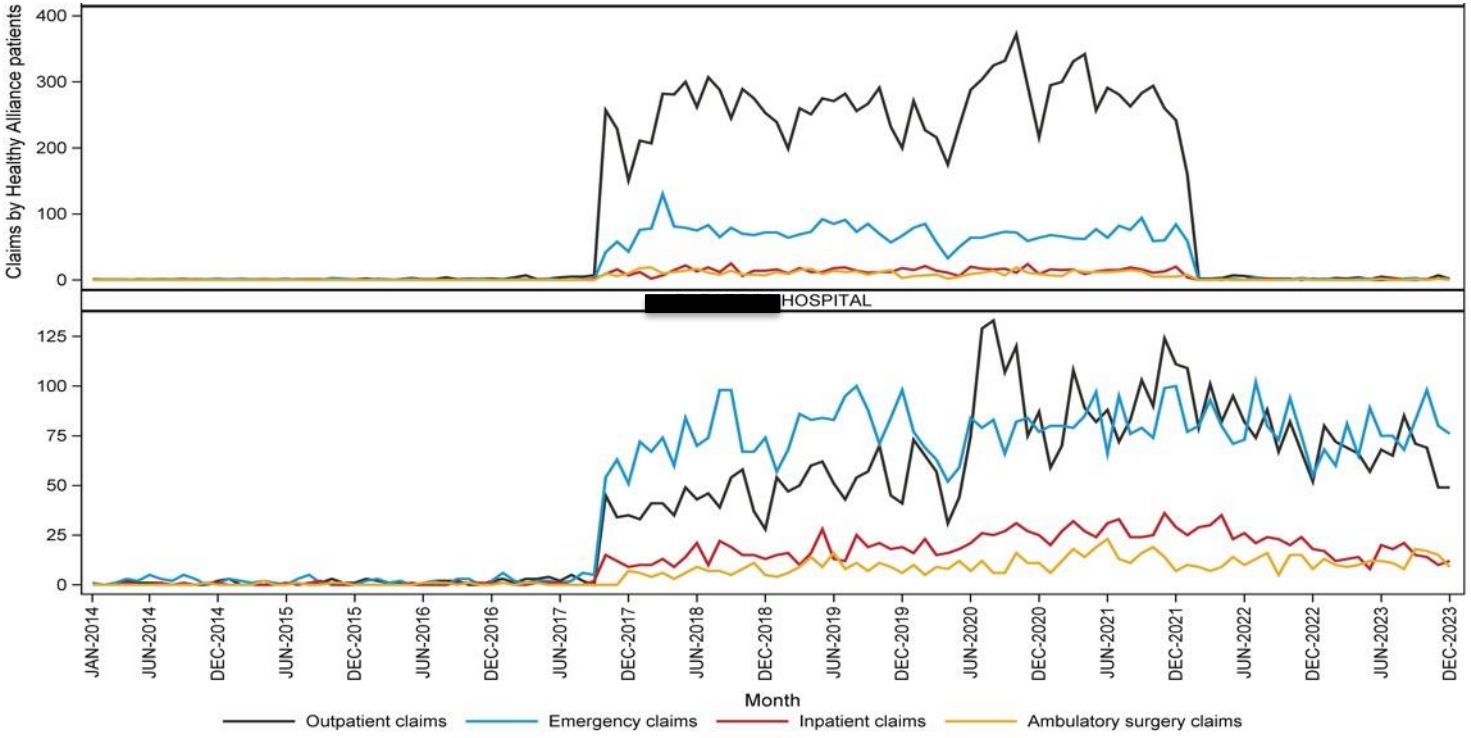
  →but efforts *did* improve

- **NY SPARCS** hospital/facility reported claims: unique identifiers

  →*harder bureaucracy to influence*

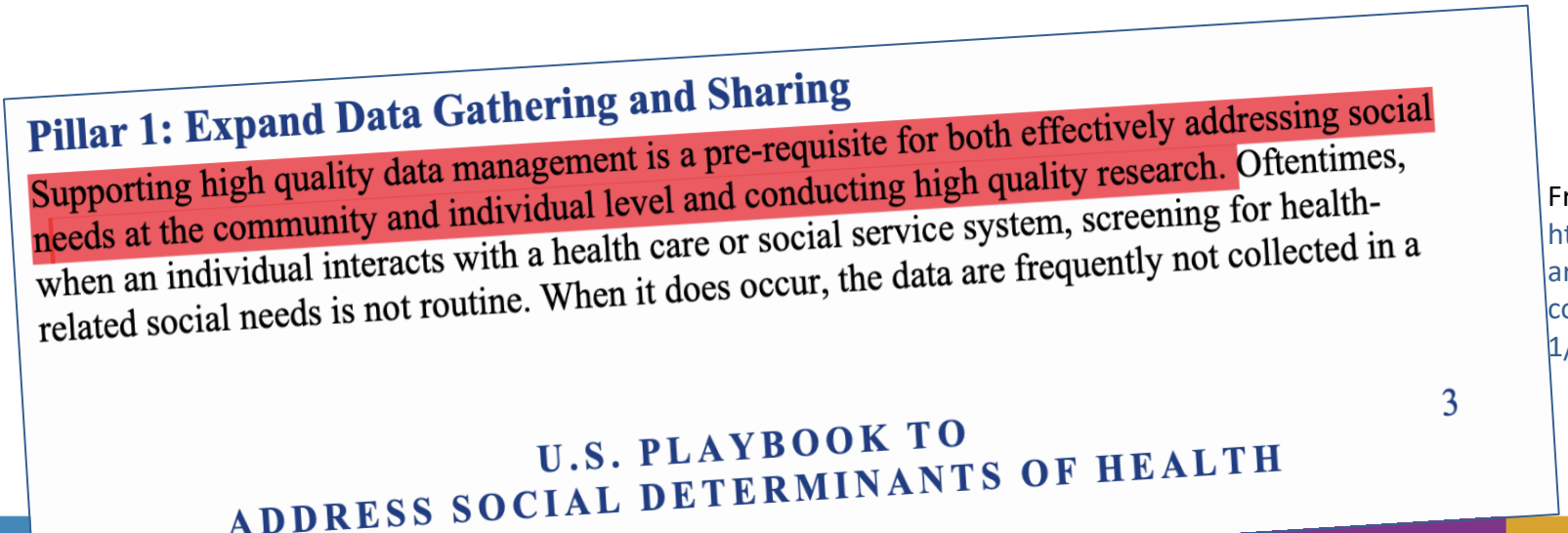
Example: Discontinuity of Claims Data

Data Linkage for Healthy Alliance Cohort for Two Hospital Systems in NY – Marked discontinuity discovered to be due to facility-level policy change in what identifiers they chose to report (i.e., 4-digits of SSN)



Challenges Linking Social and Health Care Data

- We knew that there would be challenges with linkage given the different types data sets
- Even when tried to anticipate and create different linkage strategy -- *SSN collection became a major issue
- Other researchers in other states experiences?



Pillar 1: Expand Data Gathering and Sharing

Supporting high quality data management is a pre-requisite for both effectively addressing social needs at the community and individual level and conducting high quality research. Oftentimes, when an individual interacts with a health care or social service system, screening for health-related social needs is not routine. When it does occur, the data are frequently not collected in a

3

U.S. PLAYBOOK TO
ADDRESS SOCIAL DETERMINANTS OF HEALTH

From: https://bidenwhitehouse.archives.gov/wp-content/uploads/2023/11/SDOH-Playbook-3.pdf

Linked Data Analysis: Current Aims

S4A
Systems for Action

Despite known suboptimal linkage, we still have nearly 9,000 Healthy Alliance clients with claims data, and forging ahead to see what we can learn:

- **Aim 1 - Cost of Care:** Assess the impact of coordinated social care assistance interventions on total cost of health care.
  - Total costs observable from *available* SPARCS claims

- **Aim 2 – Type/patterns of Care:** Compare the type of medical care received and assess whether there has been a shift over time in cases relative to controls.
  - ED Visits
  - Hospitalizations and length-of-stay
  - Ambulatory surgery

Linked Data Analysis: Current Methods

S4A
Systems for Action

Outcome: Hospital Claims-based Healthcare Costs and Use

Method: Difference in differences (DD) design, with propensity score weighting to adjust

