INTEGRATING SOCIAL HEALTH DATA TO IMPROVE CARE DELIVERY AND ADDRESS SOCIAL NEEDS

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Metro Community Provider Network (MCPN) is a 501(c)(3) Federally Qualified Health Center (FQHC) and integrated health care delivery system located in the metro area of Denver, Colorado. MCPN offers its patients accessible primary care and other health-related services across 26 health center locations. There are more than 40 community services staff, including care coordinators, patient navigators and health educators, working across multiple care coordination programs.[1] These programs aim to provide "whole-person care" by addressing patients' social needs while also providing support with chronic disease management. Services within these programs are tiered based on the complexity and needs of the patient:

1. The *Bridges to Care* program uses care coordinators, health coaches and behavioral health providers to provide complex care management services to the highest-risk, highest-need patients. These teams work with patients in their homes and in the community to address biopsychosocial needs. Care coordinators and health coaches have obtained a bachelors-level education; behavioral health providers have obtained masters or doctoral-level education. They maintain caseloads of 25-30 patients for 30, 60, or 90-day periods depending on patient complexity.

[1] Note: Due to recent structural changes at MCPN, some referenced departmental information may no longer apply.

Social Needs Intervention at Metro Community Provider Network

Aim: To integrate addressing social needs into a team-based model of care for all patients.

Scope of Service: Eleven clinical sites – family, pediatric and obstetric practices – have integrated efforts to identify and address patients' unmet social needs. Patient Navigators screen patients and provide basic resources and referrals. Care Coordinators follow up with patients who need a longer-term intervention. Providers from other non-integrated clinics can refer patients to work with the patient navigation team.

Top Social Needs: Use of emergency department for routine care, food resources, Medicaid information assistance, transportation assistance, housing resources

Workforce: Eight Patient Navigators are integrated in practices across the organization. Care Coordinators work within multidisciplinary care teams to prove more intensive support high-risk, high-need patients.

Technology: NACHC's PRAPARE Assessment template integrated into Centricity EMR.

Funding: Majority of funding for Patient Navigation services comes from general operating budget – HRSA 330 Grant; sub-contractor with Denver Regional Council of Government for AHC CMS Innovation Grant.

Impact Numbers: Demonstrated 10% increase in patients keeping scheduled appointments; improvements in patient experience; and 100% of patients who have screened positive for food insecurity have been given a community resource referral.

2. The Complex Care Coordination team collaborates with clinical staff as well as health educators and behavioral health providers to coordinate care and other support services across settings. They work with patients to identify barriers to health, many relating to unmet social needs. In coordination with their care team, Complex Care Coordinators develop plans to ensure comprehensive, coordinated care — holding a caseload of 70-100 patients.

3. The Patient Navigation team is within the Clinical Operations Department and is responsible for screening patients for social needs and connecting them to resources in the community. Patient navigators are located on site in the practices and do not carry a caseload, but provide an average of 3-5 encounters per patient served. In addition to screening patients for unmet social needs, they also provide referrals to resources in the community. If the identified need is greater or more complex than a navigator's skill set, they can refer the patient to other levels of care management (referenced above). This case study focuses on the Patient Navigation services provided by MCPN.

