integra

Screening for and addressing social needs for Medicaid ACO members

NAACOS Medicaid Learning Lab

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About Integra Community Care Network

Based in Providence, Rhode Island

Part of the Care New England Health System

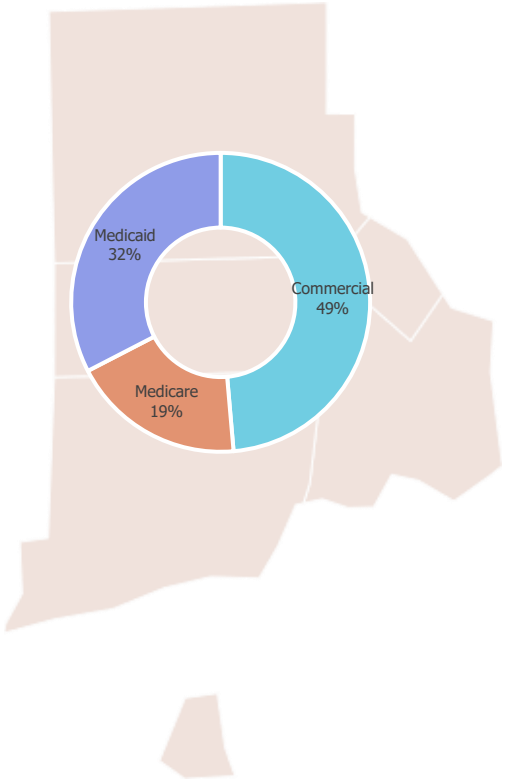
Second-largest Medicaid ACO in Rhode Island

160,000 ACO covered lives

950 providers

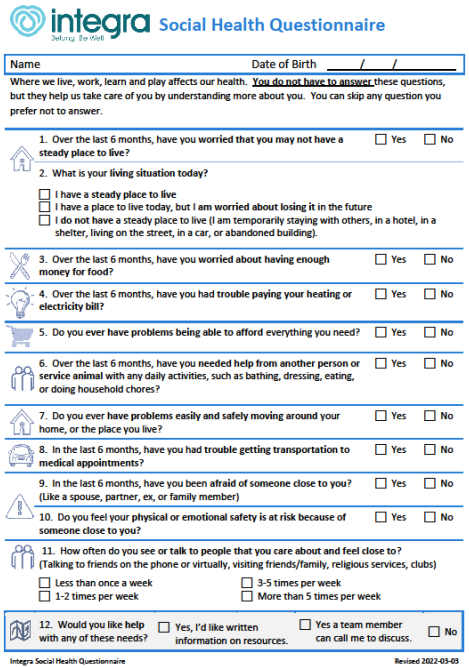
260 primary care providers in 100 practices

4 community hospitals



Rhode Island Executive Office of Health and Human Services requires Medicaid ACOs to screen for social needs

Integra implemented screening on an all-payer basis



integra Social Health Questionnaire

Name Date of Birth ___/___/___

Where we live, work, learn and play affects our health. You do not have to answer these questions, but they help us take care of you by understanding more about you. You can skip any question you prefer not to answer.

1. Over the last 6 months, have you worried that you may not have a steady place to live? ☐ Yes ☐ No

2. 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 on the street, in a car, or abandoned building).

3. Over the last 6 months, have you worried about having enough money for food? ☐ Yes ☐ No

4. Over the last 6 months, have you had trouble paying your heating or electricity bill? ☐ Yes ☐ No

5. Do you ever have problems being able to afford everything you need? ☐ Yes ☐ No

6. Over the last 6 months, have you needed help from another person or service animal with any daily activities, such as bathing, dressing, eating, or doing household chores? ☐ Yes ☐ No

7. Do you ever have problems easily and safely moving around your home, or the place you live? ☐ Yes ☐ No

8. In the last 6 months, have you had trouble getting transportation to medical appointments? ☐ Yes ☐ No

9. In the last 6 months, have you been afraid of someone close to you? (Like a spouse, partner, ex, or family member) ☐ Yes ☐ No

10. Do you feel your physical or emotional safety is at risk because of someone close to you? ☐ Yes ☐ No

11. How often do you see or talk to people that you care about and feel close to? (Talking to friends on the phone or virtually, visiting friends/family, religious services, clubs)

☐ Less than once a week ☐ 3-5 times per week
☐ 1-2 times per week ☐ More than 5 times per week