	Before Healthy Alliance Enrollment	After Healthy Alliance Enrollment (~2018-2022)
Members in Healthy Alliance Counties	Average Cost/Use per-member per-month	Average Cost/Utilization per-member per-month
Matched Controls in other NY Counties	Average Cost/Use per-member per-month	Average Cost/Use per-member per-month

Linked Data Analysis: Control Group

Comparison cohort selected and weighted to match as follows:

1. Comparable NY counties (e.g. excludes NY City)

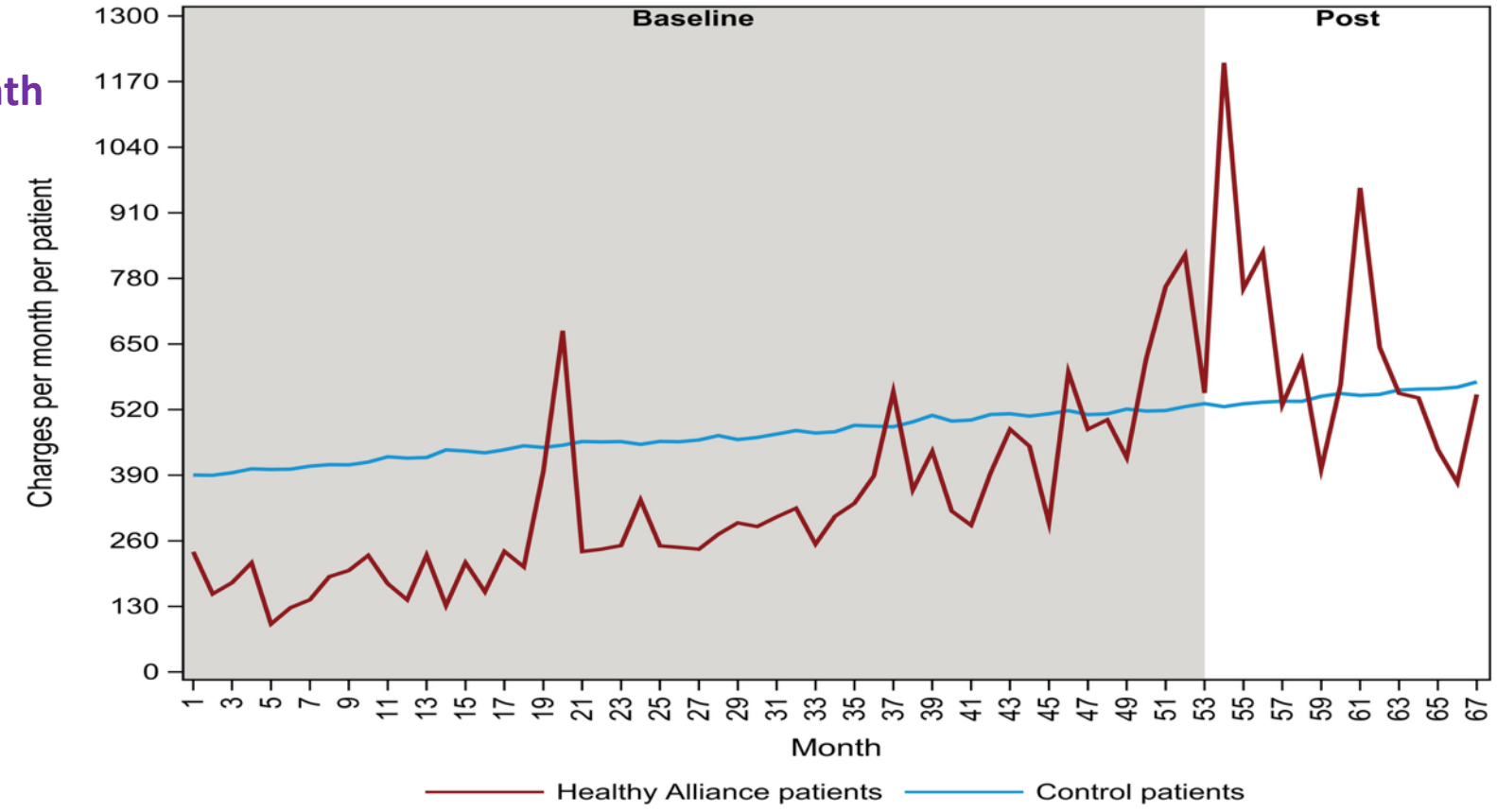
2. Randomly assigned pseudo-enrollment dates to make pre/post comparable to Healthy Alliance enrolled clients

