

IMPACT ACT Research Study: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors

Comments by Healthfirst (Contract #H3359)

Healthfirst is a not-for-profit, provider-sponsored plan serving New York City and Nassau, Suffolk, and Westchester counties. Our model promotes population health at the provider level by transferring most financial risk to our hospital system sponsors who, with their community-based partners, work with us to align incentives and ensure quality, member satisfaction, and efficiency. We are the largest Medicaid managed care plan in downstate New York and the #1 Medicaid plan for quality in the State.

We serve about 150,000 Medicare Advantage members. Approximately 60% are dually eligible for Medicare and Medicaid, and 75% receive the Low Income Subsidy (LIS). Close to 30% of our Medicare members have 3+ chronic conditions and take 8+ Part D Drugs. As a primarily low income plan, Healthfirst observes that the 25% of our membership that does not receive the low income subsidy (non-LIS) is remarkably similar to the 75% of our membership that receives the LIS. Our LIS/non-LIS members reside in the same neighborhoods and have the same challenges related to social determinants of health like education, health literacy, and cultural norms.

1. Are social risk data being used to target services or provide outreach? If so, how? How are beneficiaries with social risk factors identified?

Healthfirst recognizes the impact that social adversities play in many of our members' health outcomes and has taken the first fundamental steps in identifying and addressing social risk factors outside of traditional healthcare needs. We currently don't use "social risk data" for identifying, targeting / outreaching members. However, we are focused on developing sound approaches to proactively address and impact social determinants of health in the future.

Current Approaches:

- Stratify/target high-risk populations for outreach / interventions based on utilization patterns (e.g. frequent ED visits, hospitalizations)
- Connect members to social service vendor (Altegra/Community Link). Members are connected by our member-facing staff (Member Services, Care Management, Sales, etc.) based on the needs/ challenges identified during conversations / interactions with members. Community Link is responsible for assessing social risk factors and connecting members to appropriate community-based resources.
- Identify barriers/ needs and address social risk factors via our field-based care teams, serving as our eyes/ears in the community for our care management teams (Community Health Workers, Nurses, Patient Care Aides, etc.)

- Identify and remove barriers through telephone outreach via Care Management and Pharmacy teams by connecting members to social supports/services (transportation, appointment scheduling, housing insecurity, legal needs, etc.). Handbooks of community-based resources by NYC borough were created and are used by our Care Management teams.

Future Approaches (In-development):

- Standardize the questions we ask members about social determinants, where possible, drawing on the CMS Accountable Health Communities Health-Related Social Needs Screening Tool.
- Improve data collection of social risk data and timely referrals of social services by partnering with a vendor that provides a search engine of an up-to-date directory of comprehensive community resources and a web-based referral tool.
- Develop algorithms using machine learning to proactively identify and intervene with members that are at risk / predicted to be impacted by social risk factors.

2. Are there especially promising strategies for improving care for patients with social risk?

We believe the best and most powerful strategy for improving care for our members with social risk is to partner with providers and community-based organizations to help us identify members impacted by social risk factors and provide access to timely and needed supports/resources by using standardized data collection, referral and tracking tools.

Other promising strategies include:

- Shift care management of members from telephonic support to in-house / community-based visits – meeting members where they are and building trust face to face.
- Provide member-facing staff with access to an up-to-date “bank of community resources” and web-based referral / tracking tool.
- Extend the aforementioned screening and program software tools to health plan partners (e.g., providers, vendors, and community-based organizations).
- Leverage technology (i.e. machine learning) to proactively identify “social risk”, stratify and facilitate programs that address not only medical but the social needs of our members.

We are in the early stages of implementing some of these approaches.

3. How are costs for targeting and providing those services evaluated? What are the additional costs to target services, such as case management, and to provide additional services (e.g., transportation)? What is the return on investment in improved outcomes or reduced healthcare costs?

It is difficult /challenging to quantify the impact on health outcomes based on social services provided solely. Instead, we conduct ROIs to measure improved outcomes / reduced costs based on both care and social services provided using outcome measure indicators such as ER and inpatient utilization. In

our most recent pilot study, we found that our Community Health Workers helped to statistically significantly (p value <0.05) reduce ER and inpatient utilization among the intervention vs. control group.

What are the best practices to refer beneficiaries to social service organizations that can address social risk factors?

While reviewing published literature and best practices elsewhere, and engaging our clinical stakeholders, we identified two best practices for identifying and referring beneficiaries to social service organizations.

- Enable your member-facing workforce to assess for social risk factors by providing them with the technology to assess members' risk, access a comprehensive directory of local social services and a referral platform. Additionally, integrate "social risk data" into the 360 degree view of the member – to ensure issues / barriers are addressed and removed for members.
- Build capacity in the community to identify and refer members to social services by partnering with community-based organizations, provider groups and care management field staff.

4. What lessons have been learned about providing care for patients with social risk factors?

Every patient / member has a unique set of challenges and needs. It's important to assess social risk factors for each member and direct care and resources appropriately. Often times, this requires the health plan to go above and beyond to ensure the most important actions are taken to address the immediate needs and overall wellness of our members.