12. Would you like help with any of these needs? ☐ Yes, I'd like written information on resources. ☐ Yes a team member can call me to discuss. ☐ No

Integra Social Health Questionnaire Revised 2022-03-03

EOHHS requires screening of Medicaid members

- Implemented as a quality measure
- Current year target is 50% of patients screened

Integra has built internal capacity to address social needs

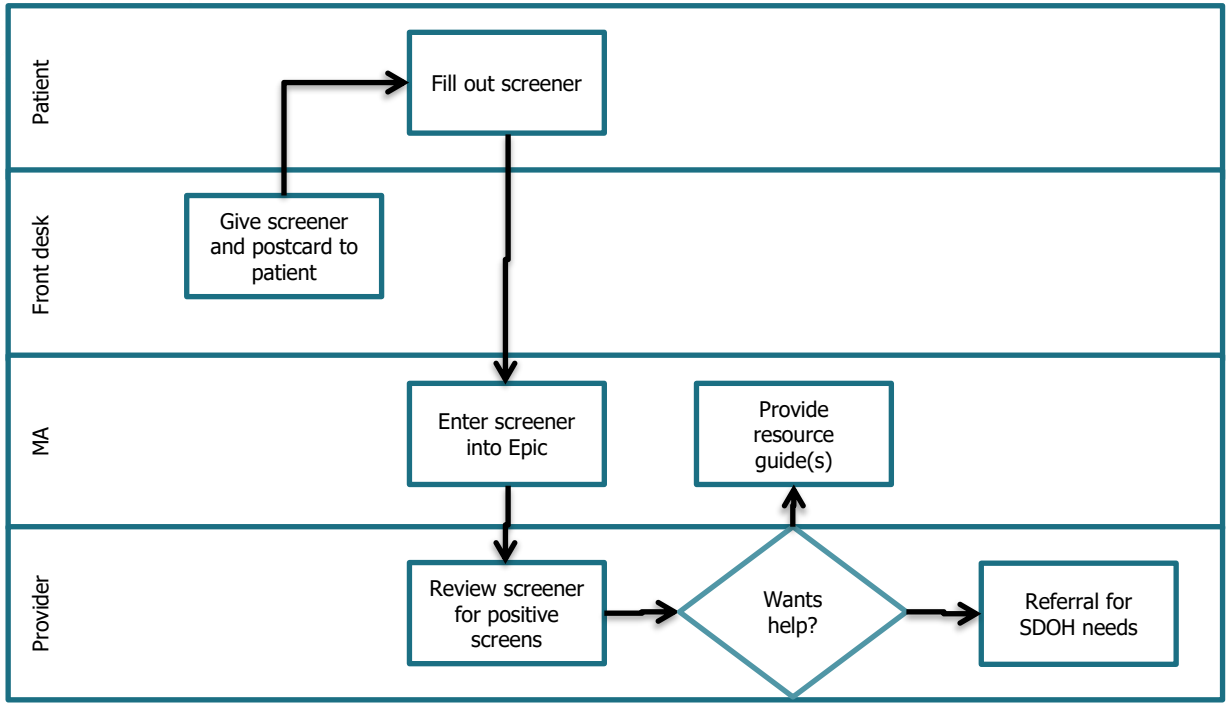
- Interdisciplinary care management team featuring Community Health Workers to address social needs
- Built public directory of community resources on *findhelp* platform
- Limited experience with and confidence in SDOH referral model

Focus on equity and sustainability

- How do we measure impact of social needs on health?
- How do we measure impact of our interventions?
- Where should we invest vs partner vs advocate?

