Identifying and Addressing Health-Related Social Needs through Primary Care Innovation in Medicaid Managed Care

September 29, 2021, 3:30-4:30 pm ET

Part of CHCS’ Strengthening Primary Care through Medicaid Managed Care learning series.

Made possible through support from The Commonwealth Fund.
Questions?

To submit a question online, please click the Q&A icon located at the bottom of the screen.
Agenda

• Welcome and Introductions

• Spotlight on health-related social needs initiatives from:
  → Hawai‘i Department of Human Services, Med-QUEST Division
  → Community Health Plan of Washington

• Q&A
Welcome & Introductions
Today’s Presenters

Diana Crumley,  
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Center for Health Care Strategies

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Med-QUEST Division Administrator,  
Hawai’i Department of Human Services

Kat Ferguson-Mahan Latet,  
Director, Health System Innovation,  
Community Health Plan of Washington
Center for Health Care Strategies

Dedicated to strengthening the U.S. health care system to ensure better, more equitable outcomes, particularly for people served by Medicaid.

Together with our partners, our work advances:

- **Effective models for prevention and care delivery** that harness the field’s best thinking and practices to meet critical needs.

- **Efficient solutions for policies and programs** that extend the finite resources available to improve the delivery of vital services and ensure that payment is tied to value.

- **Equitable outcomes for people** that improve the overall wellbeing of populations facing the greatest needs and health disparities.
Strengthening Primary Care through Medicaid Managed Care

• This webinar is part of CHCS’ *Strengthening Primary Care through Medicaid Managed Care* series.

• The series, made possible by The Commonwealth Fund, examines the tools and levers that states can use to advance comprehensive primary care strategies. Future topics include:
  → Integrating behavioral health care
  → Using technology to improve primary care access
  → Exploring state approaches to patient-centered medical homes
  → Monitoring primary care spending and investment
  → Encouraging MCO accountability for primary care goals

• Be on the lookout for upcoming webinars and new resources.
Advancing Primary Care Innovation in Medicaid Managed Care: A Toolkit for States

For implementation considerations, state examples, and sample managed care contract language, access the toolkit at: www.chcs.org/primary-care-innovation.
Core Features of Advanced Primary Care and Levers to Drive Uptake and Spread

- Enhance Team-Based Care
- Use Technology to Improve Access
- Integrate Behavioral Health Care
- Identify and Address Social Needs
- Engage Communities and Achieve Health Equity
- Promote Accountability for MCOs
- Move to Value-Based Payment in Primary Care
- Monitor Primary Care Spending and Investment

Promote Accountability for MCOs
Move to Value-Based Payment in Primary Care
Monitor Primary Care Spending and Investment
Screening for Social Risk Factors: Considerations for State Medicaid Agencies

✔ Who should be screened?
   → By whom, at what level (e.g., state, plan, & primary care team)?
   → For what social risk factors?
   → Why? Toward what goal?

✔ How will screening results be:
   → Documented?
   → Used to improve care?
   → Shared across health care organizations?

✔ How can states advance this work using their Medicaid managed care contracts?

For more information, see the Identify and Address Social Needs module in the Advancing Primary Care Innovation in Medicaid Managed Care toolkit. www.chcs.org/primary-care-innovation.
Addressing Unmet Health-related Social Needs: Considerations for State Medicaid Agencies

1. Be precise with words and goals
   - What’s at the individual-level? Community-level? Upstream? Downstream?
   - Achieving health equity will require more than addressing unmet needs.

2. Strive to be more democratic, less technocratic
   - Remember: Health equity is a process and an outcome.

3. Lead when you can
   - Explore ways to reduce unnecessary fragmentation.

4. Pay for what you want to see
   - Use available levers, such as: Medicaid managed care contracts, value-based payments, and Medicaid benefits.

