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Moving From Incremental To Transformational Strategies To Address Health-Related Social Needs

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In 2017, the Center for Medicare & Medicaid Innovation (CMMI) launched the Accountable Health Communities (AHC) <https://innovation.cms.gov/innovation-models/ahcm> Model to test the impact of screening and referrals for health-related social service needs on key outcomes including health care spending and avoidable use of medical services. Two recent analyses of AHC data show both that navigation had impressive effects and that AHC did not go far enough.

Effective navigation needs to be person-centered, including more active and long-term approaches that support every step necessary to address an individual's needs and priorities, rather than merely an enhanced referral mechanism. As critically, the social service sector requires significantly more resources if it is to have sufficient capacity to meet demand and the ability to partner meaningfully with health care providers and payers.

Accountable Health Communities Reduced Use Of Medical Services But Through Unclear Mechanisms

Leveraging the unusually robust randomized control trial design of AHC, Parish et al. <https://health-policy.healthaffairs.org/parish/june2023issue/aop> found that Medicaid, Medicare, and dually eligible beneficiaries in the Assistance Track who had health-related social needs experienced significantly lower rates of overall and avoidable emergency department (ED) visits; there were even larger (though not statistically significant) effects on total health care spending, ED visits, and hospital readmissions in the Alignment Track of the model. But analysis by Renaud et al. <https://health-policy.healthaffairs.org/renaud/june2023issue/aop> of surveys and qualitative interviews with participants revealed that those receiving navigation support had no measurable improvement in rates of connections to social service providers or closure of their social service needs compared to the control group. Beneficiaries reported challenges accessing services, including long wait lists, outdated information on social service agencies, strict eligibility rules, and frustrating administrative burdens.

Given the low survey response rate of 25 percent, response bias might imply that participants overall had even worse experiences. The authors hypothesize that navigation support could have improved some outcomes through indirect means such as building trust between patient and navigator that facilitated advice on healthy behaviors, or motivating patients to seek informal social supports through family and friends. The COVID-19 pandemic likely also complicated the evaluation. Results from the randomized design present a compelling case that navigation is impactful, although more work remains to understand the true mechanisms, which likely vary based on patients' individual contexts and preferences.

Navigation Support Needs To Solve The Last Mile Problem

These qualitative findings suggest that even when patients received navigation and social service providers had capacity, gaining access to timely social services required some combination of hours of free time to make phone calls, important paperwork at one's

fingertips to apply, and a PhD in social work to understand eligibility rules. Herd & Moynihan characterize these administrative burdens as learning, compliance, and psychological costs. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8522557/> For those who qualify for Medicaid because of low-income, or for those with intellectual and/or developmental disabilities who are dually eligible for both Medicare and Medicaid, these hurdles can be insurmountable, preventing access to services for which they are eligible <https://onlinelibrary.wiley.com/doi/abs/10.1111/puar.13497> .

In supply chains for retail products as in ensuring successful vaccinations, the "last mile" <https://medium.com/the-stigo-blog/the-last-mile-the-term-the-problem-and-the-odd-solutions-28b6969d5af8> or final step in the process is often the most time consuming and expensive, whether that involves steering a truck through city traffic to the recipient's address or ensuring that a person keeps an appointment and rolls up their sleeve to receive an injection <https://www.nejm.org/doi/full/10.1056/NEJMp2100574> . Particularly for high-risk populations such as those targeted in AHC, meaningful navigation support must solve an analogous last mile problem to not only connect patients to appropriate services, but to ensure the patient's social needs are met. Ideally, the navigator is someone the patient trusts, who can both steer referrals and relieve the patient of the administrative burden. Such support should be based on a longitudinal relationship with the patient and a deep understanding of their needs, as well as knowledge of and close working relationships with community service providers.

Structured Community Health Worker (CHW) programs that address social needs have been shown to be effective in reducing hospitalizations <https://onlinelibrary.wiley.com/doi/full/10.1111/1475-6773.13321> when those CHWs are specially hired and trained to provide tailored, person-centered supports for high-risk patients. However, not all navigation programs leverage these evidence-based approaches. AHC sites structured their navigation programs using a wide variety of staffing models; more research is needed to understand the most effective models.

Since AHC began, provider participation in social needs screening has grown considerably. In 2017-2018, 24 percent of hospitals and 16 percent of physician practices reported screening <https://jamanetwork.com/journals/jamanetworkopen/article-abstract/2751390> for the five health-related social needs included in AHC, and that number will continue to grow as the Centers for Medicare and Medicaid Services (CMS) further incentivizes screening in the Inpatient Quality Reporting, Merit-Based Incentive, and D-SNP programs. The key question remains what to do when patients screen positive. As providers and health plans increase the rate of screening, states evolve more

direct social need benefits <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2801475> , and Medicare Advantage plans offer more supplemental benefits targeting social needs, effective navigation that travels "the last mile" must be the glue to connect patients with services that should be available to them but are all too often inaccessible.