3. Propensity score matching weights, based on key factors, including
   a) Age at enrollment
   b) Gender
   c) Comorbidity status at enrollment (Elixhauser)
   d) Area deprivation index

Prelim Findings: Unadjusted Observations

S4A
Systems for Action

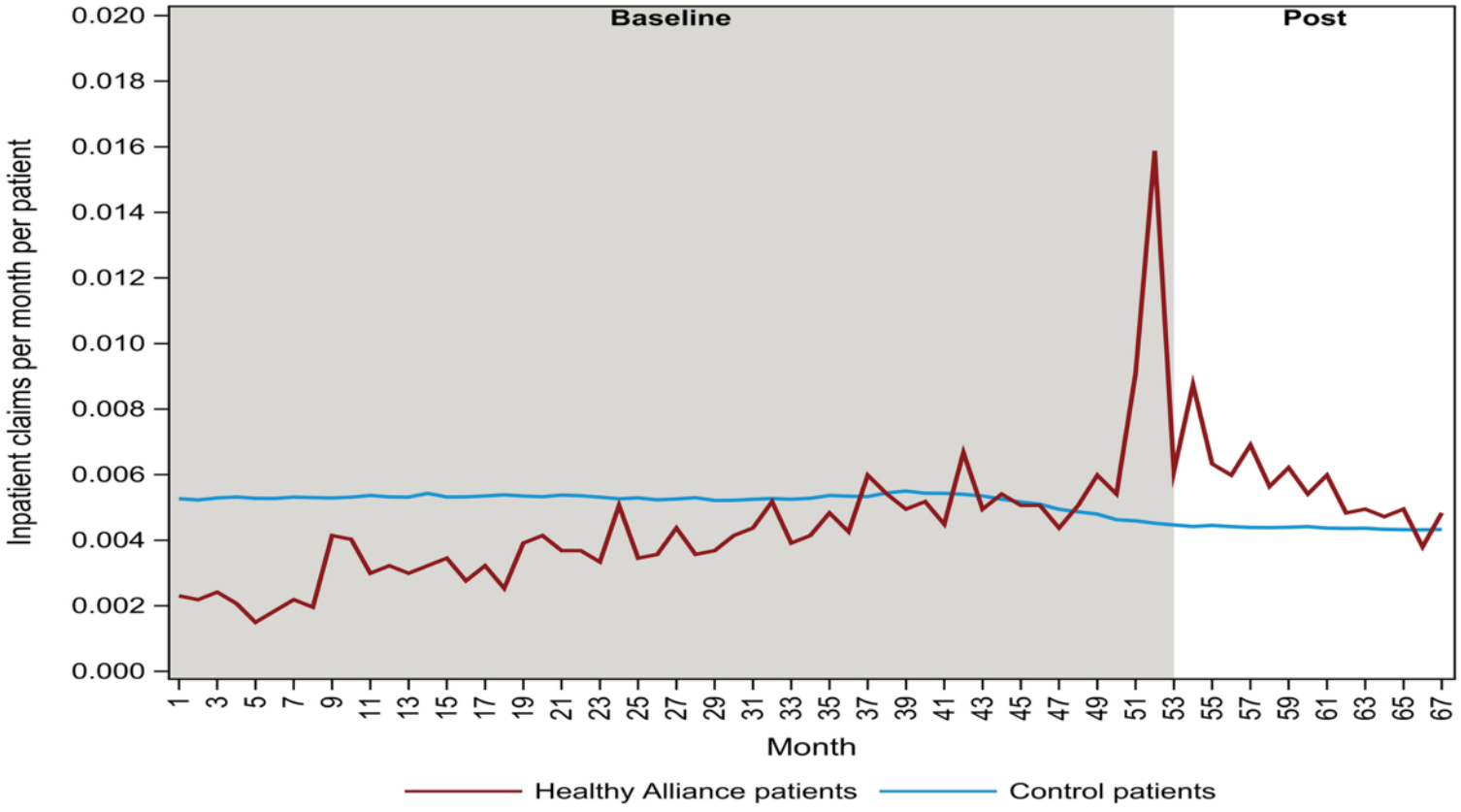
$
Charges/month



Prelim Findings: Unadjusted Observations

S4A
Systems for Action

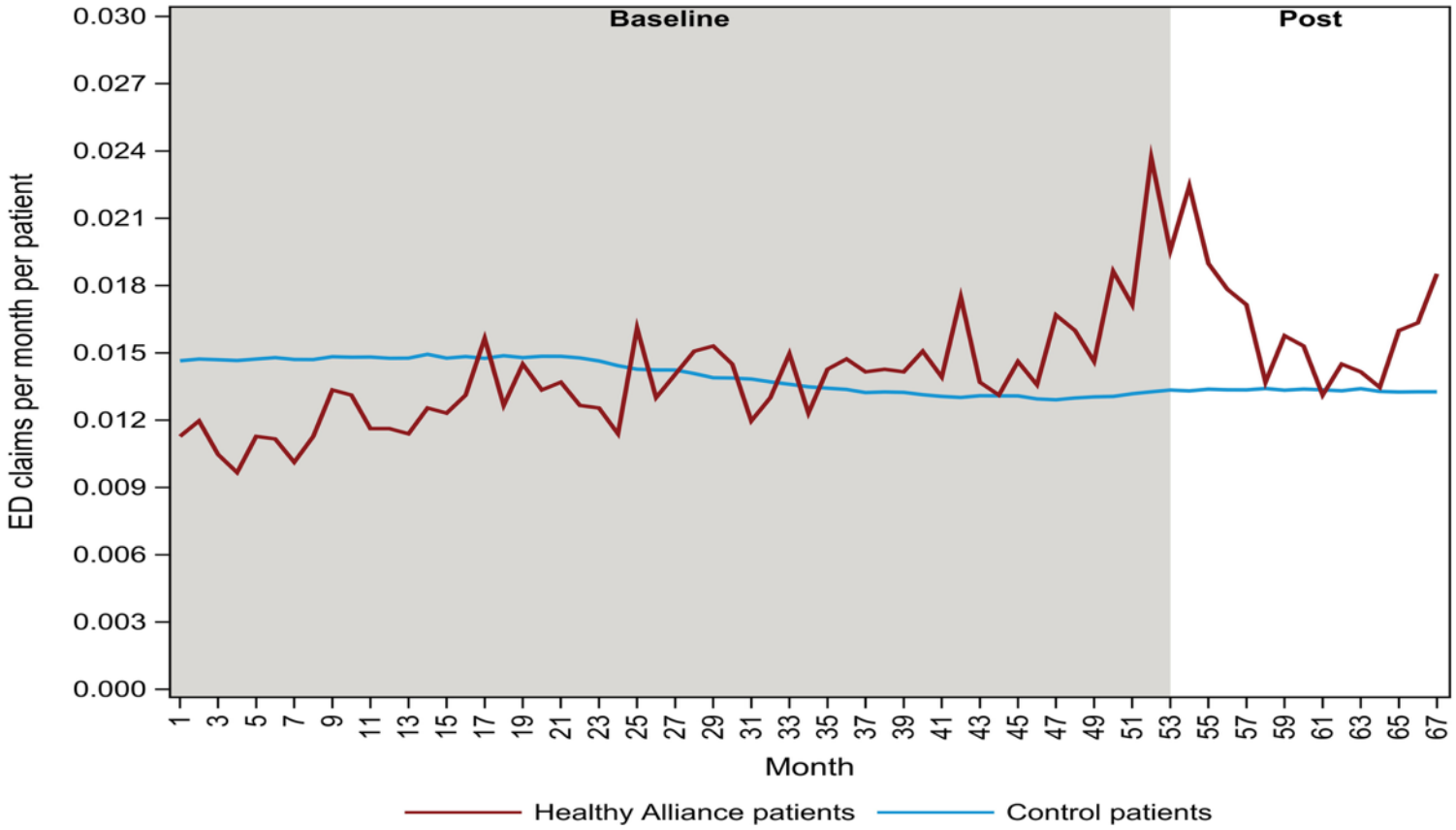
INPATIENT
Claims/month