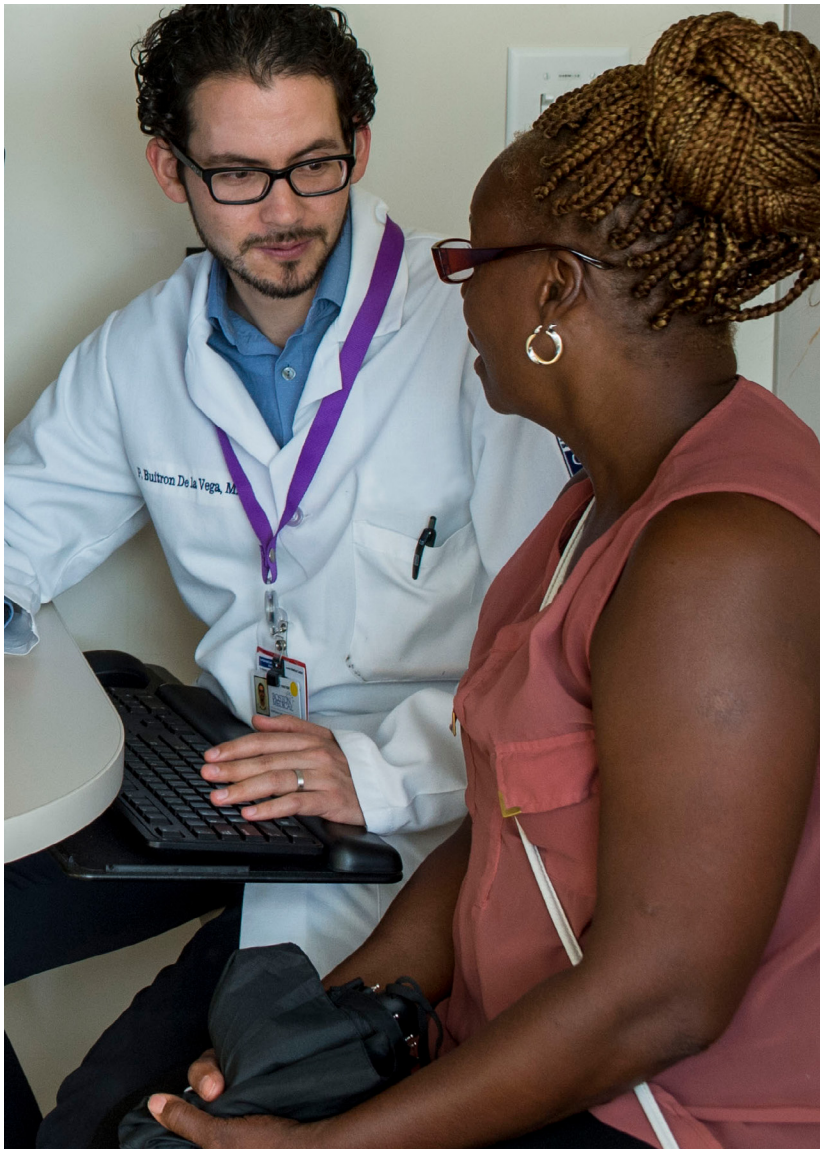
Screening Process & Social Health Data Integration

Patient Navigators verbally administer a social needs screen to all new patients, patients who have not been screened in the past six months, and any patient referred to the Patient Navigation team by medical providers, behavioral health providers or call center staff. Patient Navigators are available to screen patients in the clinics during patients' medical visits or screen patients via phone, as necessary. They are trained on how to ask patients questions and how to add diagnostic codes when entering social health data in the EHR.

Patients' needs are assessed using a hybrid assessment tool that has evolved over time. The tool includes questions developed by MCPN and from NACHC's "Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences" (PRAPARE) tool.[3]

MCPN: Health Services Data, FY2016[2]

- **Total patients served:** 50,502
- **Total visits:** 286,165 visits/services
- **Payor Mix:**
  1. **Medicaid:** 49%
  2. **No Insurance:** 40% (Note: includes self-pay, sliding fee scale, CICP)
  3. **Medicare:** 6%
  4. **Private Insurance:** 3%
  5. **Colorado Child Health Plans Plus:** 1%



[2] MCPN 2016 Annual Report. Retrieved from: http://mcpn.org/newsite/wp-content/uploads/2017/06/MCPN-AR16-051119.pdf.
[3] Natural Wonders Partnership. (2017). 2017-2019 Action Plan. Retrieved from: http://www.archildrens.org/media/file/82089%20Natural%20Wonders%20Action%20Plan.pdf.

MCPN uses the tool to screen for social needs domains, including:

- Socio-demographic information — including race, ethnicity, preferred language and refugee status
- Housing instability
- Financial and resource information — including educational attainment and employment status
- Detailed insecurities — including food, utilities, clothing child care and legal services
- Social and emotional health

MCPN tracks screening questions as diagnoses, including:

- Z59.0 – Homelessness
- Z55.3 – Underachievement in School
- Z59.4 – Lack of Adequate Food
- Z59.1 – Inadequate Housing
- Z63.9 – Problem Related to Primary Support Group

MCPN has integrated the PRAPARE Electronic Health Record template into their Centricity EHR—syncing information from the patient record into the PRAPARE template. Identified social needs are included in the EHR's problem list and are tracked until resolution. The integration allows data on patients' social needs data to be combined with health data, which is critical to analyze the impact of addressing patients' social needs on health outcomes.

