Uncovering and Addressing Disparities in Health-Related Social Needs, Social Needs Screening, and Navigation: Using Data to Drive Change

Center for Medicare and Medicaid Innovation

Allina Health

Open Path Resources

Mathematica

SIREN 2022 National Research Meeting:

Racial Health Equity in Social Care

September 27, 2022

Agenda

Welcome and introductions	Jennifer Dickey
Objectives	Jennifer Dickey
Accountable Health Communities (AHC) Model design and statistical analysis	Christine Ogbue
Use of data to drive change	Dan Behrens
Partnership to address disparities	Imam Sharif Mohamed
Lessons learned	Audience

Objectives

- **By the end of this session, participants will be able to do the following:**
  - Understand how race as a social and cultural construct affects assessment and redress of social needs
  - Apply mixed-methods data with community engagement to inform program implementation and policymaking
  - Consider how you can apply the lessons learned from the Accountable Health Communities (AHC) Model in your setting

MURAL engagement

Double click in a sticky note to type your response.

Copy and paste a thumbs up if you agree with something already written.

Chat engagement

- **If you are unable to access MURAL, type your response in the chat**
- **Type the category and your lesson in the chat:**
  - Community service providers: Lesson
  - Health systems: Lesson

Accountable Health Communities Model design and statistical analysis

What does the AHC Model test?

One Model, Two Interventions

The AHC Model uses two tracks to test two interventions to help Medicare and Medicaid beneficiaries with HRSNs resolve those needs:

The Assistance Track test universal screening to identify Medicare and Medicaid beneficiaries with HRSNs and provision of navigation assistance to connect navigation-eligible beneficiaries with the community services they need.

The Alignment Track tests universal screening, referral, and navigation COMBINED WITH engaging key stakeholders in community-level continuous quality improvement to align community service capacity with the community's service needs.

The AHC Model focuses on five core HRSNs:

- Housing instability
- Food insecurity
- Transportation problems
- Utility difficulties
- Interpersonal violence

Images: RTI International. "AHC Model Evaluation: First Evaluation Report". December 2020.
HRSNs = Health-related social needs

Model overview

Bridge organizations lead a consortium of CDSs, CSPs, and the state Medicaid agency to implement the AHC Model.

Image: RTI International. "AHC Model Evaluation: First Evaluation Report". December 2020.