More Capacity, Infrastructure, And Business Know-How For Social Service Providers

Getting people through the last mile to needed social services does no good, however, if (1) there isn't sufficient supply of those services; (2) access to services is further constrained by tight eligibility rules; and/or (3) the providers of those services do not have the capacity to efficiently deliver them and be held accountable for outcomes. Many community service providers are small non-profits that lack the electronic record systems <https://files.constantcontact.com/391325ca001/20e9c9f2-2d95-4711-8896-bacfc5d32a2c.pdf> to collect and report data on quality and outcomes. Many lack the staffing and business capacity to plan revenue cycles or enter risk-based financial relationships. Few would have systems for billing an insurer for reimbursable services even if they knew what the relevant CPT codes were. As a result of these factors, even in states where Medicaid agencies have created mechanisms for social service providers to bill for services, few do so successfully. <https://onlinelibrary.wiley.com/doi/full/10.1111/1468-0009.12514>

The social service sector needs not only the capacity to offer a greater volume of services to meet demand, but also robust new infrastructure. A social service analog of the Health Information Technology for Economic and Clinical Health (HITECH <https://www.hipaajournal.com/what-is-the-hitech-act/>) Act that funds and incentivizes investments in electronic records designed to be interoperable with existing electronic health records would allow both sectors to more easily share data, coordinate services, and hold each other accountable for meeting patients' needs.

Given the modest size and resource constraints of most social service providers, they could also benefit greatly from the support of entities that function like the management services organizations <https://copehealthsolutions.com/cblog/an-introduction-to-building-a-management-services-organization/> (MSO) that support medical practices in taking on risk contracts. This concept is distinct from consolidation of social service organizations under a single business entity; a social service MSO would provide wraparound, shared business support services to social service organizations that remain independent.

Other sources of investments could include redirected community benefit dollars <https://avalere.com/insights/how-nonprofit-hospitals-can-use-community-benefit-dollars-to-address-sdoh> from non-profit hospital systems. Some providers in value-based payment arrangements have made targeted investments of their own, such as pre-paying for temporary housing <https://www.huduser.gov/portal/casestudies/study-091319.html> for patients recently discharged from hospitals, to ensure a supply of critical social services. Some Medicaid managed care plans pay for vocational support and food vouchers at farmers' markets <https://www.sunflowerhealthplan.com/members/medicaid/benefits-services/extra-services.html> . CMS has also signaled greater flexibility for state Medicaid programs to offer "in lieu of services and settings," <https://www.cms.gov/newsroom/press-releases/hhs-offers-states-flexibility-better-address-medicaid-enrollees-needs> alternative benefits to address health-related social needs; this regulatory flexibility that could increase the flow of resources to social service providers if sustained and expanded to Medicare Advantage and value-based payment providers in traditional Medicare.

Accelerate Data Sharing And Learning

AHC was a breathtaking experiment in its size and diversity of participants. The country would benefit from deeper analysis of the model's rich data on over one million Medicare and Medicaid beneficiaries. Rather than wait for its evaluation contractor to conduct extensive studies, we would encourage CMS to make the data available to other researchers now, to speed learning.

Relatedly, as CMS implements quality measure incentives and requirements for social service need screenings across value-based payment programs, provider quality programs, and Medicare Advantage, they should also identify mechanisms for sharing data and outcomes. For example, common standards are available to share social need screening and navigation intervention data using HL7 Fast Healthcare Interoperability Resources <https://thegravityproject.net/overview/> . The Innovation Center could also require accountable care organizations and other value-based payment entities to submit information on their strategies for addressing social needs during the application or annual reporting process, and/or offer incentives for model participants to develop social service networks similar to the preferred providers <https://innovation.cms.gov/files/x/nextgenacofaq.pdf> in the Next Generation ACO Model.

CMS should also encourage shared learning across programs around strategies for navigation support. Using a shared learning platform

<https://www.cincinnatichildrens.org/research/divisions/j/anderson-center/learning-networks> that supports exchange of both formal and informal experiences and data across organizations can speed continuous improvement in navigation strategies without the expense or time lag of isolated evaluations.

It's Time To Experiment With Aggressive, Not Incremental Ways To Screen And Refer For Health-Related Social Service Needs

The United States is hardly alone in having clinical and social services historically siloed from one another, a construct that seems increasingly archaic as evidence accrues on the link between social needs and health outcomes (and between health status and life outcomes). Accountable Health Communities was groundbreaking when it launched because it was rare at the time for health insurance programs other than Medicaid to consider social services within their scope of coverage. What we have experienced and observed in the intervening years, with the COVID-19 pandemic and the attendant economic turmoil and mental health crises, has settled the question of *whether* to screen and refer for health-related social service needs. Now we need to experiment with the most aggressive, not incremental, strategies for ensuring access to a robust sector of social service providers that is prepared to engage with health care providers and payers as equal partners in addressing patients' needs.

Authors' Note

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