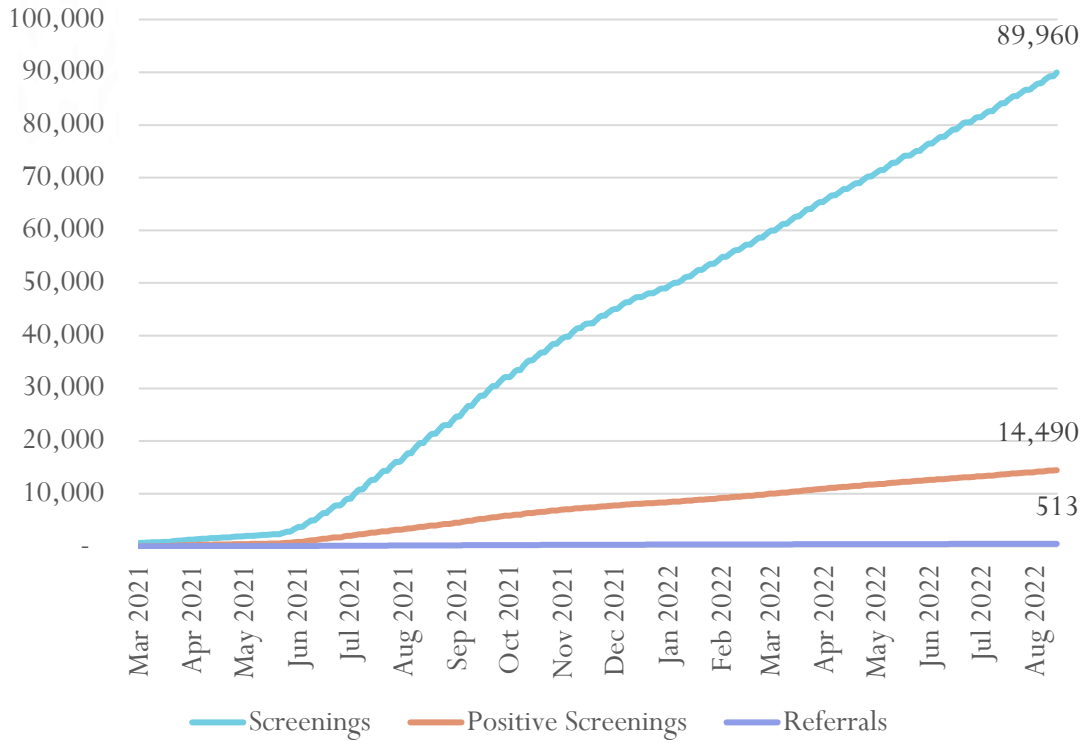
We have developed a relatively simple workflow for SDOH screening in primary care

Most patients who screen positive do not indicate that they need or want help. Less than 2 percent of screenings result in a referral to care management.