Prelim Findings: Unadjusted Observations

S4A
Systems for Action

ER Claims/month



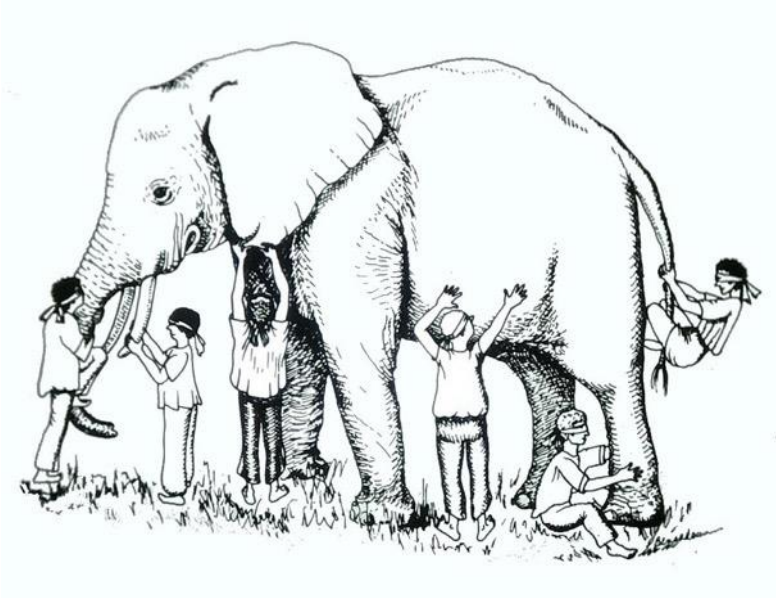
Remaining Gaps

QUANTITATIVE question still an open question:

Do the healthcare costs and outcomes improve as hoped?

- Currently running ADJUSTED analysis of 8,714 Healthy Alliance clients for whom we could match claims.

QUALITATIVE questions equally important
(patient & community-focused; equity focused)



