<u>**Social Risk Factor Questions – Allina Health**</u>

1) **Are social risk data being used to target services or provide outreach? If so, how? How are beneficiaries with social risk factors identified?**

Allina Health completes a screen that addresses potential social risk factor concerns for all Medicare beneficiaries in the following locations:

- All Allina Health primary care clinics
- Outpatient mental health clinics
- OBGYN Clinics
- Three emergency departments (78 total care delivery sites to screen),
- Inpatient mental health

Across our system, this represents 78 care delivery sites where Medicare beneficiaries are screened. We utilize the CMS approved screening form that is part of the Accountable Health Communities model. This screening includes questions on food insecurity, housing, transportation, difficulty paying utility bills and interpersonal safety. Our experience should that approximately 28% of beneficiaries completing the screen identify at least one need.

Additionally, our home health program completes a screen for every beneficiary that has 112 elements, which all may focus on social risk to some degree. Comprehensive assessments are done in our inpatient rehabilitation & skilled nursing facilities, which address social topics that could be impactful to discharge, or the receipt of follow up care. These responses are then incorporated into the discharge planning process for each beneficiary. For all of our post-acute care sites, if a social risk were identified that warrants further assistance, the beneficiary would be referred to a social worker to follow up.

We have found that knowing whether a patient is enrolled in public programs can be a good indicator as to an individual's potential risk factors. However, typically it is quite challenging to identify patients who are enrolled in such programs. Thus, many of the resources that may be available to patients often go undiscussed.

2) **Are there especially promising strategies for improving care for patients with social risk?**

One population Allina health serves is patients that have a disability. There are several support programs offered through the Minnesota Department of Human Services (MN DHS) that operate at home or in the community in order to support this population. We try to enroll beneficiaries in support programs that fit with their particular need. Additionally, Allina participates in the Medical Home model for a population of individuals with disabilities and complex health conditions, certified by MN DHS. While this is a limited population, it has allowed us to better tailor strategies for addressing all aspects associated with care of the patient's needs.

Allina also offers care coordination services, which address medical needs, however social risk factors are considered as part of this service as well. Through this service, there is continued access to a social worker as a resource to patients. For patients that are identified as having a potential risk through our Accountable Health Communities screening, we offer a referral to community resources that could help

address their need. At this time, we continue to follow the patient for up to one year to see whether they are able to obtain the services they need.

Finally, Allina Health has focused on how to better engage staff in the awareness of what social risk factors are, and how they are impactful to our patients. Ensuring that all staff understand why addressing social risk factors is impactful to total health is an important step in our work to improve health outcomes. In order to address the social risk factors of our patients, staff first need to be able to recognize what a social risk factor is and why it is important.

3) **How are costs for targeting and providing those services evaluated? What are the additional costs to target services, such as case management, and to provide additional services (e.g., transportation)? What is the return on investment in improved outcomes or reduced healthcare costs?**

As part of the Accountable Health Communities model, we are working on how best to evaluate the cost of services meant to affect social risk factors. Our care coordination model (referenced above), has actually increased outpatient costs, but likely reduced ED visits and possible readmission. The care coordinators assist patients in following up doctor visits or outpatient therapy. While we see that there is a decrease in revenue associated with employing a care coordinator, we believe that we are actually increasing value and quality care for both the patient and the organization.

4) **What are the best practices to refer beneficiaries to social service organizations that can address social risk factors?**

We believe that engaging community service providers is critical. Aside from social services, developing partnerships with organizations such as Metro Transit could prove to be impactful in addressing social risk factors. In our view, there are aligned incentives for healthcare and social/community services to work together to address social risk factors.

5) **What lessons have been learned about providing care for patients with social risk factors?**

The biggest lesson Allina Health has taken away is that the establishment of trust of key. In all of our post-acute care settings, we have found that the patient needs to feel comfortable with their care provider in order to open up regarding what challenges they may be facing. The opportunities for our care providers to establish a repoire with even one person can be very impactful in the identification of additional resources that may be available to the patient.

