Trenton Health Team:
A Holistic Approach to Social Services

April 2019

The Trenton Health Team (THT) is an innovative, multi-sector partnership dedicated to the health and well-being of the greater New Jersey Trenton community.

THT has served Trenton since 2006, as a community health care collaborative created in response to the closure of Mercer Medical Center and dedicated to improving access to quality healthcare for city residents.

The collaborative is an innovative partnership among Capital Health, Henry J. Austin Health Center, St. Francis Medical Center, and the City of Trenton Department of Health and Human Services. Over the years, our focus has expanded to meet the range of health concerns affecting our community.

THT, along with our community healthcare system partners, understand that health and well-being are inextricably linked to housing quality, food security, neighborhood safety, education, and nurturing environments – "upstream" health factors with long-term – "downstream" – influence.

To realize our Vision for a Healthy Trenton, THT must embrace a broader view of health and well-being in the community and consider how THT can work, along with partners, to advance that objective.

Using a data-driven approach, THT is working intensely with many community groups, assessing health care needs and helping residents learn how to care for – and advocate for – themselves. Data from these assessments helps to pinpoint gaps and barriers to service and identifies ways to improve delivery of preventive and remedial services. The success of this approach in Trenton will have implications throughout the state and the nation as urban areas work to improve health care and rein in costs.

Consistent with the THT mission, we are pooling resources with representatives of a variety of municipal, county and state agencies, social service groups, the faith community and higher education – a total of more than 100 different community organizations, which serve as members of our Board of Directors, its subcommittees, or the Community Advisory Board.

Collaborating for a deeper understanding of community health needs since 2006, THT has developed approaches that look at the whole person—not just an organ, or a specific disease, but everything about that person's life, including homelessness, mental illness, fear of crime, and lack of access to fresh, healthy food. This collaborative approach extends to other prominent health and social service groups in the city. Now, virtually all players in Trenton's psycho-social service network have joined the THT Community Advisory Board (CAB). Members enthusiastically share information that yields a comprehensive look at the city's people.

The purpose of the Trenton Health Team Community Advisory Board (CAB) is to encourage cross-sector communication and facilitate activities that improve the health and well-being of the greater Trenton community. This purpose is accomplished by:

1. Creating a forum for active collaboration, leveraging the collective expertise, resources, funding and support of partners throughout the community.

2. Providing input, feedback, and guidance on the key strategic initiatives and activities implemented by Trenton Health Team and partner organizations.

The CAB is a diverse body that includes representation from social services, faith communities, educational institutions, healthcare providers, health insurers, educators, students, residents, local businesses, patients, state agencies, and municipal government. With the overarching

goal of achieving health equity, the CAB serves as a resource to advise and support THT's ongoing efforts to assess the health status, needs and assets of the community; develop policy and program recommendations; provide leadership to improve health outcomes and assure the provision of needed services and support to residents.

The CAB facilitates sharing and analysis of community health data among the following members:

- Organizations with direct connections to community members, clients, patients, and/or constituents assist with gathering and disseminating information.

- Organizations with data analytics resources, including THT, assist with gathering, analyzing, and reporting on the information collected.

Together, subsets of CAB members partner to co-design interventions, create referral and information pathways between organizations, and design, implement, and support innovative programs. For this collaborative strategy, the CAB refers to itself as the PATH (Partners Advancing Trenton's Health). The CAB is formally a sub-committee of the Trenton Health Team Board of Trustees with a provision for working groups as appropriate.

IDENTIFYING THE NEED FOR A CLOSED-LOOP REFERRAL SYSTEM

In working closely with health care and social service providers throughout the city and with the formal structure of the CAB/PATH, Trenton Health Team has gained deep insight into the breadth of services that Trenton residents and families utilize on a regular basis. The 2019 Trenton Community Health Needs and Assets Assessment revealed through a resident survey of over 1400 individuals and 10 community forums that there is an abundance of free and low-cost services in Trenton. While Trenton is rich in social services (one community member said "no one in Trenton should go hungry," alluding to the abundance of food pantries and places to get free meals in the city), these services often lack coordination with one another, with this reflected in the patient or client experience.

Meetings with the Community Advisory Board revealed coordination between health care and social service facilities was also weak, and that many community resources were being underutilized. Clinical and social service staff representing different organizations came to understand that the patient at the local federally qualified health center was also visiting a nearby food pantry regularly and was also engaged with a community organization to remediate lead and mold in the home. The acknowledgement that one individual was receiving services across health care and social service providers that often didn't coordinate or communicate with one another prompted a call to action, one that demanded a means to communicate, share information and hold referral receiving agencies accountable. After conducting months of research and due diligence, Trenton Health Team engaged Now Pow, a social services closed-loop referral platform. This platform would allow residents' healthcare, social and environmental needs to be addressed and coordinated across the complex system of services provided in the city.