Alignment: Health Equity and Payment Reform

S4A Systems for Action

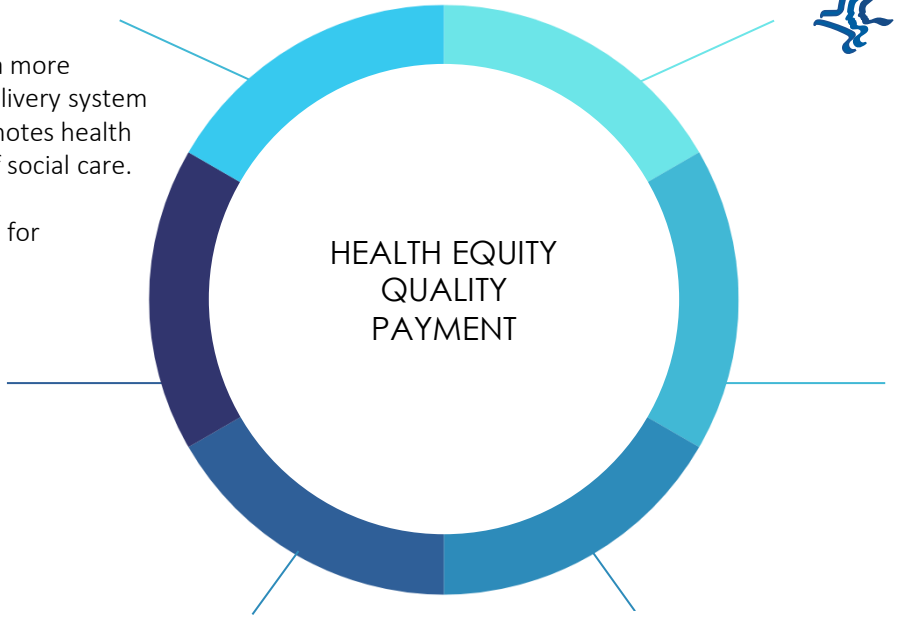
NEW YORK STATE Department of Health

NYHER 1115 WAIVER - Building a more resilient, flexible, and integrated delivery system that reduces racial disparities, promotes health equity, and supports the delivery of social care.

100% Medicaid recipients screened for health-related social needs (HRSN)

NCQA Measuring quality. Improving health care.