To learn more, read the recent CHCS blog post, *Medicaid and Health-Related Social Needs: Four Insights over Four Years*. [www.chcs.org/medicaid-and-health-related-social-needs-four-insights-over-four-years/](www.chcs.org/medicaid-and-health-related-social-needs-four-insights-over-four-years/)
Hawai‘i Department of Human Services, Med-QUEST Division

Judy Mohr Peterson, Med-QUEST Division Administrator
Plan to Identify and Address Health-Related Social Needs Through Primary Care Innovation in Medicaid Managed Care

Center for Health Care Strategies
Strengthening Primary Care Through Medicaid Managed Care Learning Series

Judy Mohr Peterson, PhD
Hawai`i State Medicaid Administrator
September 29, 2021
Hawaii Health Innovation Framework

Whole Person Health
- Integrate Care
- Mental Health & substance use treatment
- Social Risk Factors/Social Drivers of Health

Healthy Families and Healthy Communities

Whole Family - ‘Ohana Nui
- Young children and their families over the life course
- Social networks
- Build on strengths & Resilience
- Invest in primary care
- Lync & synch to services

Whole Community
- Population Health
- Health Equity and addressing disparities
- Where we live, work, play and learn
- System transformation
- Linking diverse community partners

Social Determinants or Drivers of Health
- Integration of behavioral health across the continuum
- Health Equity and addressing Health Disparities
NASEM Framework

INTEGRATING SOCIAL CARE INTO THE DELIVERY OF HEALTH CARE

- Activities focused on individuals
  - Adjustment
  - Awareness
- Activities focused on communities
  - Alignment
  - Advocacy

Addressing Positive Screens: NASEM Framework

- **Awareness**: identifying patient or community level SRFs and assets
- **Adjustment**: using SRF/HRSN information to inform clinical decision making

1. Identify the Social Risk Factor (SRF)/Health Related Social Need (HRSN)
2. Determine how to address their SRF/HRSN
3. Provide care that is informed by the SRF/HRSN
Addressing Positive Screens: NASEM Framework

- **Assistance**: linking patients to additional resources, like social services or government resources

1. Identify the Social Risk Factor (SRF)/Health Related Social Need (HRSN)
2. Identify if the patient wants help addressing their SRF(s)
3. Determine how to address their social need

Social Need: “a social risk that the patient has identified and prioritized for intervention”
## Applying the NASEM Framework

<table>
<thead>
<tr>
<th></th>
<th>Food Insecurity</th>
<th>Homelessness</th>
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</thead>
<tbody>
<tr>
<td><strong>Awareness</strong></td>
<td>Screening patients for food insecurity and alerting their clinician about the</td>
<td>Screening patients for homelessness, alerting their clinician about the</td>
</tr>
<tr>
<td></td>
<td>results</td>
<td>results, and including this information in their care plan</td>
</tr>
<tr>
<td><strong>Adjustment</strong></td>
<td>Prescribing medications that can be taken without food</td>
<td>Prescribing medications that can be taken without refrigeration</td>
</tr>
<tr>
<td><strong>Assistance</strong></td>
<td>Referring all patients who are food insecure to enroll in SNAP; hosting on-site</td>
<td>Referring patients to shelters; helping patients apply for affordable</td>
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<tr>
<td></td>
<td>food pantries that provide healthy foods</td>
<td>housing</td>
</tr>
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</table>
Managed Care Plan & SDOH

- Statewide “Social Determinants of Health Transformation Plan”
  - Stakeholder engagement
  - Build on existing efforts (Accountable Communities of Health and Community Health Ctrs, and with hospitals’ Pay for Performance)

- Health Plans Individualized work plans
  - Align with the statewide plan
  - Part of Quality Assurance and Performance Improvement Plan (QAPI)
  - Work plan address:
    - Plans for increasing the systematic collection and documentation of Member-level SDOH data through screening;
    - Plan for promoting the use of ICD-10 Z codes for SDOH documentation;
    - Plan to increase provider understanding of SDOH;
    - Plan for incorporating SDOH strategies into the overall QAPI by:
      - Linking beneficiaries to identified SDOH needs; and
      - Providing relevant SDOH value-added services offerings;
Activities Focused on Individuals

Screening for Health-Related Social Needs (HRSN) – Phase I

- Managed Care Organizations (MCO) are required to screen and provide interventions
  - Target population - Members with Special Health Care Needs (SHCN)
  - State-approved priority domains
    - Food insecurity and housing insecurity/homelessness
  - Screening Tools - MCOs must use state-approved screening questions
  - MCOs share information with primary care providers (PCP) so positive screens can inform clinical decision making
  - Screening may be done by paraprofessionals
  - MCOs are encouraged to delegate screening and other care coordination services so services are provided where members are located
Supporting Primary Care and Addressing HRSN

This Approach Addresses the Following:

- Some PCPs expressed not having the time and resources to screen for HRSN
- Other PCPs expressed they are already screening and want to continue
- Screening and interventions are focused on addressing whole-person needs and better supports the needs of this high-need/high-cost population
Issues to Resolve