STRATEGY/PROCESS UNDERTAKEN AS PART OF THIS PROJECT

NowPow Steering Committee

To drive widespread usage of the NowPow platform among local organizations, Trenton Health Team adopted a co-designing, planning and implementation process with its health care and social service partners. In conjunction with THT's Population Health team, a group responsible for the implementation of NowPow in Trenton, the NowPow Steering Committee, a group of social workers and program staff from multiple organizations in Trenton including health care, emergency housing, behavioral health, legal defense and education, and home health care, guides implementation and standard-setting for the platform.

Beyond the core members that represent the major health care institutions in Trenton, any organization who would like to play a larger role in the implementation of NowPow is invited to join the NowPow Steering Committee. The committee meets monthly in person at THT's office or via video conference and engages in additional activities as needed in between meeting over email and phone calls with the THT Population Health team.

The NowPow Steering Committee is tasked with:

1. Making recommendations for other organizations and agencies to join the platform;

2. Being a NowPow champion and resource within the home organization and the broader Trenton community-based organization/agency network.

3. Developing, testing and refining a social determinants of health screening tool.

4. Reviewing referral and social determinants of health data to identify areas of improvement and implement improvement strategies.

5. Identifying gaps in the availability of social services in Trenton and making recommendations for mitigation.

6. Setting community-wide standards for timeliness of tracked referral responses and status updates.

7. Identifying and bringing forward NowPow/HIE system and workflow issues and engaging in continuous quality improvement activities.

Social Determinants of Health Screening Tool

The Trenton Health Team's Care Management Team has been conducting a social needs assessment since it first started working with Trenton residents with complex medical and social needs in 2013. The THT's social worker assesses social need by covering an array of social needs domains including housing, transportation and employment. These needs were documented in a narrative format that cannot be aggregated across a patient population. Similarly, partner health care organizations, including the local federally qualified health center, deployed social workers and care coordinators to assess and address patients' social needs, but did not do so in a standardized way, and did not share the resulting data.

During the first meeting of the NowPow Steering Committee, members decided that it was in the best interest of their patients, organizations and health of the Trenton population to either select or develop a social determinants of health (SDOH) screening tool that could be used city-wide across institutions. Using NowPow and the Trenton Health Information Exchange, which was already widely used across institutions in Trenton, an SDOH screening tool could allow for the aggregation of SDOH screenings to collect data and better understand social needs in Trenton.

Existing SDOH Screening Tools

To develop the Social Determinants of Health screening tool, the NowPow Steering Committee reviewed several screening tools including those developed by Accountable Health Communities, Health Leads, and the PRAPARE tool. These instruments are comprised of clinically validated questions and multiple social needs domains but are not themselves validated in their entirety. The absence of a single validated tool and the variety in domains across the reviewed tools led the committee to select domains and then questions to develop a Trenton-specific SDOH screening tool.

A Community-Oriented Approach

In addition to the fact that the existing tools are not validated, the NowPow Steering Committee wanted to consider a set of standards when selecting an assessment. These considerations included:

- Selecting questions that have a literacy level that is **relative to the literacy of the population**.

- Including social needs domains that have been identified by residents, organizations and data as being pertinent to the lives of Trenton residents. The Trenton Community Health Needs Assessment was referenced to support the **prevalence of specific social needs**.

- Structuring the assessment to allow for **brevity but remain comprehensive** so that it can be administered in a fast-paced clinical setting or to patients/clients with limited time.

The NowPow Steering Committee used the Social Interventions Research and Evaluation Network's (SIREN) Social Needs Screening Comparison Table to compare and contrast screening questions for each domain, seeking questions that use a "Yes/No" response type, are written below a 7th grade reading level, and are for domains that are relevant to the lives of Trenton residents. After reviewing a variety of screening questions and domains, the group settled on a 14-question SDOH screening that includes the following domains:
- Food Insecurity
- Housing and Housing Quality
- Utilities
- Child Care
- Transportation

- Primary Care
- Dental Care
- Health Literacy
- Financial Security
- Intimate Partner Violence
- Public Safety
- Legal Issues
- Employment

Standardized screenings for depression (PHQ-9), anxiety (GAD-7), drug abuse (DAST) and alcohol abuse (AUDIT) are available as "add-ons" to the SDOH screening. These were deemed optional because some local health care partners already screen for depression, anxiety, drug abuse and/or alcohol abuse as part of an existing intake or screening process that oftentimes is documented within an organization's electronic medical record (EMR) system.

