Advancing Screening, Referral, and Navigation Beyond the AHC Model

Overview

The Centers for Medicare & Medicaid Services (CMS) held the final virtual Accountable Health Communities (AHC) Meeting, Sustainability Beyond the AHC Model, on November 9 and 10, 2021. This meeting provided a forum for bridge organizations and their partners to discuss strategies for sustaining and scaling social needs screening and for community service referral and navigation beyond the AHC Model Cooperative Agreement period. Attendees included representatives from the 28 bridge organizations and partners, including community service providers, state Medicaid agency representatives, CMS leaders, and CMS contractors. This summary includes highlights and key takeaways from each session.

Day 1 Session Summaries

Keynote Address

Speaker:

- Daniel Tsai (Deputy Administrator and Director, Center for Medicaid and CHIP Services, Centers for Medicare & Medicaid Services)

During his keynote address, Deputy Administrator Tsai discussed the Center for Medicaid and CHIP Services (CMCS) strategy under the Biden-Harris administration and engaged in an open dialogue with the audience. CMCS's key strategic goals include improving health care coverage and access, advancing health equity, and implementing innovations in whole-person care. Deputy Administrator Tsai emphasized how addressing health-related social needs (HRSN) is central to CMCS's strategy.

Key takeaways from Deputy Administrator Tsai's remarks include the following:

- Speaking from experience as the former state Medicaid Director for the Commonwealth of Massachusetts, Deputy Administrator Tsai acknowledged the challenges of building partnerships between health systems and community-based organizations (CBOs). An audience member noted the financial and political power imbalance that exists in these partnerships and the need for opportunities to address it, including direct funding for CBOs and continued funding for intermediaries such as bridge organizations to facilitate the partnerships. Deputy Administrator Tsai emphasized the important role of state innovation when considering how to support existing partnerships and thoughtfully bring more health systems and CBOs together.

Addressing Health-Related Social Needs through Accountable Health Communities

- Although Deputy Administrator Tsai focused his remarks on Medicaid strategy, he noted that advancing health equity and promoting innovations in whole-person care were core goals across CMS. He acknowledged that statutory limitations of Medicare and Medicaid can sometimes be a barrier to certain funding or implementation strategies, but he went on to highlight the flexibilities that do exist. For example, Medicaid managed care plans can broaden funding streams and provide wraparound services.
- Deputy Administrator Tsai closed his remarks by encouraging bridge organizations to leverage the experience and partnerships they built through the AHC Model to support policies that encourage health care providers to partner with CBOs to address social needs within their states. He acknowledged that those closest to the community are best equipped to define whole-person and wraparound care for individuals.

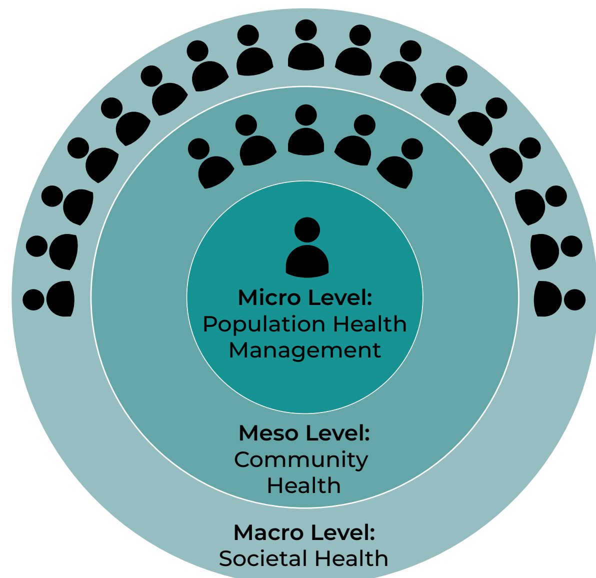
Embedding Health Equity in Sustainability Plans

Speakers:

- Rishi Manchanda, M.D., M.P.H. (HealthBegins)
- Sadena Thevarajah, J.D. (HealthBegins)
- Dodi Meyer, M.D. (NewYork-Presbyterian Hospital)
- Brian Youngblood, L.C.S.W. (NewYork-Presbyterian Hospital)
- Lauren Bartoszek, Ph.D., M.C.H.E.S. (The Health Collaborative)
- Virginia Brooks, M.H.A., C.P.H.Q. (Health Quality Innovators)

During the session, HealthBegins introduced a framework that identifies levels of action an organization can target to improve the social and structural drivers of health equity for beneficiaries and communities. AHC Model awardees NewYork-Presbyterian Hospital, The Health Collaborative, and Health Quality Innovators described different levels of action they are taking to address social and structural drivers of health equity at the population, community, or societal level. They also highlighted the strategies they use to scale up and sustain social needs interventions from a health equity perspective.

Levels of Action to Improve Health Equity



Building on a presentation about promoting health equity through the AHC Model at the February 2021 Virtual AHC Meeting, Dr. Manchanda emphasized that changes at the population, community, and societal levels are critical to advancing health equity. Addressing social determinants of health alone is not sufficient to move the needle on racial equity; it requires a commitment to improving the distribution of power and resources at the societal level. Bridge organization presenters shared that they work at the population and community levels and plan to expand to the societal level in the future. Bridge organization presenters discussed the following challenges of and strategies for advancing health equity.

Key takeaways from the session include the following:

› **Capturing accurate demographic data**

Challenge: Gathering widespread, reliable, and consistent data about the race and ethnicity of beneficiaries is a challenge. Structural racism shapes health opportunities and outcomes, so collecting and analyzing race and ethnicity data is critical to informing health equity initiatives within and beyond the work of the AHC Model.

- **Strategy:** NewYork-Presbyterian Hospital launched a system-wide campaign in 2020 to improve collection of race and ethnicity data. It added race and ethnicity questions to its intake process and standardized them as required fields in its electronic medical records. As a result, the bridge organization increased collection of race and ethnicity data of beneficiaries screened through the AHC Model from less than 50 percent to 90 percent.

› **Sustaining efforts to address food insecurity beyond the AHC Model**

Challenge: AHC Model awardees identified high levels of food insecurity throughout the COVID-19 public health emergency, especially from families affected by loss of work and lack of access to pantries and shelters.

- **Strategy:** When reviewing the data from the AHC Model, The Health Collaborative found that food and transportation needs often occurred concurrently among beneficiaries. The bridge organization conducted an analysis using social needs screening and geographic data and identified the areas with the highest food and transportation needs. The Health Collaborative then spoke with its local transportation agency to share the information that would be relevant to routes that service neighborhoods with high food and transportation needs. Within the organization, The Health Collaborative is trying to obtain more bus and metro train passes for patients with food needs.
- **Strategy:** NewYork-Presbyterian Hospital expanded its emergency food assistance program together with food providers and CBOs to provide produce to those experiencing food insecurity. The bridge organization started a pilot program that focused on women and children at one location, expanded the program during the COVID-19 public health emergency to include everyone, and engaged CBO partners to spread the program across multiple campuses, showing the scalability of HRSN interventions. In addition, NewYork-Presbyterian Hospital created a food insecurity order in the electronic medical record so that physicians can document information of their patients' food need in a centralized work queue.

› **Building CBO capacity**

Challenge: CBOs are critical for addressing beneficiaries' HRSNs and for reducing health disparities, yet many struggled to meet increased demand and remain open during the COVID-19 public health emergency.

- **Strategy:** Health Quality Innovators analyzes levels of HRSNs by zip code and shares those data with CBOs to help them develop a strategy for pursuing additional funding. These data add credibility to the anecdotal experiences collected by CBO staff.
- **Strategy:** The Health Collaborative hosts a monthly meeting with CBOs from two geographic target areas representing Latinx and African American communities to discuss the data they collect on beneficiary needs and to gauge their capacity at the community level to resolve needs.