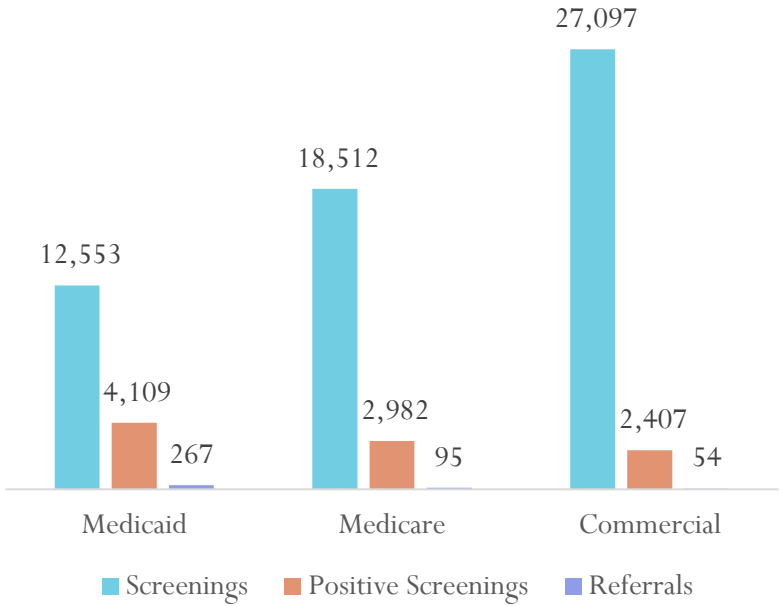


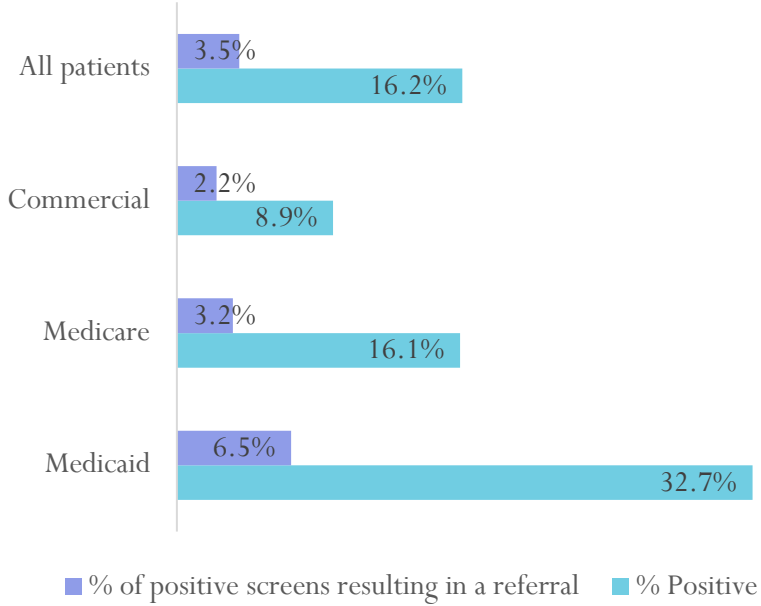
DATA FROM SDOH SCREENING

Integra implemented universal screening for SDOH in primary care in June 2021 and has completed 90,000 screenings to date