ENGAGING COMMUNITY PARTNER ORGANIZATIONS

After engaging core health care partners in the NowPow Steering Committee, it was important to develop an approach to introduce NowPow to various agencies and community-based organizations in Trenton. These organizations play the role of the referral receiver, outreaching to patients after they have been referred by a healthcare organization. This part of the NowPow implementation process, engaging community partner organizations, is equally as important as engaging healthcare providers, as generating a closed-loop referral requires the participation of the referral receiving organization on the NowPow platform.

To engage community partner organizations, Trenton Health Team and the NowPow Steering Committee host Town Hall meetings where any staff person from any organization can learn more about NowPow, watch a demonstration of the platform, and brainstorm how the tool can enhance their organization's current workflows and communication with other organizations.

Town Halls

The Trenton Health Team Community Advisory Board (THT CAB) was the first group of organizations to learn about and see a demonstration of the NowPow platform. The initial introduction of NowPow to the CAB provided a forum to introduce the concept to the group, promote and engage organizations and individuals and to extend a verbal invitation for partners to attend the NowPow Town Hall.

Following the CAB meeting, attendees received an email with a calendar invite to the first NowPow Town Hall, along with a video demonstration of the platform and a two-page NowPow overview document. Recipients were encouraged to share the information with colleagues and partners. Before and during the Town Hall, THT staff asked partner organizations to help spread the word about NowPow and to suggest organizations whom they typically refer to or interact with, so that THT could reach out to and invite them to the Town Hall. This snowballing of community organizations referring other organizations to NowPow is the key to engaging a diverse and broad range of community-based organizations. This approach allows THT to engage organizations with which they may not have had a previous relationship in NowPow and other services and programs offered by THT.

The NowPow Town Hall format provides a semi-structured informal setting for organizations to learn about NowPow and begin to contemplate how the tool could enhance their current workflows. The Town Hall agenda begins with a round of introductions from THT staff and participants, followed by a brief history and background of THT and how the implementation of NowPow fits into the attendees' organization's current scope of work. THT staff then describe their administrative and supportive role to partner organizations in the implementation process, as well as the Steering Committee's role and co-design approach with partner organizations. Town Hall attendees then view a live demonstration of the NowPow tool, presented by a NowPow instructor through a teleconference platform. This instructor walks viewers through the tool, reviewing key functionalities: searching the community resource directory, conducting a social determinants of health screening, generating a HealtheRx (a geographically and demographically curated list of community services based on the individual's identified social needs), and sending and receiving tracked referrals. Viewers are also invited to receive a text message with information about a specific community resource to see how the message

(translated, if needed, into eight different languages) would appear for a patient/client. Participants then have an opportunity to ask questions about the platform.

After the live demonstration, clinical staff who currently use NowPow share some of their experiences in using the tool, how it is beneficial to their workflows, and how it directly impacts patient care and the patient experience. THT staff then discuss the following steps of the NowPow onboarding process:

1. Review the organization's profile page, and request required edits
2. Sign contract
3. Register the organization's NowPow users
4. Get trained on the NowPow technology
5. Use NowPow!

Participants are then invited to spend some time brainstorming, either as a large group or in smaller affinity groups, to explore how NowPow can impact both their workflow and communication between organizations.

Due to the participant agreement that needs to be signed for organizations to participate in NowPow, THT has worked to engage staff at health care and social service organizations at multiple levels. When those in leadership or executive-level roles learn about NowPow and experience a demonstration of the system alongside their colleagues in department head, supervisory, and service delivery roles, organizations are more likely to become onboarded within a shorter time frame. The front-line staff involved in patient care can understand the benefit of the tool for their workflows and patients/clients, while leadership representatives can then more easily articulate the value to others, including legal departments, boards, or other signatories.

Organizations of varying types respond positively to THT's outreach. These include mental health service providers, food pantries, homeless shelters, home care agencies, the school district, and primary care providers. Organizations that operate programs with a case management aspect show outsized interest in NowPow, because the tool allows them to document progress for clients/patients over time by tracking referral outcomes and patient

engagement. NowPow helps such programs with an easy yet effective way of tracking participants through a referral process in addition to generating reports of use in management or to funders. Organizations that are seeking to increase case/client load or participant reach are typically interested in receiving referrals through NowPow.

NOWPOW TRAINING AND ONBOARDING

As organizations edit their profile page and engage appropriate personnel to sign the NowPow Participant Agreement, they are encouraged to think about which staff members will be using the tool to conduct social determinants of health screenings, search for services and generate tracked referrals, as well as determine who will be responsible for processing incoming referrals. It is essential for organizations to determine which staff will be responsible for both incoming and outgoing referrals before staff begin to use the tool.

NOWPOW AND THE TRENTON HEALTH INFORMATION EXCHANGE

Health care and non-health care organizations who have professionally licensed personnel (e.g. homeless shelter social workers) have an option to access NowPow through the Trenton Health Information Exchange (HIE). Eligible organizations who do not

Referral Receiving: CommRx

What: CommRx is the NowPow functionality that allows organizations to receive referrals for specific services or programs; organizations can choose to receive referrals for one, a few or all their services/programs, depending on the nature of the program(s).

