EXPANDING AND SCALING EFFORTS TO IDENTIFY AND ADDRESS HEALTH-RELATED SOCIAL NEEDS: LESSONS FROM THE AHC MODEL

Identifying and addressing health-related social needs (HRSNs) has the potential to improve patients' health outcomes and reduce health care costs and unnecessary utilization. The Centers for Medicare & Medicaid Services' (CMS) Accountable Health Communities (AHC) Model aimed to systematically identify and address the HRSNs of Medicare and Medicaid patients through screening, referral, and community navigation services. Organizations that participated in the AHC Model strived to build the capacity and expertise to scale up these services. Ballad Health, an AHC Model awardee that serves the rural Appalachian region in southwest Virginia and northeast Tennessee, used the infrastructure it developed through the AHC Model as the foundation for three new screening, referral, and navigation programs, each of which focuses on a different patient population (Figure 1).

As highlighted below, this resource features strategies that health care or community-based organizations working to identify and address HRSNs can consider as they establish or expand screening, referral, and navigation efforts by describing how Ballad applied its experience implementing the AHC Model to screen new patient populations for HRSNs outside of the model.

Key strategies for scaling up HRSN screening, referral, and navigation:

1) Expand or adapt HRSN screening to address additional populations' needs

2) Recruit appropriate staff who represent the patient population

3) Leverage existing data resources to include additional populations

Expand HRSN Screening to Address Additional Populations' Needs

CMS developed the AHC Screening Tool so participating organizations could identify patients with HRSNs in a standardized way. Though the AHC Model's target patient population was Medicare and Medicaid beneficiaries, the AHC Screening Tool is appropriate for a wide range of health care settings and can be used or adapted to screen other populations.[1]

Building on its AHC implementation, Ballad adapted the AHC Screening Tool for its new programs by adding questions to assess the acuity of a patient's medical and social needs. The screening tool assesses not only whether patients are experiencing housing instability but also the severity of that need. The additional questions also identify whether patients need services that were not a part of AHC, such as specialty care or complex care management. Ballad also uses the adapted tool to determine the level of navigation support a patient needs (Figure 2).

Patients with many complex medical and social needs received a higher level of navigation support, while patients with fewer and relatively simpler HRSNs required less intensive support to resolve needs. For example, a patient who has multiple chronic conditions, does not speak English, is experiencing food insecurity, and does not have reliable transportation will likely require a higher level of navigation support than another patient with no chronic conditions who has reliable transportation and employment but needs to be connected with a food bank. This tiered approach is intended to maximize the efficiency of their staff, help manage caseloads, and allow each team member to practice at the top of their scope. In general, Ballad found that its uninsured patients tended to require a higher level of support compared to Medicare and/or Medicaid beneficiaries in the AHC Model due to a greater number of barriers to accessing and receiving health care and social services.

Flexible Screening Workflows

While implementing the AHC Model, Ballad integrated screening into diverse clinical sites, such as urgent care centers, labor and delivery units, and emergency departments. In doing so, Ballad learned that each screening site has its own culture and workflows.

Ballad translated this experience into new screening programs by allowing clinical sites the flexibility to adjust the screening process to fit their workflows. In turn, this helped increase buy-in from staff at screening sites.

[1] For more information on effectively using the AHC Screening Tool, the Centers for Medicare & Medicaid Services has this guide, which has promising practices and key insights. Additional translations of the AHC Screening Tool are also available via the AHC website.

Figure 1. Ballad Health Scales Up its HRSN Programs

PROGRAM	CMS's Accountable Health Communities Model	Strong Pregnancy	Strong Starts	Appalachian Highlands Care Network (AHCN)
GOALS OF HRSN PROGRAM	Ballad aimed to determine whether systematically identifying and addressing health-related social needs - including housing instability, food insecurity, and needs related to transportation, utilities, and interpersonal violence - of Medicare and/or Medicaid beneficiaries led to improved health care costs and utilization.	Ballad strives to improve maternal health and health in early childhood, prevent future disease, and reduce health costs and avoidable utilization by intervening early on HRSNs in children.		As an organization, Ballad is financially responsible for its uninsured patients. By addressing their health-related social needs, Ballad intends to improve chronic conditions, care for uninsured patients more efficiently, and reduce health care costs and avoidable utilization.
FOCUS POPULATIONS FOR SCREENING, REFERRAL, AND COMMUNITY SERVICE NAVIGATION	Community dwelling Medicare and/or Medicaid beneficiaries with 2 or more ED visits in the previous 12 months.[1]	Expectant parents and young children (prenatal to three months of age) regardless of payer — patients can transition to the Strong Starts program when their child reaches three months of age.	Parents with children age three months to five years, regardless of payer.	Uninsured patients living within Ballad's service area with an income at or below 225 percent of the federal poverty level.

[1] Community-dwelling beneficiaries are individuals who do not reside in a correctional facility or long-term care institution and who live within the awardee's geographic target area.