● Further clarify the role of PCP regarding HRSN
  ○ Physicians/clinics ≠ Social Workers/community resources

● Multiple platforms are emerging that capture and track HRSN
  ○ Multiple platforms may increase administrative burden for providers

● Closed loop referral system is goal but is not yet fully developed

● Screening questions that may be used in future phases to address other HRSN need to be identified, adapted and adopted to meet Hawaii’s needs

● How to capture information (coding, EHRs); Workflow to screen and then refer

● If/how to pay for what HRSN services
# Resource – Screening Q’s and Coding Requirements

<table>
<thead>
<tr>
<th>#</th>
<th>Social Risk Factor Questions</th>
<th>Procedure Codes</th>
<th>Diagnosis Codes for Positive Screens</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>Within the past 12 months, you worried that your food would run out before you got money to buy more. Often true, Sometimes true, Never true</td>
<td>CPT 96160: Administration of a patient-focused health risk assessment instrument; OR CPT 96161: Administration of caregiver-focused health risk assessment instrument for the benefit of the patient</td>
<td>ICD-10-CM Z59.4: Lack of Adequate Food &amp; Safe Drinking Water IF the response is “often true” OR “sometimes true” (for either question)</td>
</tr>
<tr>
<td>2</td>
<td>Within the past 12 months, the food you bought just didn't last and you didn't have money to get more. Often true, Sometimes true, Never true</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>What is your living situation today? • I have a steady place to live • I have a place to live today, but I am worried about losing it in the future • I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)</td>
<td>ICD-10-CM Z59.9: Housing or economic circumstance (i.e. at risk of homelessness) IF the response is “I have a place to live today, but I am worried about losing it in the future” ICD-10-CM Z59.0: Homelessness IF the response is “I do not have a steady place to live”</td>
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Questions?

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Advancing Whole Person Care

Addressing Health Equity and Social Needs
Learn whose land you are on.
https://native-land.ca/
Who we are?

Founded and governed by Community Health Centers (CHC) with roots in the social justice movement

We are rooted in Washington State

The whole health of our members is our primary concern and focus

Our staff and board are local and part of the fabric of the communities we serve
<table>
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<tr>
<th>Plan Description</th>
<th>Members</th>
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<tbody>
<tr>
<td>Apple Health Integrated Managed Care</td>
<td>220,000</td>
</tr>
<tr>
<td>Medicare Advantage (includes Dual)</td>
<td>14,000</td>
</tr>
<tr>
<td>Behavioral Health Services Only</td>
<td>27,500</td>
</tr>
<tr>
<td>Cascade Select (WA state’s Public Option)</td>
<td>500</td>
</tr>
</tbody>
</table>

Snapshot Data. Varies Monthly
Incentivizing Whole Person Care

Built in collaboration with Community Health Network of Washington (CHNW)

CHCs
- Total Cost of Care Model, including primary care, hospital, specialty, pharmacy and behavioral health. HCPLAN 3B
- Performance on 13 Quality Measures (HEDIS, CAHPS, WA developed BH measures) determines ultimate earnings or deficit payment
- Strategic Initiative program funding

Access and technical support to population health platform that integrates claims, clinical data and other population health management tools

Dedicated practice coaching and support and peer learning opportunities

Community investment and partnerships
Strategic Initiatives, Capacity Development, Quality Improvement

Underneath the dominant payment methodology:
CHPW has developed sub-payment programs to support strategic efforts:

- Mental Health Integration Program
- Social Determinant of Health and Social Need Identification Support and
  Program Development
- Population Health Management tool adoption
- Equity Learning Collaborative
Addressing Social Needs and Social Determinants of Health at CHPW

Survey of Community Health Centers in our network about their collection and use of Social Determinants of Health data.

- Only half of the CHCs were using a standard assessment tool in their EHR
- Need identified to support efforts to systematically collect and document data in the electronic medical record (EHR) for integration with clinical data.
- 80% of CHCs would find additional data on SDoH helpful
- Action: Community Health Centers were funded to electronically integrate SDoH assessment data into their EHRs

CHC projects also included:
- Training on workflow integration for assessment tools
- Strategies for completing patient assessments
- Coding education--- Especially around Z-codes
- Expanding assessments to all patient populations
National standardized patient risk assessment protocol to assess social determinants of health

Some EHRs automatically document Z-codes with the PRAPARE template

PRAPARE has many EHR templates available for integration into the EHR

Find the PRAPARE implementation and action toolkit at: [http://www.nachc.org/research-and-data/prapare/toolkit](http://www.nachc.org/research-and-data/prapare/toolkit)
Of the members that completed CHPW’s annual Health Risk Assessment, **23.3%** of members reported an unmet social need.