Risk Stratification Pilot

MCPN is piloting a risk stratification process in partnership with Children's Hospital of Colorado to ensure that patients are directed to the appropriate level of care and services, both at MCPN and within the community. Development of the risk stratification tool has been a collaborative effort between medical, behavioral health, patient navigation, care coordination and operational staff. Criteria include ER utilization, diagnoses, social determinants, medications, housing status and activities of daily living, among others.

Information collected from the social needs screen is included in the risk stratification algorithm. The risk stratification score is communicated to all members of the care team through the EHR, and specific activities are assigned based on the score.

Currently, Patient Navigators and Care Coordinators are testing the risk stratification tool with current patients to inform efforts to empanel patients onto care teams and ensure that patients are directed to appropriate level of wraparound services. By mid-2018, MCPN plans to roll out a process to risk stratify patients across all providers to better target services to individual needs.

Incorporating Patient Navigation into the Clinic Setting

Eight Patient Navigators are integrated within six clinics in MCPN's network. Larger clinics receive two Patient Navigators, and some Patient Navigators are assigned to float across clinics. They often reference providers' schedules to identify patients that may need referral and navigation assistance based on previously identified social needs documented in their EMR. Patient Navigators also frequently meet with patients during their medical visits to provide referrals in real time.

The Consumer Care Services manager, who oversees the program, has focused on building relationships among providers and clinic staff to establish an integrated workflow. Patient Navigators are encouraged and empowered to build strong relationships with providers, to navigate clinical hierarchy and assert themselves as part of the care team.

The concept of addressing patients' social needs as part of care delivery is still new for a lot of providers. To help address this, the Care Coordination Manager and Consumer Care Services Manager frequently go to the practices where navigation staff are located, especially when there is a staffing change or a new staff member. They attend meetings with the medical and behavioral health providers, clinical support staff, and operations staff to provide an overview of the scope of navigation services offered, the roles of Patient Navigators and Care Coordinators, and how they can all collaborate.

To support staff in their new roles, Patient Navigators are required to complete the Patient Navigation Training Collaborative Level 1 course within their first year of employment. The collaborative is a national program that aims to grow and sustain the patient navigation workforce, including free courses for Colorado residents. Patient Navigators and care coordination staff are also required to complete training on motivational interview techniques.

Evaluation & Outcomes

The Community Services Department aggregates, analyzes and disseminates social health data across their programs in the form of a monthly dashboard. This has helped to engage key stakeholders and to motivate staff to review progress against their program aims. This monthly dashboard has been used to elevate programmatic growth and successful resource connection rates with MCPN's CEO and Board of Directors.

This dashboard uses both qualitative and quantitative data pulled from the EMR to highlight:

- Total patients connected to medical and dental services
- Completed appointments
- Health education services provided to the patient population served, stratified by disease status and insurance type
- Screening and resource referral rates for social needs, such as food insecurity

Additionally, integrating stories about patients' positive health outcomes and the impact of MCPN's services (e.g. quitting smoking, lost weight) into the monthly social health dashboard has been very inspirational for staff.

Since MCPN began their efforts to address patients' social needs in the fall of 2016, they have demonstrated successful resource connections as well as positive impacts at the practice level. For example, as of October 2017, 100% of patients who screened positive for food insecurity were provided a resource to address this need. And among its practices, MCPN has experienced a 10% increase in patients keeping appointments.

As part of their work to address social needs, Patient Navigators will follow up with patients who have missed appointments to uncover the reason and reschedule. If necessary, they will also connect these patients to resources, such as transportation or child care, so that the patient is able to access the care they need. Across the three programs (Patient Navigation, Care Coordination and Bridges to Care), MCPN aims to increase the number of patients keeping appointments by 25-30%. Not only will this support the organization's bottom-line, but

> **"[You] get into the work because you know that it helps, and it's good, but you need the data to support it. Can't just be the 'right thing to do' – it has to be productive."**
>
> Allison Draayer, LCSW
> MCPN Patient Navigation Manager

MCPN has also found that the navigation and care coordination services have helped to improve individual relationships and the overall patient experience.