Maintain an Accurate and Comprehensive List of Community Resources

Maintaining an accurate repository of the characteristics and capacity of resources available in a community is critical to successfully address patients' HRSNs. AHC Model awardees created and periodically updated community resource inventories (CRIs), or compilations of community-based organizations, which navigators used to effectively tailor referrals for beneficiaries.

Through AHC, Ballad developed a CRI and built partnerships with community-based organizations to address the AHC Model's five core HRSNs: housing instability, food insecurity, utility needs, interpersonal violence (safety), and transportation needs. AHC awardees experienced rapid changes in the availability and types of community services available over the course of the five-year model, particularly at the onset of the COVID-19 public health emergency. That experience prepared organizations like Ballad to adapt and refine its partnerships with community service providers to meet the needs of its patients. When scaling its screening and navigation programs, Ballad expanded its CRI to add community service providers specific to its new target populations. For example, Ballad sought out community service providers with expertise to support maternal health and new mothers for its Strong Pregnancy and Strong Starts programs. Ballad's population health department, leveraging its experience implementing AHC, understood how to build successful partnerships with CBOs and what details, such as specific eligibility criteria, to document in the expanded CRI.

Recruit Navigation Staff that Represent Targeted Populations

To provide culturally concordant, community-based care, Ballad used community navigators and community health workers (CHWs) to support patients who were eligible for community navigation services during the AHC Model. Both community navigators and CHWs are representatives of the communities they serve, but CHWs have received more training to prepare them for the higher level of support they provide.

Through direct outreach and discussion with patients participating in navigation services, the navigation staff learned more about the patients' HRSNs, identified key barriers to addressing them, and developed person- centered action plans to help patients connect with relevant community services to resolve their needs.

Ballad's staffing approach for hiring CHWs has evolved based on its experience hiring navigators and CHWs for the AHC Model. Through AHC, Ballad learned that employing CHWs who have a personal understanding of patients' experiences can make patients more comfortable discussing sensitive topics such as HRSNs. To better meet the needs of its new focus populations, Ballad put greater emphasis on hiring CHWs with similar backgrounds and demographics to their patients. The health system then worked with staff to provide the training and licensure they needed for their roles.

> "We try to find a person who's a mirror image of the population they serve. So, many times, it's a person who has utilized the services they're referring patients to"
>
> ***– Casey Carringer, Director of Clinical Engagement***

Figure 2. Ballad's Appalachian Highlands Care Network Two-Tiered Screening and Navigation Process

Step 1: Patients are screened for HRSNs and medical needs.

Step 2: Screening staff sort patients into two groups, those with simple needs and those with more complex needs. The level of complexity is determined based on the presence and acuity of the HRSNs the patient reports.

Patients with **Simple Needs**	Patients with **Complex Needs**
Step 3: Patients with simple needs are assigned to a navigator.	**Step 3:** Patients with more complex needs are assigned to a trained community health worker (CHW).
Step 4: Navigators refer patients to community-based organizations who can assist them.	**Step 4:** CHWs refer patients to community-based organizations and provide tailored support, such as home visits, accompanying patients to medical appointments, or helping patients complete paperwork to apply for other services. CHWs can also refer patients to care managers for specific chronic conditions such as diabetes or chronic obstructive pulmonary disease.
Step 5: Navigators periodically follow up with patients and make additional referrals, as needed, to ensure patients' needs are met. Navigators monitor patients for one year to ensure they have no new needs.	**Step 5:** When a CHW determines a patient's needs have been resolved or when adequate wrap around services are established, they transfer the patient's case back to a navigator. The navigator will continue to monitor the patient for up to a year and can refer the patient back to a CHW if needed.

Leverage Existing Data Systems Across Programs

To participate in AHC, awardees agreed to collect and submit data on screening, referral, and navigation to CMS to help it evaluate the model. Ballad built its own data system to collect the required information which enabled customization to fit the organization's needs and allows the awardee to continue using the system beyond its participation in the AHC Model. As Ballad expanded its HRSN initiatives, it leveraged the system built for AHC to support new programs. Ballad's data system was already integrated into their workflows and staff were familiar and comfortable with the existing system.

Using one system across all screening and navigation programs enabled Ballad to:

- Track similar metrics, such as the number of patients screened and the number of HRSNs resolved through navigation, across screening programs
- Center patient experience by preventing over screening; staff can easily see if a patient is already receiving services through another HRSN program

Next Steps for Sustaining and Scaling HRSN Programs

As the AHC Model has ended, many participating organizations are sustaining, expanding, and adapting their efforts to address HRSNs among their patients. Ultimately, Ballad plans to expand HRSN screening, referral, and navigation services to its entire patient population. Ballad is primed to provide universal screening thanks to their experience implementing the AHC Model, which provided the infrastructure and a strong base from which to continue scaling HRSN programs to additional populations. Other organizations can leverage the infrastructure and lessons learned from the AHC Model as they adapt their approaches to staffing, workflows, data systems, and other resources to address HRSNs.

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