› **Offering screening services in multiple languages**

Challenge: Although many sites translate their screening tools into languages other than English, they might lack non-English-speaking staff to sufficiently help connect beneficiaries to resources.

- **Strategy:** St. Joseph's Hospital and Medical Center described how its staff have access to Cyracom Interpreter Services, a large-scale interpreter contact center for health care organizations, and can add an interpreter to a call when necessary.
- **Strategy:** Hackensack University Medical Center offers internships to surrounding schools and recruits bilingual interns. Multiple awardees discussed how bilingual staff are incredibly helpful in reaching non-English-speaking beneficiaries and connecting them to community resources.

Building a State-Wide Sustainability Strategy for Addressing HRSNs

Speakers:

- Alissa Beers, M.H.C. (Center for Health Care Strategies)
- Ellen-Marie Whelan, N.P., Ph.D., F.A.A.N. (Chief Population Health Officer, Centers for Medicaid and CHIP Services)
- Bruce Goldberg, M.D. (Oregon Health & Science University)
- Anne King (Oregon Health & Science University)

How State Medicaid Agencies are Addressing HRSNs

Data sharing and information exchange with state-level partners and health plans are a common goal among bridge organizations. During this session, the Center for Health Care Strategies, CMCS, and Oregon Health & Science University (OHSU) discussed approaches for bridge organizations to engage state Medicaid agencies in an aligned approach to address HRSNs outside the model. Attendees participated in an extended discussion with the presenters and their peers on mechanisms they have used or are considering using to sustain efforts to address HRSNs in their state.

- The Center for Health Care Strategies discussed how addressing beneficiaries' HRSNs supports care management for beneficiaries at higher risk of ED admissions and advances health equity. State Medicaid agencies can use mechanisms at four levels to address HRSNs—the state level, the managed care plan level, the provider level, and the community level—through expanded benefits, contract requirements, and financial investment.
- Ellen-Marie Whelan elaborated on CMCS's role in building states' capacity to address HRSNs. She emphasized CMCS's core strategic goals of expanding health care coverage and access, health equity, and innovation in whole-person care. In partnership with state Medicaid agencies, CMCS develops mechanisms to address HRSNs, including addressing needs under federal authorities such as managed care authorities, state plan amendments, and 1115 waiver demonstrations. Dr. Whelan shared that 1115 waiver demonstrations are the most flexible of these authorities, as long as the state can show its demonstration is consistent with the state's plan and the cost is budget neutral.
- OHSU shared its experience working with Oregon's Medicaid Coordinated Care Organizations (CCOs). CCOs are Oregon's equivalent to managed care organizations and provide capitated payments to cover the full spectrum of physical and behavioral health benefits. OHSU collaborated closely with nine of Oregon's 15 CCOs to apply for the AHC Model Cooperative Agreement, recruit clinical sites, and provide navigation. As the bridge organization considers opportunities to scale and sustain efforts to address HRSNs in Oregon, it partnered with the CCOs to add quality measures related to HRSN screening and navigation to the state's Medicaid-required performance improvement projects. OHSU also demonstrated the prevalence of HRSNs among Medicaid beneficiaries, which provides a compelling business case to scale screening and navigation activities across the state.
- Other approaches for enhancing statewide strategies to address HRSNs include the following:
  - United Healthcare Services uses AHC Model data to inform its state Medicaid agency in Hawaii about the most prevalent HRSNs among beneficiaries. This led to a greater focus on food insecurity by the state Medicaid agency, which had long assumed that housing was a much more significant need.
  - Allina Health's SDOH 2.0 model with Blue Cross Blue Shield of Minnesota focuses on its efforts to develop shared goals with the health plan and implement a statewide referral platform.