5. What are barriers to tailoring services to patients with social risk factors? How can barriers be overcome?

- The lack of a standardized social determinants of health (SDH) assessment tool is one of the biggest barriers to capture data related to SDH, and this makes tailoring targeted interventions and services for those with SDH even more difficult. Furthermore, there is an underutilization of ICD-10 codes related to such SDH, this presents a challenge to Population Health initiatives aimed at reducing such disparities.
- Health care providers often do not have the time and/or lack capacity to screen patients for SDH, making it difficult to connect patients to needed services in the community. Additionally, health care providers are often unaware of Community Based Organizations and/or services that are available to meet needs of patients with social risk factors.
- Members "near poor" (i.e., just over the federal poverty level and who don't qualify for Medicaid) have the biggest barriers and don't qualify for the following:
 - a. Personal care/home attendant services and often cannot afford to pay out of pocket for the help they need with their ADLs.
 - b. Long term custodial SNF care – even if they reach a point where 24/7 care is necessary.
 - c. Bathroom DME as they are aging and becoming more frail (i.e., shower chair, grab bars, essentials for tub safety/fall prevention).

- Social service agencies that are best suited to address member social needs are often not prepared to work with health plans and may not have invested in the infrastructure to do so (technology platforms, expertise/capability around billing, security and compliance safeguards, reporting and communication).

Members can and do change to different health plans. Long term investments in addressing some of the most pervasive and difficult social determinants (i.e. housing) may not accrue to the health plan.

6. For patients with social risk factors, how does patients' disability, functional status, or frailty affect the provision of services?

Functional status, disability and frailty play a critical role on a patient's ability to engage in care. Often these patients are isolated and are unable to seek services, making it even more difficult to remove SDH related barriers. If members are unable to physically get to their doctor appointments, they are not able to benefit from any interventions aimed at reducing such barriers.

7. Which social risk factors are most important to capture?

- **Housing insecurities.** Housing stability is a key indicator of socioeconomic status and is the single greatest monthly expense. Members with low income spend a larger proportion of earnings on securing housing. Those in urban areas are also facing high rent due to higher housing demands. Unstable housing is a stressor and can present problems with properly storing medications, accessing educational and healthcare services.
- **English language proficiency and cultural understanding.** Most healthcare services are rendered in the English language while our population is becoming more and more culturally diverse.
- **Health literacy and educational level.** This helps us understand members' ability to obtain, process, and understand basic health information needed to make appropriate health decisions such as managing chronic conditions.
- **Food insecurities.** Inability to access healthy foods increases malnutrition and obesity and decreases the ability to properly manage certain high prevalence diagnoses such as heart failure and diabetes.
- **Transportation.** Members who are frail or live alone can have challenges in taking public transportation or driving to appointments. Private car service can be costly.

8. Do you routinely and systematically collect data about social risk?

We collect some social risk data, but not consistently and systematically for all members. Currently, social risk data is collected by our care management teams, which are typically during interactions with high-risk members. Data is used to inform care planning at an individual level.

In 2019, we will embark on a standardized approach for collecting social risk data by providing a social determinants screening and referral web-based tool to member-facing staff. In addition, we will be using machine learning (as described in our response to question 1 above) to help us predict /estimate "social risk" for our population. In the future, we hope to work with our providers to standardize data

collection efforts in EMRs and the Health Information Exchange, along with our vendor partners who support members in the home in order to incorporate social risk into the members' care plan.

9b. Who collects this data?

See Q8.

9c. When is it collected? Is it collected only once or multiple times for a beneficiary?

Currently, it is collected during initial and ongoing assessments while members are supported by care management. In the future, we hope all of our member-facing staff (telephonic and field-based staff) will be able to screen, collect, and act on social determinants of health data.

9d. Is it collected consistently across populations (i.e. Medicare beneficiaries, Medicaid beneficiaries, patients receiving specific services, etc.)?

Currently, SDH data is not collected consistently across our Medicare population. Only high-risk members and members with high behavioral health needs are assessed for social determinants of health.

9e. What are the burdens of this data collection on plans, providers, and beneficiaries?

See Q10.

9. Would standardized data elements for EHRs help you to collect social risk data? If so, how could these data elements be standardized?

Yes. We recommend that standard definitions / data elements for social needs be established. In addition, there is a lack of provider coding for Z-codes. We recommend that there be alignment between Z-codes and standard definitions / elements.

10. What are barriers to collecting data about social risk? How can these barriers be overcome?

There are a number of barriers to collecting social risk data:

- Limited available social risk data; underutilization of ICD-10 / Z- codes related SDH
- The lack of a standardized SDH assessment tool
- Difficulty in measuring/quantifying the impact of social risk factors and their contribution to health outcomes
- Under-representation of social risk factors due to sensitivity and/or very personal information
- Highly confidential data and the consequences of breaches in data security
- Members unengaged with the health plan and providers – very difficult / challenging to collect data for members that are homeless, transient, don't have a working phone number, etc.
- Health care providers often do not have the time and/or lack capacity to screen patients for SDH.

In order to overcome these barriers, providers will need to understand the importance of collecting and coding this data. They will also need education on the impact of social determinants on health outcomes and how to use Z-codes related to social determinants.

Incentives to support the identification and “treatment” of social determinants should be considered.

11. What do you see as promising future opportunities for improving data collection? For using existing or future data to tailor services?

CMS could incorporate SDH-related measures into provider quality programs, first by measuring the degree to which SDH data is collected by providers, by conclusively mapping Z-codes to SDH risk factors, and eventually by introducing an expectation that providers address social risk factors.

Additionally, a further promising opportunity is to define and use a metric for ‘overall wellbeing’, which can be incorporated into provider data collection and reporting. A uniform, high-validity metric would enable health plans and providers to support their members and patients in a holistic, person-centered way, and we would welcome the leadership of CMS in this regard.