Social Care Screening and Intervention within 30 days



U.S. Department of Health and Human Services
Enhancing the health and well-being of all Americans

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

New models of care and payment (MCP, ACO, CMMI Models, VBP)

Grant Applications

OASH Office of Disease Prevention and Health Promotion

Healthy People 2030

healthy alliance

www.healthyalliance.org

1115 WAIVER SCN LEAD ENTITY

CORE RESPONSIBILITES

- Build and maintain a comprehensive Social Care Network (SCN) of contracted organizations
- Enroll in the NYS Medicaid Program as a Medicaid billing social provider.
- Intensive coordination of HRSN services for Medicaid Managed Care Members eligible for Enhanced HRSN Services
- High quality customer experience for Medicaid Members seeking HRSN services
- Build the capacity and provide administrative support to Community Based Organizations (CBOs)
- Establish financially and operationally sustainable, self-innovating ecosystems.
- Promote equitable delivery of HRSN services and address the health, racial, ethnic, socioeconomic, and geographic disparities in existing access and quality.

HRSN Covered Services- NY

S4A
Systems for Action

SCREENING:

Medicaid Fee for Service and Medicaid Managed Care Members NYS version of the Accountable Health Communities Health-Related Social Needs screening tool

NAVIGATION:

Most Medicaid Fee for Service and Medicaid Managed Care Members are eligible for Navigation to existing federal, state, and local benefits and programs

ENHANCED HRSN SERVICES:

Some Medicaid Managed Care Members may also be eligible for Enhanced Health-Related Social Needs Services, each with eligibility requirements, service limitations and restrictions, and allowable providers

CARE MANAGEMENT:

- Navigation to existing federal, state, and local benefits and programs
- Enhanced Health-Related Social Needs Services care management

HOUSING SUPPORTS:

- Home accessibility and safety modifications
- Home remediation service
- Asthma remediation and supportive products
- Recuperative Care (Medical Respite)
- Rent/Temporary Housing
- Utility set up/assistance
- Pre-tenancy and tenancy sustaining services
- Community transitional supports
- Housing transition and navigation services

NUTRITION SUPPORTS:

- Nutritional counseling and classes
- Medically tailored meals
- Clinically appropriate home-delivered meals
- Medically tailored or nutritionally appropriate food prescriptions
- Fresh produce and nonperishable groceries (pantry stocking)
- Cooking supplies (pots, pans, etc.)

TRANSPORTATION:

- Transportation related to health-related social needs service or care management