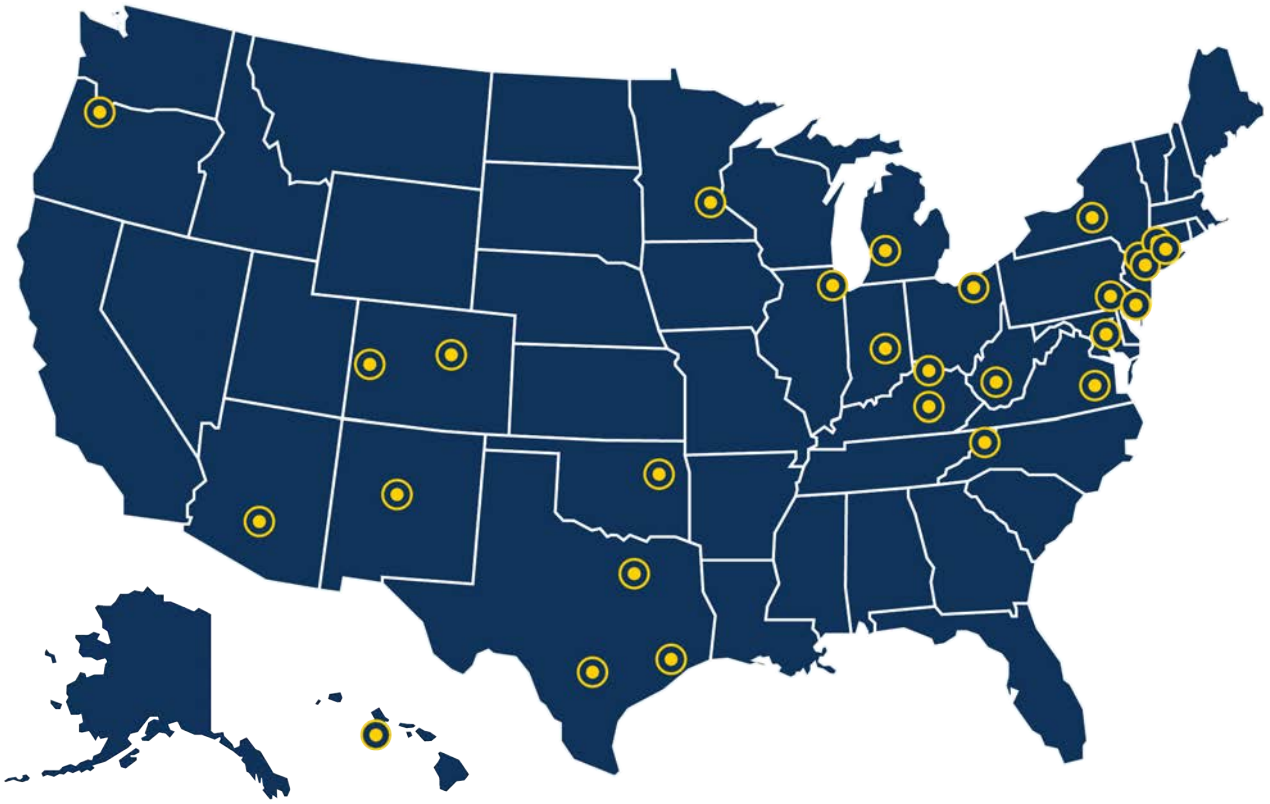
Assistance Track

Bridge organizations in this track provide community service navigation services to *assist* high-risk beneficiaries with accessing services to address health-related social needs.

Alignment Track

Bridge organizations in this track encourage partner *alignment* to ensure that community services are available and responsive to the needs of beneficiaries.

Bridge organizations



28 bridge organizations:

- Hospitals, health systems, and health care organizations (19)
- Community-based or social services organizations (2)
- Health plans (2)
- University or research organizations (2)
- Health information exchanges (2)
- Health department (1)

Model timeline

Time period	Model activities	Evaluation reports
May 2017 to April 2018	Start-up period for AHC Model bridge organizations	
May 2018 to April 2022	Implementation period for AHC Model bridge organizations	December 2020: First evaluation report (public) August 2021: Interim evaluation report (internal)
May 2022 to April 2023	No-cost extension period for some AHC Model bridge organizations	Early 2023: Public evaluation report
May 2023 and beyond		Early 2024: Public evaluation report Early 2025: Public evaluation report

AHC evaluation overview

Evaluation purpose

- How was the model implemented?
- What were the model impacts?
- How did contextual factors and implementation affect model impacts?

Mixed methods

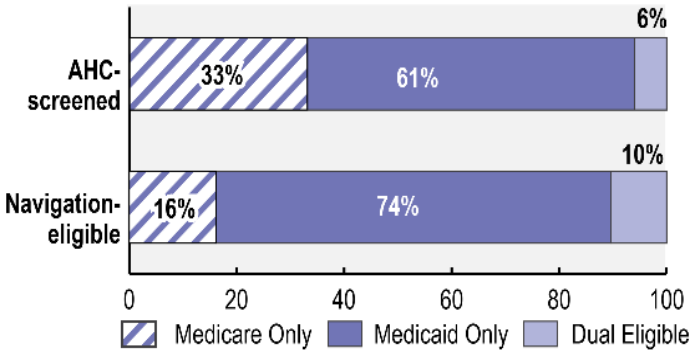
- Surveys and interviews with bridge organizations, partners, and beneficiaries
- Screening and navigation data
- Claims data: Medicare fee-for-service (FFS), Medicare Advantage, and Medicaid
- Randomized and matched comparison group design

One report to date: RTI International's First Evaluation Report

Community service navigation preliminary impact findings

- Beneficiaries who qualified for the AHC Model intervention were disproportionately likely to have low incomes, to be racial and ethnic minorities, and, among Medicare beneficiaries, to be disabled

