FREQUENTLY ASKED QUESTIONS:
Leveraging Integrated Networks in Communities (LINC) to Address Social Needs Act

Senators Dan Sullivan (R-AK) and Chris Murphy (D-CT) have introduced the *Leveraging Integrated Networks in Communities (LINC) to Address Social Needs Act of 2021 (S. 509)*, which would establish a program to assist States in establishing or enhancing community integration network infrastructure for health and social services.

Why are actions to address social needs critical to health?

- Economic and social conditions have a powerful impact on our health and wellness. Stable housing, reliable transportation and access to healthy foods are all factors that can make a difference in the prevention and management of many health conditions like diabetes, asthma and heart disease. Known as Social Determinants of Health (SDOH), these coordinated efforts help meet non-medical needs to improve health outcomes and wellbeing.
- States, local governments, providers, health plans, and community-based organizations are increasingly looking to deploy cross-sector holistic interventions. Collaborations across the country are seeking to identify and address health and social needs to improve health outcomes and lower long-term costs. However, there are persistent challenges in replicating, scaling, and ensuring sustainability of these high-impact interventions given the siloed nature of our health and social services systems.

Why do we need the *LINC to Address Social Needs Act*?

- Americans across the country lack access to affordable, safe housing, adequate nutrition, energy assistance, or other critical needs. Individuals seeking assistance often rely on emergency rooms and health systems in addition to churches, food banks, and nonprofit organizations in their communities.
- The health care sector is also increasingly screening for and identifying these types of social needs because research has shown that social factors can drive up to 80 percent of health outcomes.[1] Health care entities have begun to develop partnerships with community-based organizations and other entities to make referrals to help address individuals' social needs, and to expand the scope of care coordination activities.
- However, unlike the increasingly coordinated way in which health care entities currently refer, coordinate care, share individuals' health care information, and develop value-based arrangements with other health care entities, the health care and social service systems often reside in separate siloes. This results in an incomplete understanding of individuals' holistic needs, an inability to efficiently coordinate service delivery, and an increasingly complex system for individuals to navigate.
- The *LINC to Address Social Needs Act* seeks to solve these challenges by building an outcome-focused infrastructure to connect entities in the health and social service systems for purposes of communication, service coordination and consumer assistance, referral and capacity management, outcome tracking and other related services.
- The *LINC to Address Social Needs Act* will fund public-private partnerships to establish or enhance the development of infrastructure that can serve as a regional or statewide point of connection, allowing

[1] Hood, C. M., K. P. Gennuso, G. R. Swain, and B. B. Catlin. 2016. County health rankings: Relationships between determinant factors and health outcomes. *American Journal of Preventive Medicine* 50(2):129-135.

entities to benefit from a common resource, rather than increasing provider and community-based organization (CBO) burden through multiple one-off, and often, conflicting connections and exchanges.

What does this look like in practice?

- A particularly strong example of this work is currently underway in North Carolina, where a public-private partnership of state government, the United Way, private foundations, and tech vendors are showing the way though NCCARE360 -- which connects CBOs and the state's health system in a way similar to this proposal. NCCARE360 leverages partnerships that provide expertise in building the following components of the network:
  - A robust statewide resource directory which includes a call center with dedicated navigators, a data team verifying resources, and text and chat capabilities.
  - A community data repository that integrates multiple resource directories across the state and allows data sharing. The model will be extended to manage resources specific to the social determinants of health in North Carolina.
  - A shared technology platform that enables health and human services providers, community-based organizations, and others to send and receive electronic referrals, seamlessly communicate in real-time, securely share client information, and track outcomes.
- Another example of this important work has started in Connecticut, where the Connecticut Hospital Association and its member systems are working with CBOs on a statewide coordinated care network of health and social service providers to deliver integrated care. The network uses a technology platform to better connect patients to local service agencies that help with housing, food, transportation, and employment services. This new statewide coordinated network:
  - Allows health providers and CBOs to send and receive secure referrals to connect individuals to services to address social needs.
  - Partners with 211 Connecticut, a program of the United Way of Connecticut and the state's primary resource and referral platform, to connect to 211's database of more than 4,000 CBOs.
  - Pilots at some hospitals already are strengthening care coordination with local social service organizations, seeing positive results for patients, community organizations, and care providers.
- A final example is the CMS Accountable Health Communities (AHC) Model, which tests whether connecting beneficiaries to community resources can improve health outcomes and reduce costs by addressing health-related social needs (HRSNs). The first Evaluation Report for the model revealed:
  - More than half of navigation-eligible beneficiaries reported more than one core need. Food insecurity was the most commonly reported need with a median prevalence of 69 percent across bridge organizations.
  - Of the eligible beneficiaries that accepted assistance, only a small proportion had their social needs resolved due to difficulties with data reporting, loss of contact, and insufficient community resources. The *LINC to Address Social Needs* Act responds to these challenges.