**SDOH Needs Across the Network**

- **Employment %**: 8.4%
- **Housing %**: 8.0%
- **Transportation %**: 7.6%
- **Interpreter %**: 6.3%
- **Legal support %**: 5.3%
- **Food %**: 2.1%
SDOH Needs Across the Network

2020 Referral Needs

- Housing & Shelter
- Individual & Family Support
- Employment
- Mental/Behavioral Health
- Legal
- Social Enrichment
- Income Support
- Education
- Substance Use
- Physical Health
- Food Assistance
- Other
- Transportation
- Physical Health
- Clothing & Household Goods
- Benefits Navigation

Bar chart showing referral needs across different categories with percentages. The chart includes categories such as Housing & Shelter, Individual & Family Support, Employment, Mental/Behavioral Health, Legal, Social Enrichment, Income Support, Education, Substance Use, Physical Health, Food Assistance, Other, Transportation, Physical Health, Clothing & Household Goods, Benefits Navigation.

Legend:
- Z Codes: N=34,831
- JIVA: N=477
- Unite Us: N=120

Source: COMMUNITY HEALTH PLAN of Washington®
The power of community
Addressing Social Needs and Social Determinants of Health at CHPW

**Member**
- Health risk assessments
- Access to peer support services
- Connection to social services
- Case management and health coaching
- Access to medically tailored meals
- Access to CHW’s and in-home visits
- Support for housing needs

**Community**
- Policy and advocacy
- Community engagement and outreach
- Partnership and collaboration with CBOs and ACHs
- Participation in community-based initiatives and projects

**CHCs**
- Delegated case management support
- Reporting/analytics
- Arcadia CIS
- Unite Us platform
- Grant supported initiatives and incentives
- Patient engagement and outreach
- Training, education and support
- Documentation support

**State**
- Policy and advocacy
- Engagement in SDOH initiatives
- Leading the build out of Unite Us Washington
- Participation in key collaboratives and workgroups
Equity Learning Collaborative and Funding

$50,000 in funding per CHC and a Learning Collaborative

- CHPW, CHNW and WA Health Care Authority participated in the Advancing Health Equity Initiative with the charge to develop care transformation and payment reform
- Funding to address identified health disparities and advance equity in member experience and access to care, pregnancy care, chronic disease management and depression management
- Fall Learning Series to support application process, monthly cohort calls for peer learning, quarterly convenings with featured speakers and CHC sharing
Equity Learning Collaborative and Funding: Year 2 Design

- CHCs need support and partnership to build culture of equity in their organizations to make this work sustainable
- Support to build and scale “equity infrastructure”
  - Foundational training, education on implicit bias, anti-racism
  - Understanding your data and measures; what story does it tell you
  - Root cause analysis and exploring the why
  - Ensure those individuals and communities most impacted by the work are engaged from design to evaluation
  - Community based work force development
Building Equity into Program Design

- Addressing needs of individuals experiencing homelessness transitioning from psychiatric inpatient treatment through additional staffing supports and community partnerships
- Developing strategies to support individuals to engage in postpartum care, by providing transportation and childcare
- Supporting individuals experiencing homelessness engage and build connection and support telehealth access through smartphone access and support
- Building a sustainable framework for engaging patients/consumers in program design for projects that address social needs
Reflections, Considerations and Next Steps

- Recognition that capacity investment is still very much needed to support the shared goals we would like to see around health and health care.

- We tend to focus on what we can already measure, however often that is not giving us the full picture. How can we incent/encourage collection of new and different measures, push for improvement in those areas we want to see change in.

- Invest in addressing social supports while also committing to address the systems that determine those needs.

- We must recognize the power we have and share it. We are not adequately involving people most impacted by the work in the work.

- Partnering with our State Medicaid Agency is key to advance work around payment redesign, care transformation, addressing social needs and advancing equity.

- Programs developed to address social needs must be rooted in equity.
Questions?

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Visit CHCS.org to...

• Download practical resources to improve health care for people served by Medicaid.

• Learn about cutting-edge efforts from peers across the nation to enhance policy, financing, and care delivery.

• Subscribe to CHCS e-mail updates, to learn about new resources, webinars, and more.

• Follow us on Twitter @CHCShealth.