Beneficiaries served, by program



Beneficiaries served, by program and race/ethnicity

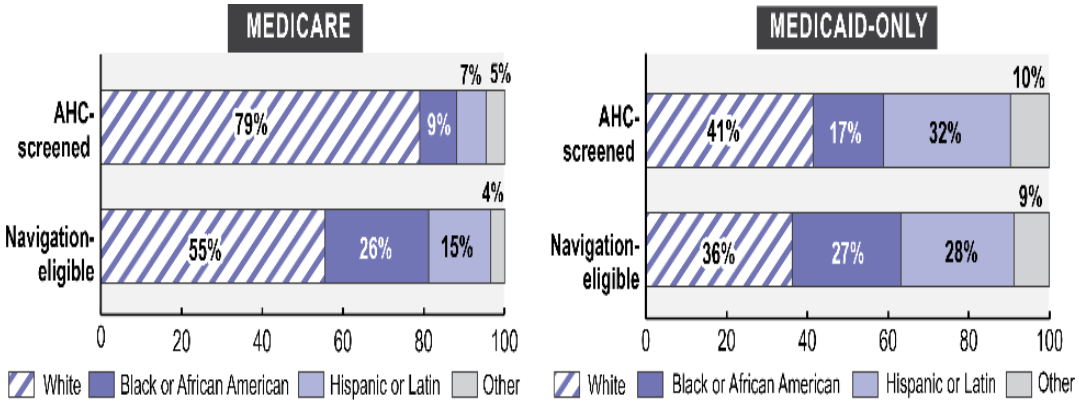


Image: RTI International. "AHC Model Evaluation: First Evaluation Report". December 2020.

Use of data to drive change

Allina Health

Who are we?

Allina Health is a not-for-profit health care system that cares for patients from beginning to end of life through its:

- 12 hospitals
- 90+ clinics: primary care, urgent care, everyday, hospital-based clinics
- 52 rehabilitation locations
- 15 retail pharmacy sites
- 2 ambulatory care centers
- Specialty medical services, including hospice care, oxygen and home medical equipment and emergency medical services.

Allina Health AHC screening data

AHC screening results

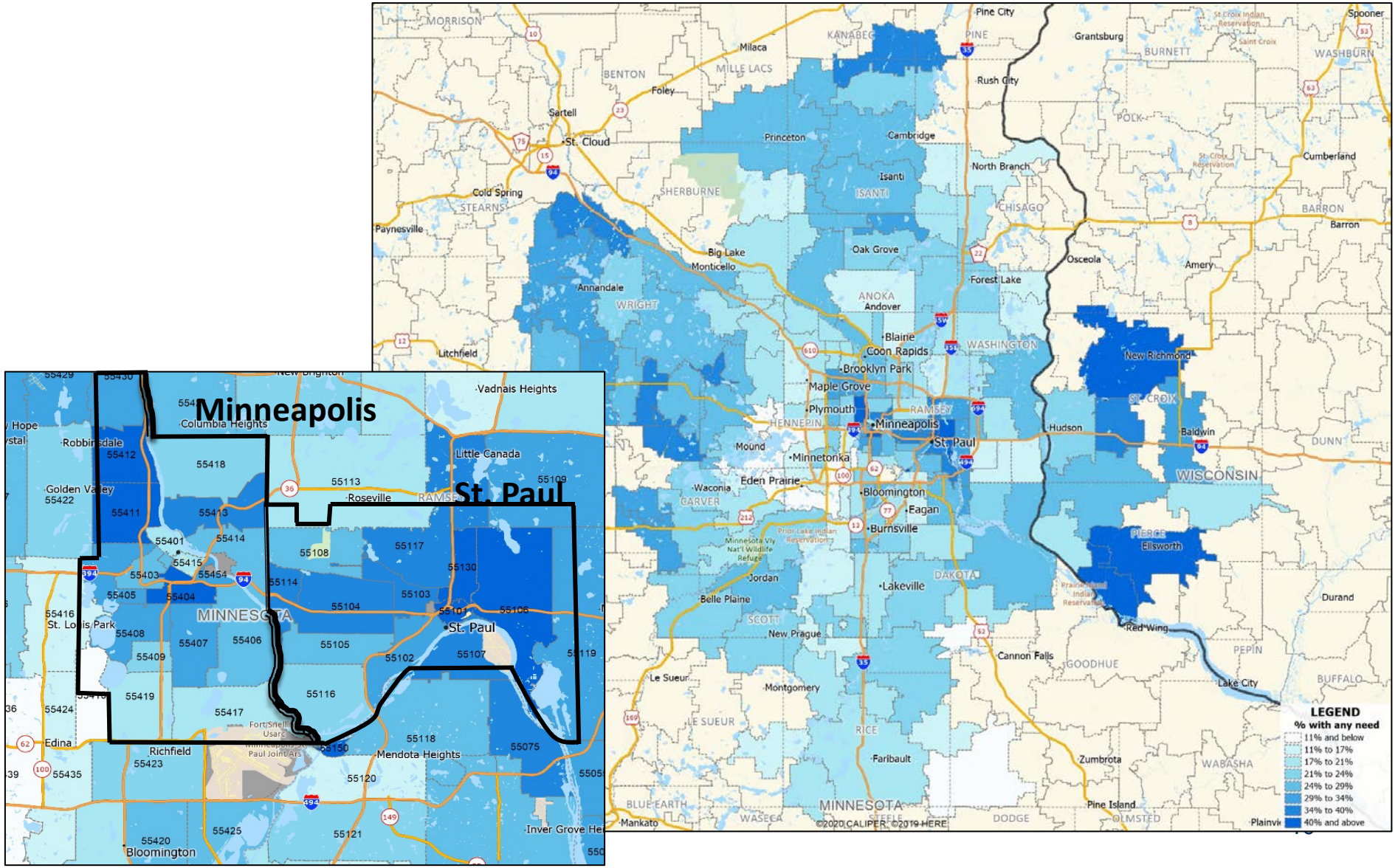
Summary of screening results by unique visit and unique patients