Day 2 Session Summaries

Building a Business Case for Addressing HRSNs Beyond the AHC Model

Speakers:

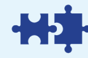
- Anna Spencer, M.P.H. (Center for Health Care Strategies)
- Alissa Beers, M.H.C. (Center for Health Care Strategies)
- Leslie Wainwright, M.D. (Parkland Center for Clinical Innovation)
- Jacqueline Naeem, M.D. (Parkland Center for Clinical Innovation)

This session focused on strategies to demonstrate the value of investing in identifying and addressing HRSNs. Speakers from Parkland Center for Clinical Innovation, an AHC Model awardee, discussed their approaches to building a business case

for addressing HRSNs, including highlighting the importance of community alignment to drive systems change and leveraging bridge organization-level data to inform sustainability discussions and decisions. Attendees participated in small groups to workshop scenarios for developing business cases that justify continuing to address HRSNs to different audiences. Each group tailored their business case to a specific audience, including a state philanthropic foundation, managed care organization, large health system, or a state Medicaid agency.

- The Center for Health Care Strategies noted that as health systems consider investments to address HRSNs and value-based payment strategies become more widespread, they have begun to shift their focus away from financial return on investment toward other outcomes, such as quality of care. Moreover, addressing HRSNs is a key consideration for advancing health equity. In using an equity framework to approach this work, it is crucial to incorporate community perspectives. Often, the most cost-effective solution is not sustainable in the long term because it does not resonate with community priorities.
- Presenters from Parkland Center for Clinical Innovation shared their strategies to leverage qualitative and quantitative data from the AHC Model to tell the story of the model's success. They gather beneficiary stories from case managers and identify common themes across beneficiaries served. They pair these qualitative insights with quantitative data of the model, such as emergency department use, treatment for chronic conditions, and number of social needs resolved. Presenters from Parkland Center for Clinical Innovation said that "impact is in the eye of the beholder." In other words, when presenting data, it is crucial to tailor the data to the perspective and priorities of the organizations you hope to work with.

In small group discussions, bridge organizations discussed the following strategies for building a business case for addressing HRSNs:



Prioritize the staff and funding that will provide the largest impact. For example, one awardee collected data that showed community health workers are most effective in providing navigation services.

Tailor the business case by noting the benefits of addressing HRSNs for specific target populations. For example, when presenting a business case to a philanthropic foundation with a focus on maternal health, the AHC Model awardee could include AHC data on average emergency department visits for mothers and children.

Leverage the experience of convening community and state-level partners through the AHC Model in future programs focused on addressing HRSNs. For example, AHC Model awardees can provide unique expertise by serving as liaisons between communities and managed care organizations or large health care systems.

Leveraging Technology to Sustain Screening, Referral and Navigation

Speakers:

- Aleta Rupert (AMITA Health)
- Anna Alonzo (Dignity Health)
- Alyssa Bosold, M.P.H. (Mathematica)
- Toni Abrams Weintraub, M.D., M.P.H. (Mathematica)
- Jennifer Pugh, M.H.A. (Mathematica)

In this session, AMITA Health and Dignity Health (AHC Model awardees) shared their partnerships and processes to implement screening and referral platforms. Bridge organizations and their partners met in small groups to discuss common challenges and promising solutions for leveraging technology. In addition, partners discussed opportunities that technology provides to advance equity.

- AMITA Health described its initiative to implement a shared screening and referral platform across its health care system.
  - AMITA Health's goals are to increase the uptake of screening, referral, and navigation across its system; improve the collection and use of data; standardize assessment of health-related social needs; and ensure beneficiaries can access resources and technology.
  - To accomplish these goals, AMITA Health is assessing current efforts across its system and partnering with other departments and clinics within the health system to integrate data and implement a shared referral platform.
- Dignity Health described its efforts to align with a statewide initiative to implement a health information exchange, including a closed-loop referral system.
  - The goals of this initiative are to connect health care and community-based organizations, streamline referrals, enable CBOs to report whether needs were resolved, use a data-driven approach, and improve health outcomes.
  - To support these efforts, Dignity Health administered a survey to CBOs to understand their use of existing platforms and interest in using a referral system. In partnership with the statewide health information exchange initiative, Dignity Health used the survey results to inform the selection of a referral system and signed a letter of intent to participate in the referral platform starting in fall 2022.
- During small group discussions, bridge organizations and their partners identified key challenges, strategies, and opportunities for leveraging technology to sustain screening and referral processes and advance equity:

Challenge: Establishing partnerships within health care systems and across CBOs to select and use integrated screening and referral systems.

- **Strategies:** Tailor messages to prospective partners; assess the existing landscape and partners already engaged in screening and referral efforts; convene partners to define a community-level approach; acknowledge power imbalances, understand different perspectives among health care systems and CBOs, and recognize the strengths each partner brings.

Challenge: Building staffing models and capacity of clinical providers and staff to screen and refer beneficiaries.

- **Strategies:** Engage organizational leaders; determine and define roles; designate specific staff or teams to lead integration work; hire dedicated staff members to analyze, interpret, and share insights from the data; and provide technology training and support for CBOs to ensure they can document referral and navigation status effectively.

Challenge: Securing funding for infrastructure and resources to operate screening and referral systems.

- **Strategies:** Align with existing organizational, community, or statewide efforts to share data; explore opportunities for local payers and health plans to invest in referral technology; and investigate opportunities for foundation grants.

Challenge: Leveraging data from integrated screening and referral systems.

- **Strategy:** Share utilization and cost data with health system leaders to gain buy-in.

Bridge organizations discussed the following opportunities for technology to advance equity:

- Provide access to culturally competent screening tools and referral resources in languages appropriate to the community.
- Collect, store, and analyze race, ethnicity, and language data to understand patient population and existing disparities.

Closing Remarks

Speaker:

- Elizabeth Fowler, Ph.D., J.D. (Director, Center for Medicare and Medicaid Innovation, Centers for Medicare & Medicaid Services)

Liz Fowler commended bridge organizations' response to the COVID-19 public health emergency and commitment to addressing health disparities and improving health equity. She remarked on early indications of the importance of universal screening for social needs to identify beneficiaries at higher risk of ED admissions, noting that as of 2020, 59 percent of navigation-eligible beneficiaries screened through the AHC Model reported more than one HRSN[1]. Dr. Fowler also emphasized the significant learnings from the experience of the AHC Model around meaningful, cross-sector collaboration and investment in community capacity to address HRSNs. Dr. Fowler encouraged bridge organizations to review the Center for Medicare and Medicaid Innovation's recent white paper, "Innovation Center Strategy Refresh" and asked bridge organizations to provide their feedback as pioneers in CMMI's work to address HRSNs.

Endnote

[1]Dr. Fowler cited the finding from the Accountable Health Communities Model Evaluation: First Evaluation Report prepared by RTI International, evaluation contractor of CMS's AHC Model.

Additional Resources from the AHC Model

- Planning for Sustainability and Advancing Health Equity during the Public Health Emergency: February 2021 Virtual Meeting Summary (PDF)
- AHC Fact Sheet and Preliminary Findings (PDF) - October 2020
- Partnering for Impact: Early Insights from the Accountable Health Communities Model: November 2019 Annual Meeting Summary (PDF)
- You've Got Mail! Using Email to Screen for Health-Related Social Needs - Denver Regional Council of Governments Spotlight (PDF)
- Aligning Provider and Payer Activities to Address Social Determinants of Health - Allina Health Spotlight (PDF)
- Building Strong Community Partnerships to Address Social Needs - Health Net of West Michigan Case Study (PDF)
- Promising Strategies for Community Service Navigation - Health Quality Innovators Case Study (PDF)
- Using Data for Quality Improvement - St. Joseph's Hospital Case Study (PDF)
- A Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tool (PDF)

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