As MCPN continues to evolve its measurement and evaluation strategy, the organization is looking to demonstrate the value of the program across multiple points of impact. The integration of social health and clinical data within the EHR is considered vital to this effort. Implementing a robust measurement strategy will help MCPN prepare for and participate in Phase II of the Health First Colorado (Colorado Medicaid program) Accountable Care Collaborative, that aims to improve members' health outcomes and reduce costs through several regional entities.

In the future, MCPN plans to evaluate:

- The impact of resource connections on keeping medical appointments in the long term
- How HbA1c levels are affected by providing food resources to diabetic patients with food insecurity
- Reduction in ED utilization
- Reduction in hospital admissions due to poor health
- The financial impact of supporting self-pay patients to obtain Medicaid coverage

Funding

The majority of funding for Patient Navigation services comes from MCPN's general operating budget, which receives funding as a HRSA program grantee, under Section 330 of the Public Health Service Act. Currently, six Patient Navigators are covered under the general operating budget and two Patient Navigator positions are 100% funded by private foundation and state grants.

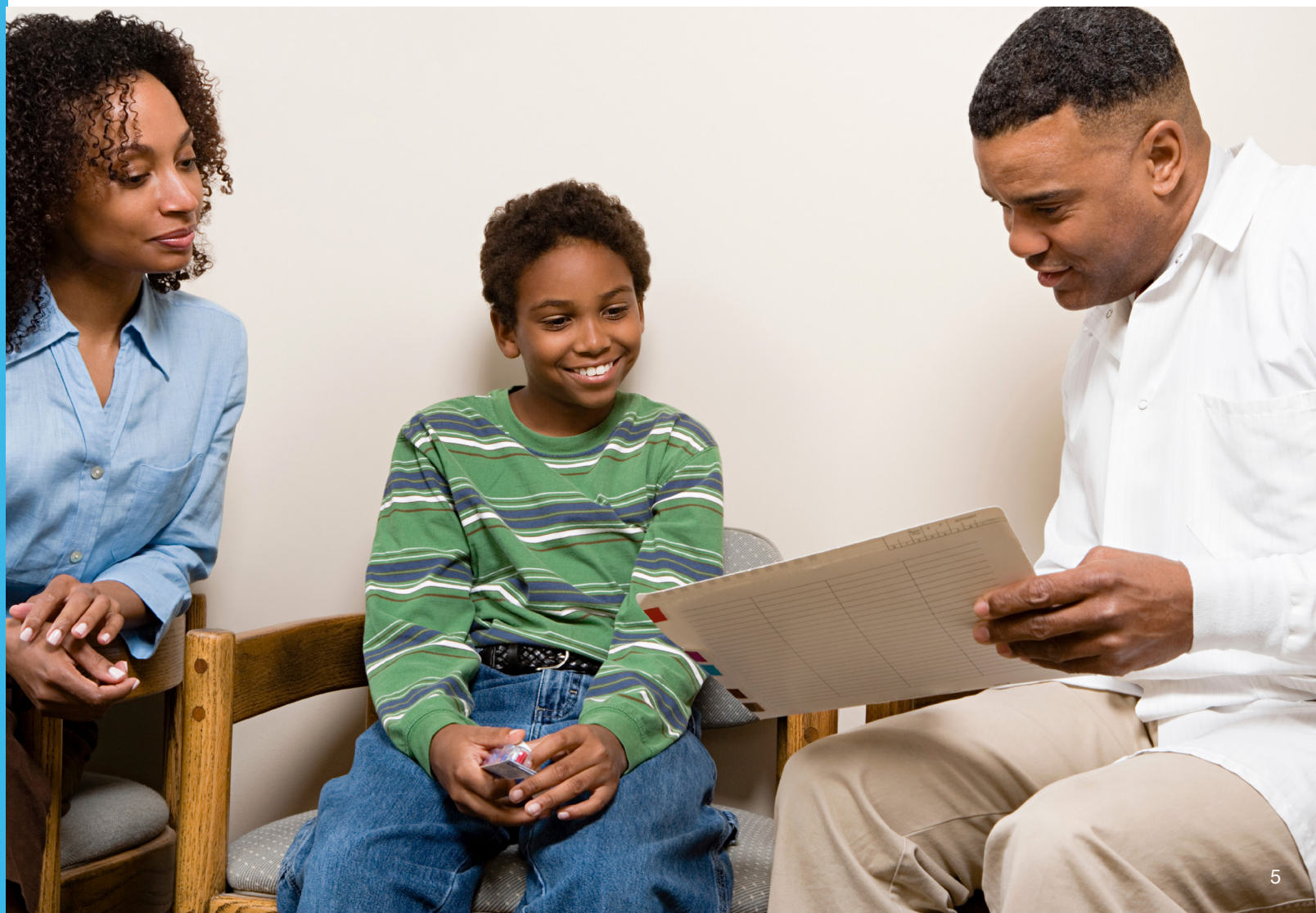
Additionally, MCPN is a sub-contractor with The Denver Regional Council of Governments (DRCOG) for the Accountable Health Communities model, funded by the Centers for Medicaid and Medicare Services (CMS).[5] Under the 'Alignment Track,' cross-sector organizations partner "to bridge the gap between clinical and community service providers...[to] strengthen the network of health and social providers to better assist Medicare and Medicaid recipients."[6]