June 5, 2018 – January 31, 2022

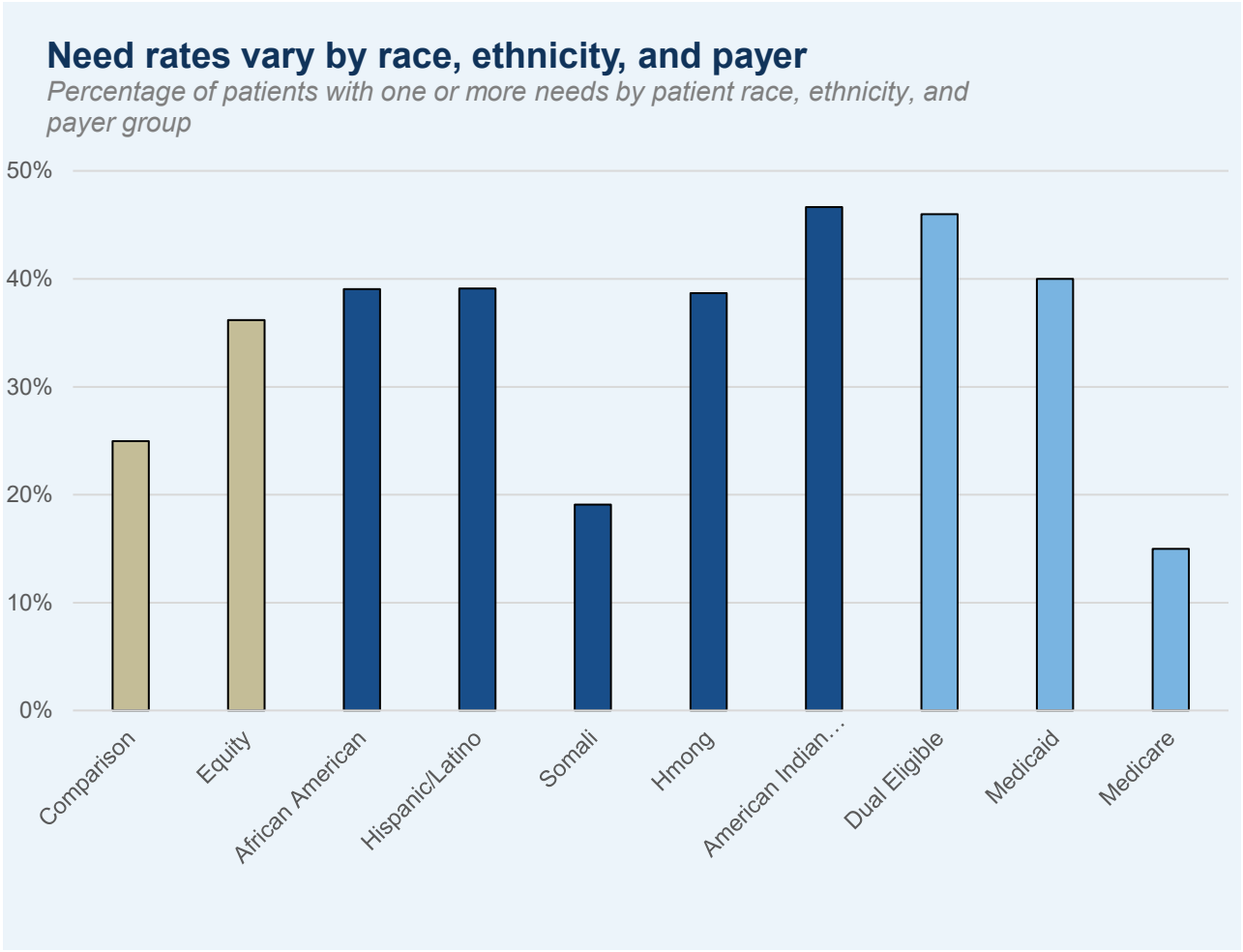
	Visits	Unique patients*
Eligible for screening	990,691	378,413
Offered a screening	597,127 (60% of eligible)	299,032 (79% of eligible)
Completed screenings	266,948 (45% offered)	166,682 (56% of offered)
Screenings with 1+ need	60,521 (23% completed)	46,997 (28% of completed)