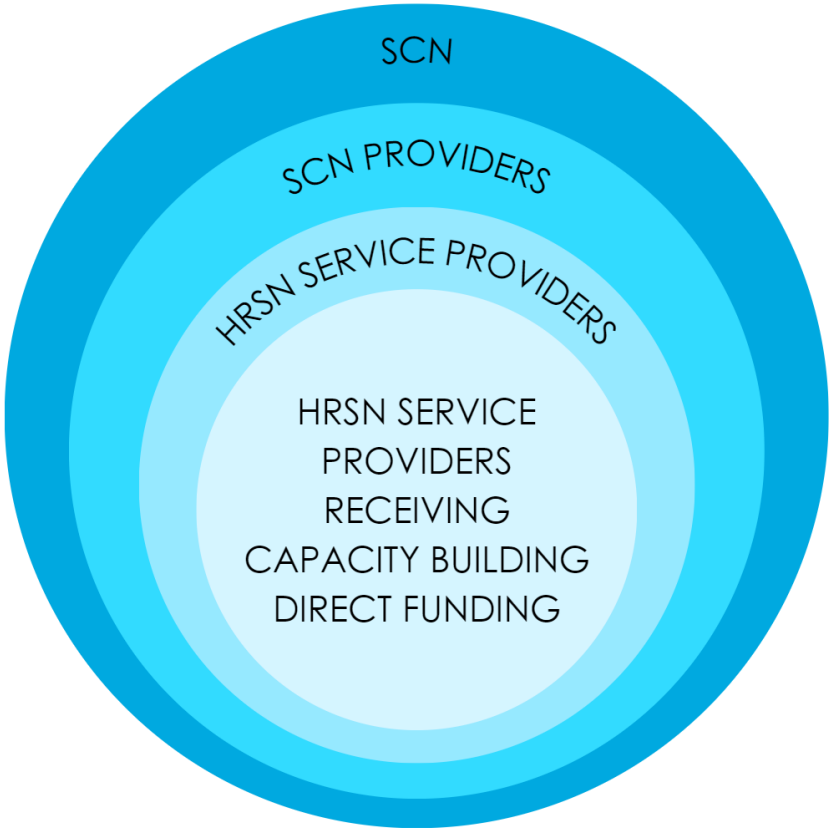
Enhanced Population

- Members with substance use disorder or serious mental illness
- Members with intellectual and developmental disabilities
- Pregnant or postpartum persons
- Member recently released from incarceration and have chronic health conditions
- Children under 18 who are high risk or have chronic health conditions, including youth in care
- Frequent health service users
- People enrolled in Health Home

CBO Journey

Application	Service delivery
Contracting	Regular convening
Credentialing	Governance/workgroups
Training/onboarding	Ongoing admin support
Capacity Building	Continuous feedback

Non-profit CBOs: Capacity Dollars



SOCIAL CARE NETWORK

Challenges

S4A
Systems for Action

- Closed loop referral technology
- Workforce hiring challenges
- Overall policy environment and social service environment chaotic. CBOs less interest in participating even if funded.
- Short time frame for implementation. Takes **time** to have conversations and understand individual CBO needs.

Next steps: Qualitative study / Quality improvement

S4A
Systems for Action

Evaluation Leads: Nadia Safaeinili PhD, MPH & Steve Asch MD, MPH (*Stanford School of Medicine*)
Time period: May 2025 – March 2027

Explore **Medicaid beneficiary** and **community-based organization (CBO) leadership and staff** perspectives on:

- What makes CBOs successful or not in **engaging** Medicaid beneficiaries in social service delivery?
- What makes CBOs successful or not in **connecting** Medicaid beneficiaries with social services?

- What **interpersonal factors** influence Medicaid beneficiaries' engagement with CBOs to receive social services?
- What **structural factors** influence Medicaid beneficiaries' engagement with CBOs to receive social services?

Methods

Methods | Data collection & analysis

(across 24 counties in Upstate NY)

- ~ 70 semi-structured interviews with CBO leadership & staff
- ~ 70 semi-structured interviews with clients/Medicaid beneficiaries of those CBOs
- Hybrid inductive-deductive rapid analysis approach

Methods

Methods | Community engagement

Team composition	Community feedback sessions	Final stakeholder convening
Community research team members participate in study design, data collection, analysis, & writing. ***Community capacity building*** Local university students will receive qualitative methods training to conduct client / Medicaid beneficiary interviews, with opportunities to participate in and receive training for analysis & writing.	Interim findings will be shared back to study participants and the broader community for feedback and validation at regular intervals.	Study participants, community members, state policymakers, and local funders will be invited to hear study findings and brainstorm ways to leverage strengths and address challenges identified.

Our Key Learnings

1. **Opportunities to inform policy** →

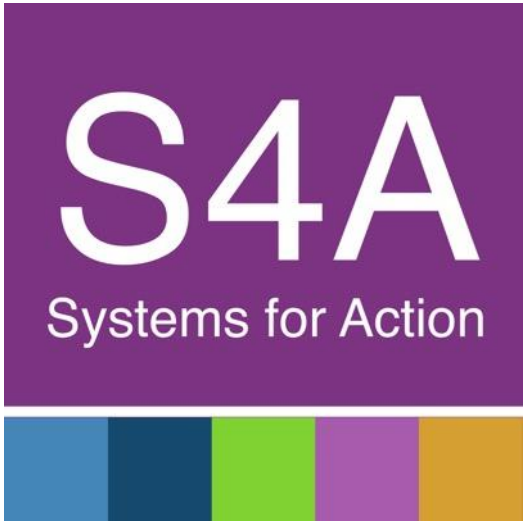
And policy need for investment in:

2. Better data and data access

3. Qualitative / mixed methods

Questions?

S4A
Systems for Action



www.systemsforaction.org

Acknowledgements

Systems for Action is a National Program Office of the Robert Wood Johnson Foundation and a collaborative effort of the Colorado School of Public Health, administered by the University of Colorado Anschutz Medical Campus in Aurora, CO.

Robert Wood Johnson Foundation

colorado school of public health