Why Now?

- Establishing infrastructure responsible for identifying, sharing information, and coordinating care will expand and improve efforts to address health and social needs and can help to advance health equity.
- The COVID-19 pandemic has exposed longstanding health and social inequities, which are driven in part by a greater need for social services and decreased access to health care. While data show higher rates of COVID cases and hospitalizations among individuals dually enrolled in Medicare and Medicaid, as well as individuals who are Black and Hispanic, similar disparities exist in the prevalence of chronic and other health conditions in these populations.
- Moreover, the ongoing pandemic continues to exacerbate challenges with food insecurity, housing instability and transportation, among other issues, that were already barriers for many. These challenges will continue for the foreseeable future – far beyond the pandemic.
- While there are regional pockets of community integrated network innovation, social service systems and the health care system are not generally connected in a sustainable, standardized way, which limits data sharing, shared accountability, and service coordination. These limitations make it difficult for states to promote coordinated service delivery and manage public health emergencies.

Have others made the case for this?

- The HHS Administration for Community Living (ACL) has strongly articulated the need for community-based organization networks that can better connect with the health care sector. ACL published a blog post, vision statement and a Strategic Framework for states to integrate services, which is focused on older adults and people with disabilities.
- In a December 2020 Request for Information, the Centers for Medicare & Medicaid Services (CMS) solicited stakeholder comment on challenges in collecting, exchanging, and leveraging social needs information to inform and improve care, including a request for insights on key challenges related to exchange of social needs data between providers and community-based organizations.
- HHS recently held a series of roundtable discussions on social determinants data, which culminated in a report on Leveraging Data on the Social Determinants of Health. The report calls for the development of sustainable social determinants data infrastructure and support for state and local efforts.
- The National Academy of Medicine has recommended the development of linkages and communication pathways between health care and social service providers.
- Nemours Children's Health System published a brief presenting emerging elements for closed-loop technology systems and accelerators and challengers to financing community care coordination systems.
- Several health care thought leaders published a blog in Health Affairs in December 2020 calling for the Center for Medicare and Medicaid Innovation (CMMI) to declare reducing health care inequities as a twin goal alongside improving value, and recommending that all models should require program participants to uniformly screen for and document social needs, which can be used to improve care.
- HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) recently published a report presenting a landscape review of community-level efforts to address social determinants of health, including interviews with participants in three community-level initiatives that have built networks to coordinate clinical and social services.

- Nearly 100 leading organizations have already joined Aligning for Health in supporting proposals to better connect health care and social service organizations, including leading associations representing local governments, hospitals, health plans, business groups, housing, food, and service workers.

Will this lead to more referrals to already overwhelmed service organizations?

- Currently, social service providers often have to use different formats for referral and service coordination with each health care provider and/or plan. The goal of a technology-enabled referral management system is to better align the capabilities of the health and social services sectors with their corresponding needs, in a manner that is standardized and coordinated amongst all partners. Better alignment means that capacity can be managed in both directions, and utilization can be documented. With better documentation, decision makers will be able to target interventions to address shortcomings in their communities and provide more holistic health care.

- The proposal would include targeted training and technical assistance for community organizations to adopt the platform and help them engage with health care organizations.