*Patients were eligible to be offered a screening every six months. Most patients had multiple visits eligible for screening during the model period.

Unmet needs affect all communities in Allina Health's service area



Disproportionate need

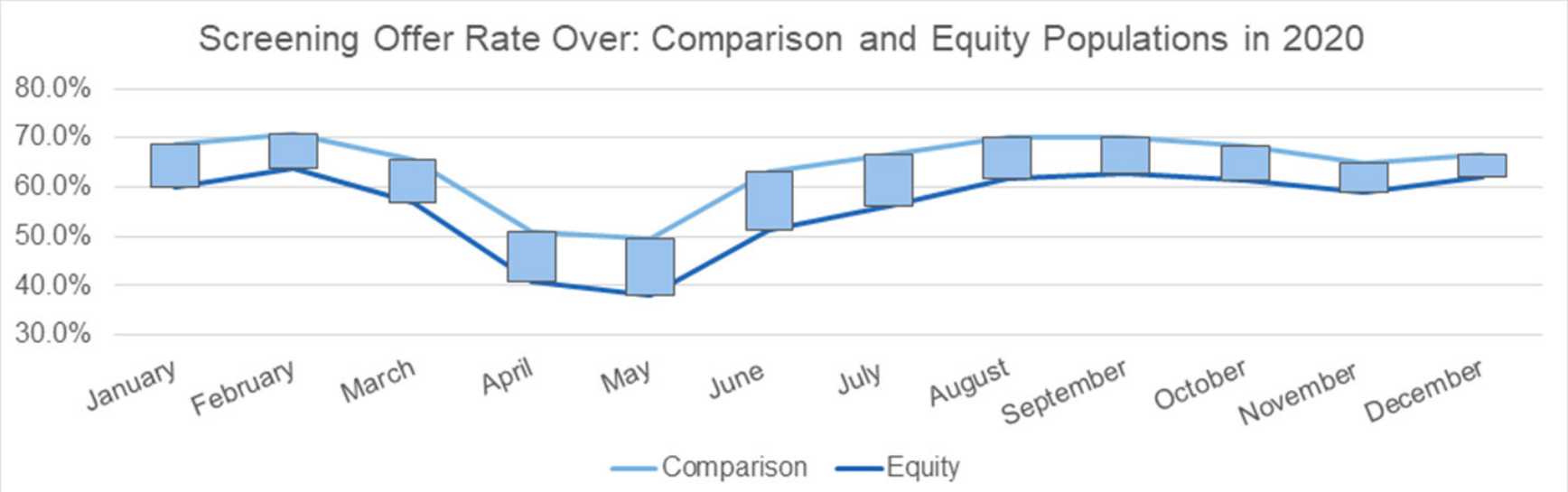


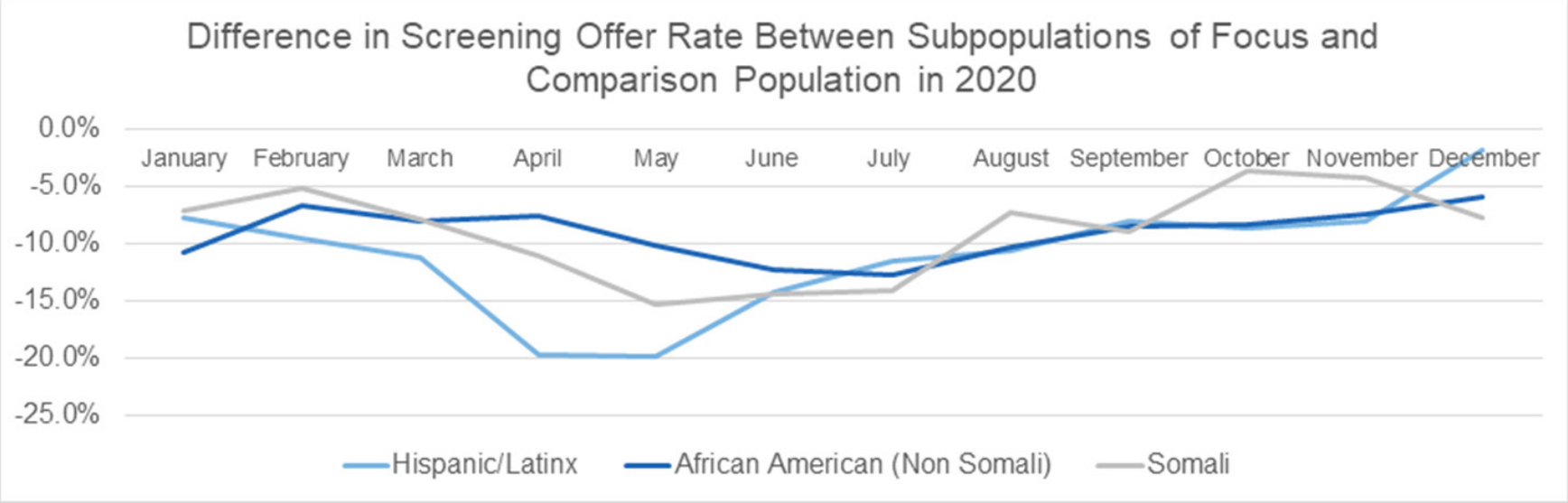
- Needs vary significantly by race and ethnicity.

- Racial and ethnic disparities in need rates are present in all geographies.

- Medicaid and dual-eligible patients are more likely than Medicare beneficiaries to identify need in the general population.

Disparity in social needs screening





Approach to reducing AHC screening disparities

- **Cross-organizational AHC Equity Team developed**
- **Data transparency**
  - Site-level data shared with regional directors, cascading to site leaders
- **Identifying the root cause**
  - Interviews led by AHC Equity Team
    - Virtual interviews with staff, exploring personal and organizational barriers and perceived barriers
- **Action**
  - Development of operational strategies to overcome organizational and personal barriers to AHC screening process for equity population
    - Scripting developed for introducing screening through an interpreter
    - Cultural humility video produced and distributed in partnership with HealthFinders
    - Equity screening rate included in system scorecard measures

Addressing health care disparities and social needs

Decreasing preventable readmissions

Population focus: Native American patients

- Improve care transitions
- Inpatient care management and clinic intervention collaborative intervention

Increasing colorectal cancer screening rates

Population focus: African American patients

- Clinic-based community health worker focused on improving ambulatory quality measures and patient, staff, and provider experience

Shared tactics

- ✓ **Health-related social needs screened**
- ✓ **Community leader collaboration**

Partnership to address disparities

The relationship in development between a large healthcare system, Allina Hospitals, and a community-based organization, Open Path Resources, to address critical health disparities.

