Coronavirus disease 2019 (COVID-19) has exposed the profound shortcomings of our nation’s approach to health. Lacking a robust public health infrastructure with federal coordination to contain the spread of the virus, the United States was seventh in the world in COVID-19 mortality per 100,000 residents on July 8, 2020.

However, just as the pandemic has shined a light on the failures of the system, it also accelerated work to improve health access and outcomes among people with complex health and social needs. We are hopeful that we can further advance these innovations in the four following areas: telehealth, social determinants of health, multisector collaboration, and payment reform.

**Telehealth Is Here to Stay**

Telehealth has expanded access to care that is convenient for patients, simultaneously spurring the needed transition to health care teams practicing at the top of their training. With recent regulatory changes that enable payment for audio-only telehealth—particularly for people who lack videoconferencing capabilities—more clinicians and health care systems are assigning visits to nurses or social workers, thus freeing up physicians and nurse practitioners to do what only they can do. These telehealth changes need to be made permanent, with the assurance that all clinicians will be reimbursed.

We also need to improve the capacity to predict risk. When COVID-19 closed nonessential services, resulting in a decline in health care appointments, some clinicians used risk prediction to identify and reach individuals with the most risk. More sophisticated tools for intervening with those patients can help prevent unnecessary emergency visits and hospitalizations. The Geisinger health system’s new initiative to remotely care for patients with COVID-19, with self-monitoring equipment, masks, acetaminophen, and support from a nurse, could be a long-term model for a range of conditions. These so-called hospital-at-home programs are being piloted by Intermountain Healthcare and others and include a strong telehealth component.

However, to make these models work, Congress must invest in broadband infrastructure, such as that proposed by the Rural Broadband Acceleration Act, to reduce health disparities in rural and underserved communities. In addition, the Centers for Medicare & Medicaid Services (CMS) should make permanent the emergency scope of practice authorizations that enabled clinicians to practice across state lines and with full practice authority during the pandemic.

**Social Needs Screening Is No Longer Optional**

Although the shutdown was necessary to contain the virus, the unemployment rate has increased and, with it, the number of people who are uninsured and experiencing food insecurity and inadequate housing. Moreover, people of color have 5 times the rate of hospitalizations for COVID-19 compared with non-Hispanic White individuals because of structural inequities and racism in health care. Medicaid recipients are also at particularly high risk for social factors that undermine health.

Unfortunately, screening for social needs and risks is inconsistent and limited, but it is critical for eliminating inequities, controlling health care costs, and improving health outcomes. We should strengthen our efforts to do these screenings as well as add questions to determine eligibility for and
access to telehealth (ie, assessing health literacy and access to broadband and video-enabled devices).

Importantly, screening and action must go hand in hand. For example, Kaiser Permanente's Food for Life program proactively reaches out to people eligible for the Supplemental Nutrition Assistance Program to provide information and support to help them apply.

We also need strong community partners able to provide services. The Center for Healthcare Strategies has advocated for Medicaid, particularly managed care organizations, to collaborate with other entities to address social needs through activities such as outreach to at-risk populations, requirements to collect complete demographic information on people served by organizations in health care and social services, and the use of value-based payments to encourage clinicians, hospitals, and other entities to address disparities.

Stimulating Multisector Communication and Collaboration

The need for and benefit of multisector relationships to address social needs during a crisis became obvious in Lake County, California, at the onset of the COVID-19 pandemic. Meals on Wheels could no longer be delivered by older adults. Senior centers were closed to visitors. Unhoused populations lacked access to safe environments. Children lost food security that schools provided. People living in violent domestic situations were isolated with their abusers. Most health services shifted to telehealth. However, because the community had already invested in a county-wide collaboration infrastructure involving coalitions of local health systems, county leaders and others—through Hope Rising and Project Restoration—were able to rapidly organize stakeholders across health care, social services, police, fire, emergency medical services, and criminal justice to collectively address the needs of at-risk populations.

Established relationships allowed the collaborative to immediately implement an action and accountability structure. Within days of the pandemic, they reorganized food distribution using closed restaurants to accept and prepare food; volunteers replaced older drivers to deliver meals to families and the elderly; 40 congregate shelter beds were made available for unhoused individuals and 15 hotel rooms were opened to quarantine; police and care coordinators connected with the most at risk; and a donation network was formed to support local businesses and residents. As Shannon Kimbell-Auth, MDiv, manager of Project Restoration for Adventist Health, told us, "Everything moves at the speed of trust."

Health care cannot operate in a silo to address social needs. From housing to criminal justice, care often involves the same individuals who interact with a variety of systems. Collaboratives such as those in Lake County, Destination Home in Santa Clara County, California, and the Bronx Health and Housing Consortium in New York City are vital to addressing complex health and social issues.

Payment Reform and Funding

To scale and sustain these changes, we must prioritize value-based payment reform that affords flexibility in the design and delivery of services. Indeed, hospitals with a portion of value-based payments may be reluctant to take on risk after the unpredictability of COVID-19 and the fear of a second pandemic of untreated or worsened conditions associated with delayed care, but, federally qualified health centers in Oregon, Washington, Illinois, and Minnesota have benefited from value-based reimbursement during this time.

Furthermore, we must prioritize collaboration. With improved budget flexibility in state and federal government programs, cross-sector collaboration has the potential to yield substantial cost savings and improved health outcomes. For example, Maryland's All-Payer Model successfully pushed hospitals to collaborate with community-based organizations and has resulted in meaningful savings. Innovative approaches to funding community collaboratives are emerging nationwide,
including Healthy Community Funding hubs that pool funding from multiple sources and collaboratively distribute those investments into local initiatives to address health and social needs. Indeed, more than 25 communities across the country are testing this wellness fund infrastructure.

**Power in Whole Community Approaches to Health**

Former CMS Administrator Donald Berwick, MD, MPP, recently advocated for health care providers to embrace the "moral determinants of health," with action to advance universal health coverage, human rights, and criminal justice reform and address poverty. Among the lessons learned from the COVID-19 pandemic is that we are only as strong and as safe as the members of our society with the most risk. Faced with the threats of the pandemic and economic devastation, now is the time to ensure our new normal truly leaves no one behind.

**ARTICLE INFORMATION**

**Open Access:** This is an open access article distributed under the terms of the CC-BY License.

**Corresponding Author:** Diana J. Mason, PhD, RN, Center for Health Policy And Media Engagement, George Washington University School of Nursing, 1919 Pennsylvania Ave. NW, Ste 500, Washington, DC 20052 (djmasonrn@gmail.com).

**Author Affiliations:** National Center for Complex Health and Social Needs, Camden Coalition of Healthcare Providers, Camden, New Jersey (Hardin); Center for Health Policy and Media Engagement, George Washington University School of Nursing, Washington, DC (Mason).

**Conflict of Interest Disclosures:** None reported.