

REQUEST FOR INFORMATION

IMPACT ACT Research Study: Provider and Health Plan Approaches to Improve Care for Medicare Beneficiaries with Social Risk Factors

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Delivery of Services

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

- CMS grant collects social risk data on food access, transportation, housing, utilities, social and emotional isolation and safety, which is used to target the appropriate community-based partners to deliver services for our beneficiaries. We identify our beneficiaries initially by grant-defined eligibility criteria of geography (zip code) and Medicare/Medicaid qualified.

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

- Our patients are screened for social risk factors upon entry to a clinical site, which is a promising strategy. It is part of the initial registration process. This promising innovation that could be easily, effectively and widely deployed.
- Screening results are entered into patient EHRs.
- CMS grant supports tracking on all individuals across the life of the grant, for some longitudinal data.
- Interventions for social risk factors need to become the standard of care for high-risk patients.

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

- Our grant has not progressed far enough to have cost data to evaluate, but the intention is to have before and after cost comparison data for Medicare/Medicaid usage. It is in the intention of the grant to reduce these costs to our east Indianapolis population.
- Given that our grant is still in its earlier stages, the return on investment we forecast right now is not based on cost data but on the value of identified best practices in building the foundation for and the next iterative layer of the grant and our larger eastside population health and community development project, Community Collaborations.
- Initial data indicates that the top social risk factors in our area are 1) food access, 2) safe housing and 3) transportation. We also see large numbers of patients without a primary care provider, so connecting them to care is a top ambition of the program.

- Data about social risk factors garnered from initial screening and then subsequent interviews allows us to target on behalf of the patient the community-based organizations likely to be of the greatest benefit.
- Technology is a best practice for referrals of beneficiaries for social service organizations that can help to address social risk factors. Our Community Health Advocates (CHAs) have an independently funded pilot in place with our local United Way agencies that allows our CHAs to refer patients directly into the United way's Efforts to Outcomes program for services and tracking.
- The CHAs currently have about 200 people for whom they are providing navigation services. About 75% cannot be reached subsequent to initial contacts; CHAs use phone numbers as listed in EHRs. Partner organizations report similar challenges to reaching clients for follow-up so there is a clear opportunity to develop best practices for effective and ongoing communication.

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

- Especially in emergency departments, our best lesson has been the value of asking questions about social risk at the critical moment of high need. Patients may not be used to being asked these kinds of questions or interacting with an advocate, but they will and do share about their lives. Our grant staff typically screen clients in clinical settings before they speak with any medical personnel. We are asking them about their lives, not their medical conditions, and get generally very candid and useful responses.
- While the initial screening is a window of opportunity, follow-through remains a challenge. We continue to revise and tweak standard operating procedures, searching for better follow-up results.

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

- Our greatest barrier to tailoring services is to achieve ongoing communication, beyond the initial screening. Phone follow-up is proving to be difficult; it could be linked to caller IDs showing a hospital or health network is the caller. One group of CHAs tried texting and we hope to develop some comparison results as to whether texting is a better mechanism for follow-up outreach.
- Time factors can be a barrier, as to how much time is possible for initial screening. Then when advocates are able to schedule and conduct follow-up interviews and development of healthcare access plans, initial projection of needs typically gets complicated by a host of additional challenges that are uncovered. Ex: referral for food sources reveals a transportation challenge. More time at initial screening may reveal a more complete initial picture.

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

- If a patient enters the emergency department with a disability, a functional challenge or frailty, they typically have a higher acuity level, which means on a practical level that those patients screenings are often delayed until after admission or discharge. If CHAs can reach the client at all, these are phone screens, which present diminished effectiveness in comparison to in-person screenings.
- Even when these individuals screen for transportation needs, there are few truly helpful solutions that either the CHAs or other community-based organizations have to offer.

Data

Which social risk factors are most important to capture?

- Food, transportation, housing, economic situation and primary care status are the social risk factors most critical to capture.

Do you routinely and systematically collect data about social risk? Who collects this data? When is it collected? Is it collected only once or multiple times for a beneficiary? Is it collected consistently across populations (i.e. Medicare beneficiaries, Medicaid beneficiaries, patients receiving specific services, etc.)? What are the burdens of this data collection on plans, providers, and beneficiaries?

- When a patient presents to a primary care office or the emergency department (ED), a Community Health Advocate or Front Desk Staff will check for Medicaid/Medicare status and zip code. A staff member will then give patient a screener tablet device, or paper, and have the patient complete a screening that collects data on social risk factors. Staff will tabulate screener and provide relevant resource information to the patient. In addition, some patients who have presented in ED twice within the past 12 months will be able to utilize a CHA.
- Data is collected from identified beneficiaries several times a year.
- Our program does consistent and universal screening of Medicare/Medicaid patients at different locations.
- There are different workflows at different locations that can burden providers and affect the willingness of providers to screen, including that staff must be trained. Sometimes staff are unaware of resources to assist patients.

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

- Our EHR does contain some standardized data elements for at least some social risk factors. The challenge is to convince more providers to screen for these elements, but providers need to have solutions at hand to present to patients before they are willing to ask social risk factor questions.

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

- Barriers to collecting data about social risk include staffing, limited time with patients, buy-in from staff and technology challenges.

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

- Promising opportunities for improved data collection include EHR integration and a greater quantity of data reflecting the importance of social determinants of health would allow for more tailoring of services.