Formation and Vision of OPR

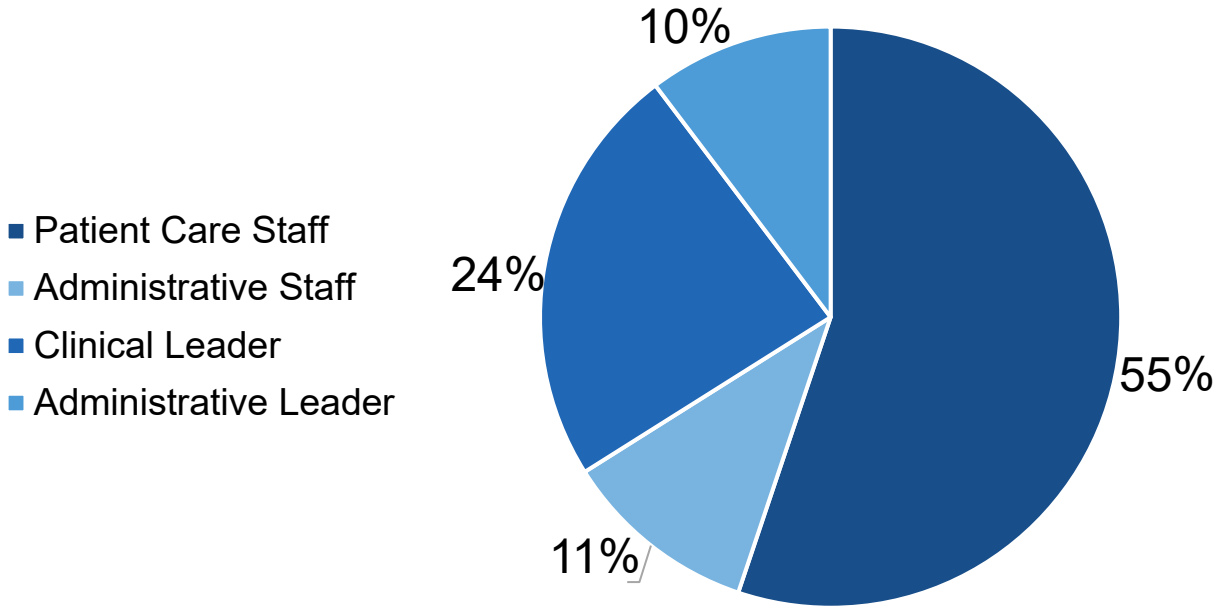
- Community leaders for last 20 years addressing significant disparities on social determinants of health
- Faith as central guide and resource to addressing health inequity and quality of care
- Community Mandate
- Focus upon building capacity of families to produce next generation
- Restructure relationship between mainstream systems (i.e., healthcare) and community

Evolution of Relationship

- Spiritual care as route into healthcare system & most specifically the clinical portion of hospital
- Doctors and nurses request help in their care models with Muslim patients
- Development & delivery of Culturally Responsive Care (CRC) Model/Training
  - Very positive response from staff regarding trainings (high attendance). CHART
- Looking for specific applications of the CRC model in clinical settings
  - Colorectal Cancer Screening (videos developed)
  - Expanse of Spiritual Care Program to include Muslim Chaplains
  - CHNA relationship support to community

Survey Respondents Overview

Roles



Other Roles:

- Independent non-medical healthcare provider (Audiologist)
- RN Clinical Data Abstractor
- Insurance
- Fundraising
- Research
- Social Work
- Research
- Advance Care Planning Coordinator
- Access Center
- Performance Improvement Advisor
- Interpreter
- Care Coordination
- Community Engagement/Outreach
- Educator

What was most helpful?

Most Helpful (Open-Ended):

- Having representatives from the community present and share stories
- Practical application
- The way information was presented – in a conversational, nuanced way
- Input from Imam
- Virtual options
- Q&A section
- History and cultural background as foundation
- Framing faith and culture as assets in care
- Handouts for ongoing learning
- Recordings

What was least helpful?

Least Helpful (Open-Ended):

- Virtual format
- Balance of content with time (large amount of content in short amount of time)
- Would like more opportunities for questions
- Timing/schedule: meeting conflicts, 1 hour too long for clinical staff
- Practical information for medical application
- All from a male perspective
- So much for all of us to learn; this is just the beginning

Q&A

Audience Engagement

Thank You!