Who: Staff who already process incoming referrals, through phone calls, email or in-person.

How: New referrals are displayed by program or service and can be processed by multiple individuals; users can set up email notifications to be alerted when new referrals are received.

Referral Sending: PowRx

What: PowRx is NowPow's tool for conducting social determinants of health screening and sending tracked referrals.

Who: Anyone who interacts directly with patients/clients/community members who is in a position to provide them with a referral or conduct a SDOH screening; case managers, care coordinators, social workers, nurses, medical assistants.

How: Users can send tracked referrals to a specific program or service or to multiple program and services based on social needs identified from the SODH screening.

currently have HIE access are encouraged to become HIE participants. There are several advantages to accessing NowPow through the integrated version with the HIE:

- Single sign on (when users log in to the HIE, they can be directed to NowPow without having to enter additional logon information)

- NowPow patient profiles are automatically generated with patient demographic information for the patient's unified medical record

- NowPow activities can be viewed across other HIE-using organizations (e.g. a SDOH screening conducted during a primary care visit can be viewed by staff in the Emergency Department)

This integration of NowPow and the HIE also provides benefits to non-NowPow users. For example, if an Emergency Department nurse has not been trained in NowPow, he or she can still view NowPow documents in a PDF form (e.g., social determinants of health screening results document). These documents appear alongside clinical reports, such as X-Ray results or an Emergency Room chart, in a patient's unified record in the HIE.
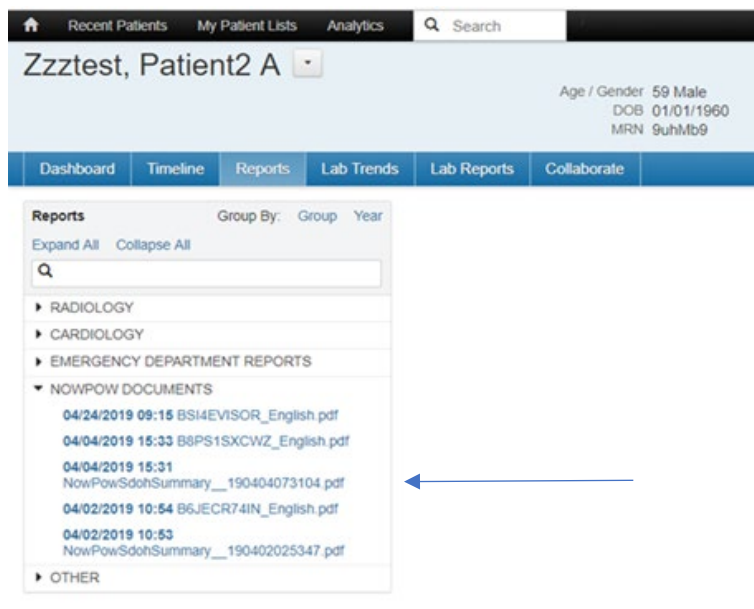

Figure 1:

Social needs screening results available to health care providers in the Trenton Health Information Exchange.

LESSONS LEARNED

Resources

Closed-loop social service referral platforms are resource intensive and require substantial effort in the set-up phase, as well as ongoing maintenance. Sufficient financial, personnel, and activation resources, as well as time for planning, convening stakeholders, and addressing technical implementation concerns, should be allocated and planned for. In addition to the costs associated with implementing the platform from an administrative perspective, it is important to consider costs to community organizations, whether they a large health care institution or weekly food-pantry, the cost of the platform to these organizations should be considered carefully and in deliberate conversations with a variety of community agencies.

Community Engagement

Through this experience, Trenton Health Team has identified community partner engagement and implementation co-design as the most fundamental ingredients to its successful implementation of the social service referral platform, NowPow. NowPow's core function, equipping health and social service professionals with a tool to connect patients with needed resources, requires a high level of interorganizational collaboration and commitment. Strengthening and expansion of linkages between community agencies first through classic relationship-building means and then through technology sews the seeds of trust that are needed when making referrals to address social determinants of health.

For access to additional materials, please contact Natalie Terens nterens@trentonhealthteam.org or Ernie Morganstern emorganstern@trentonhealthteam.org.

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DASH aims to align health care, public health, and other sectors to systematically compile, share, and use data to understand factors that influence health and develop more effective interventions and policies.

DASH is a partner of [All In: Data for Community Health](#), a learning network that provides a space for sharing resources like this one that help communities share data across and beyond traditional health care sectors. With a diverse learning collaborative of 150+ projects that is still growing, the All In offers many technical assistance and networking opportunities to communities across the country.