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6) **What are barriers to tailoring services to patients with social risk factors? How can barriers be overcome?**

In our skilled nursing and inpatient rehabilitation facilities, our experience is that it can be very difficult to find a safe and appropriate discharge destination for a patient. With the combination of needing

accessible housing, the need for physical assistance, and potentially the need to move to Medicaid or Medicare payment, patients may not be admitted, or their discharge may be delayed because of anticipated problems at discharge. At this time, we are unable to consistently consider and identify the social risk factors outlined in this RFI, when discharge planning. Absent this information, it is very possible that once discharged, a patient will not be able to either care for himself or herself or receive adequate care once they have left our facilities. This increases the chance for readmission and poor outcomes.

Our experience in the home health population is that this service is often not the provider's first choice for additional care. Patients may be better suited to be admitted to a transitional care unit, however cost or insufficient access may prohibit them from going that route. Home health then becomes second choice, but is not the best/safest option for the needs of that patient. Allowing beneficiaries to be able to receive follow up care in the healthcare environment that is best suited to their particular needs is one barrier we would like to see addressed.

Finally, we have seen that many of our Medicaid population is unable to receive care as their spend-down limits is challenging to reach. We continue to encourage MN DHS to address the Medicaid spend down limits, as we believe this is an unwarranted obstacle to patients receiving needed care.

7) **For patients with social risk factors, how does patients' disability, functional status, or frailty affect the provision of services?**

For patients that are disabled, adequate housing, transportation and follow-up with a provider all become more challenging. While there are many resources available to patients that are disabled, frail or have limited functional status, often times these services are counterproductive to what the health system is trying to accomplish. For example, a disabled patient may have to rely on community-based transportation in order to attend health appointments. In many cases, transportation is only available on a routine schedule. For a patient that is unable to sit, stand or wait until the community vehicle can pick them up and drop them off, the choice often becomes to skip the appointment rather than go in for the follow up care they need. Further, we have seen that for patients who have limited food access, community resources that are available to them are often unable to be utilized due to scheduling limits. Limited schedules or pick up locations make it challenging beneficiaries to access the resources they need.

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Data:

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1) **Which social risk factors are most important to capture?**

   Income and whether or not the patient is currently on Medical Assistance.

2) **Do you routinely and systematically collect data about social risk?** Yes, for all beneficiaries of government programs.

   - **Who collects this data?** A clinical assistant collects this information on a paper form, and is entered into a flowsheet in the electronic health record (EHR).

- **When is it collected?** In the outpatient setting, information is collected when patient comes in for visit. In the inpatient or emergency department setting, information is collected at discharge. Home health collects information at admission, every 60 days while receiving home care services and again at discharge.

- **Is it collected only once or multiple times for a beneficiary?** Information is collected every six months.

- **Is it collected consistently across populations (i.e. Medicare beneficiaries, Medicaid beneficiaries, patients receiving specific services, etc.)?** Yes, Medicare, Medicaid, Dual Eligible.

- **What are the burdens of this data collection on plans, providers, and beneficiaries?** Data collection is time intensive, not only to actually collect but to also get into the EHR. Technology always presents a challenge, as systems have limitations and change frequently. We want to ensure that the data we are entering is correct, and is entered in a consistent manner for all patients, which requires staff training. On top of that, routine quality monitoring/auditing is needed to assess areas for improvement within our process.

3) **Would standardized data elements for EHRs help you to collect social risk data? If so, how could these data elements be standardized?**

As part of the Accountable Health Communities model, we have standardized data elements collected. Our experience thus far leads us to believe that it is beneficial.

4) **What are barriers to collecting data about social risk? How can these barriers be overcome?**

No response at this time.

5) **What do you see as promising future opportunities for improving data collection? For using existing or future data to tailor services?**

Allina Health has been in conversation regarding how to engage patients through their own personal devices, such as a cell phone. We believe that patients may be more willing to share information about social risks/concerns electronically than they would in the health care setting. In our experience, allowing people to utilize their own devices often achieves better response rates than requiring an actual computer to log in. We continually encourage patients to sign up for our online patient portal, however many patients to not have access to a computer & the internet. We find that this can actually lead to patients becoming non-responsive because they do not have the means to review information available to them. Developing a way for patients to utilize their phone for these communications could potentially address some of that divide.