Patient & Community Engagement

A patient advisory panel was created in 2016 to inform the organization's social needs strategy. To date, patient leaders have helped to identify gaps in service delivery, as well as the community resource providers MCPN might build relationships with to improve connections to vital services. MCPN also plans to develop a patient advisory panel to specifically focus on improving navigation services.

Additionally, Patient Navigators call a sample of each other's patients to obtain feedback about their experience with the program. This strategy was developed after finding it challenging to establish meeting times that aligned for an adequate cross-section of patients.

[5] CMS. (2018). Accountable Health Communities Model. Retrieved from: https://innovation.cms.gov/initiatives/ahcm/.
[6] The Denver Regional Council of Governments (DRCOG). (April 2017). Press Release: DENVER REGIONAL COUNCIL OF GOVERNMENTS AWARDED $4.5 MILLION IN FUNDING FROM CENTERS FOR MEDICAID AND MEDICARE SERVICES. Retrieved from: https://drcog.org/sites/drcog/files/resources/2017DRCOG_CMS.pdf.



Success Factors

- Patient Navigation Program seen as an integral part of the organization's strategy
- Integration of social needs data into the EHR
- Highly developed team-based care, with activities assigned by tier to improve service delivery
- Robust training and coaching empowers the social needs workforce, and helps providers and clinic staff collaborate with new team members and services
- Patient voices inform service delivery improvements and make the work more powerful

Challenges

- PRAPARE is a long assessment, and requires time, space and patient buy-in to complete – something not guaranteed with every patient
- Alternative payment models do not cover program costs and grant funding can be inconsistent — MCPN is building an evidence base to convince payers to take larger steps to support this work
- Setting reasonable expectations for patients and staff around the scope of services provided by Patient Navigators and Care Coordinators

Looking Ahead

Over time, MCPN has stayed the course and even intensified its motivation for addressing patients' unmet social needs. The organization's approach to whole-person care has led to improvements in patient engagement and experience — along with anecdotal stories of how patients' lives have improved through quitting smoking or losing weight.

Their efforts to address patients' social needs as an integrated part of care has helped to position them well for value-based payment opportunities including Phase II of the Accountable Care Collaborative. It has also been a critical piece of their on-going effort to implement a multidisciplinary risk stratification approach ensure that all patients are able to access the care and services they need to be healthy.

MCPN will document screening, referral and navigation service data for Medicaid beneficiaries as a Track 3 sub-contractor with Denver Regional Council of Government for the AHC CMS Innovation Grant.[7] MCPN believes that their efforts to provide whole-person care and address social needs will prepare them to be successful in these initiatives and to sustain this model of care in the future.

[7] Centers for Medicare and Medicaid Services. (2017). Accountable Health Communities Model. Source: https://innovation.cms.gov/initiatives/ahcm/.

About Health Leads

Health Leads is a U.S.-based non-profit organization working toward a vision of health, well-being and dignity for every person in every community.

For more than 20 years, we've worked closely with hospitals and clinics to connect people to essentials — like food, housing and transportation — alongside medical care. Today, we're partnering with communities and their local organizations to address systemic causes of inequity and disease. We do this by removing barriers that keep people from identifying, accessing and choosing the resources everyone needs to be healthy.

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