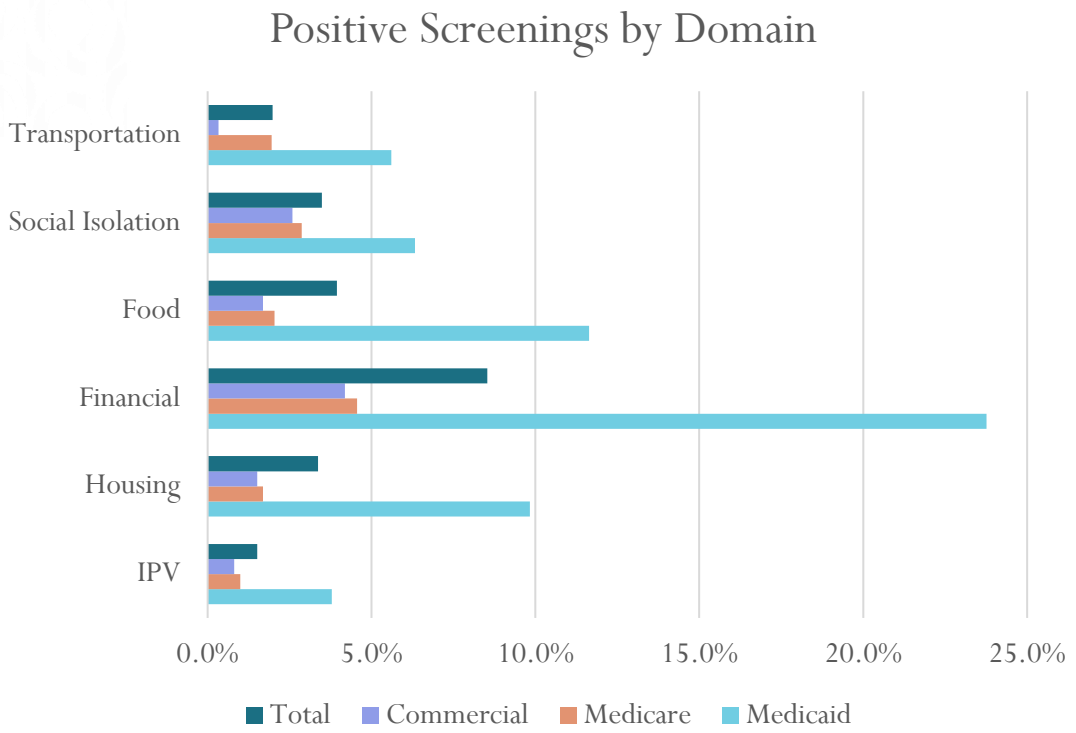


16.2% of screenings positive for at least one domain

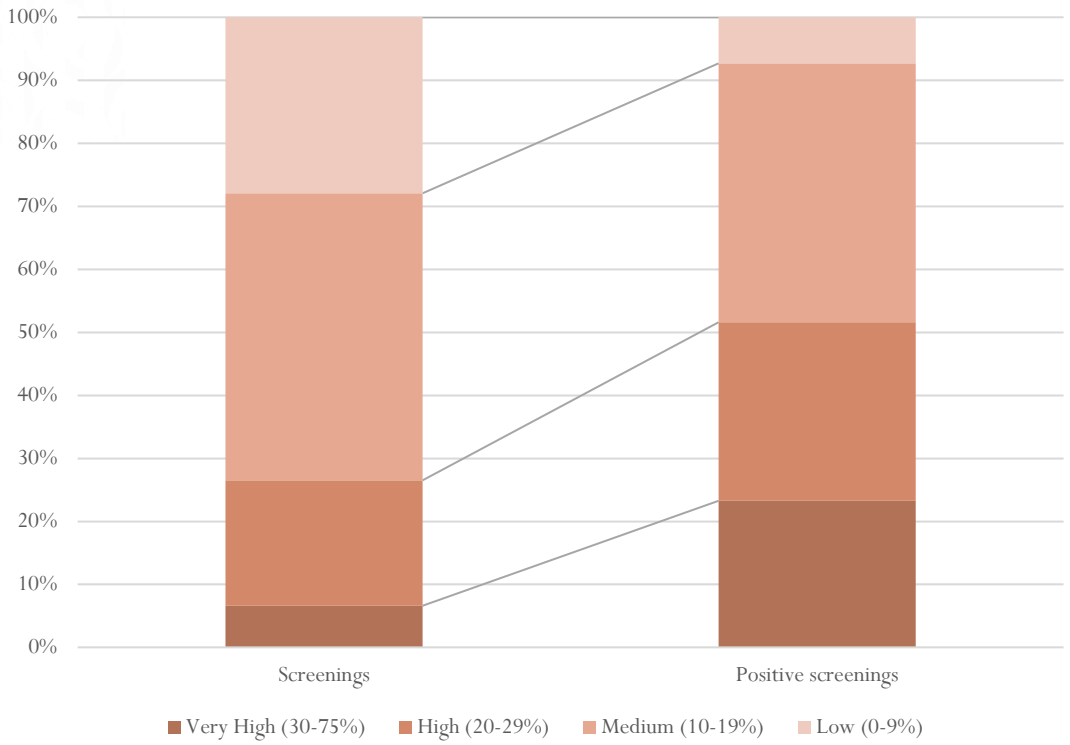




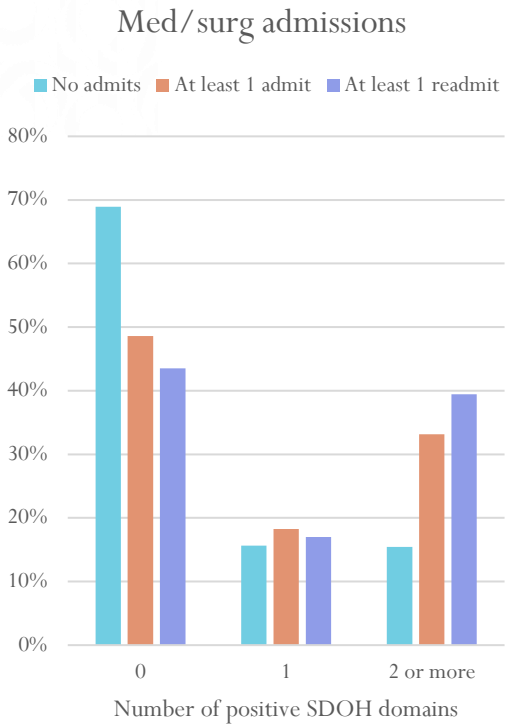
Most frequently identified needs were money, food, housing, and social isolation.

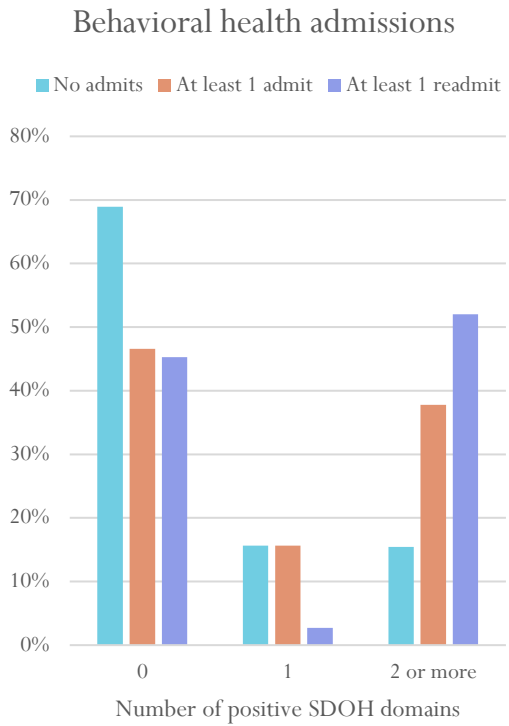


Social needs are not evenly distributed: more than 50% of all positive screenings are from 19 practices with “high” or “very high” positivity rates

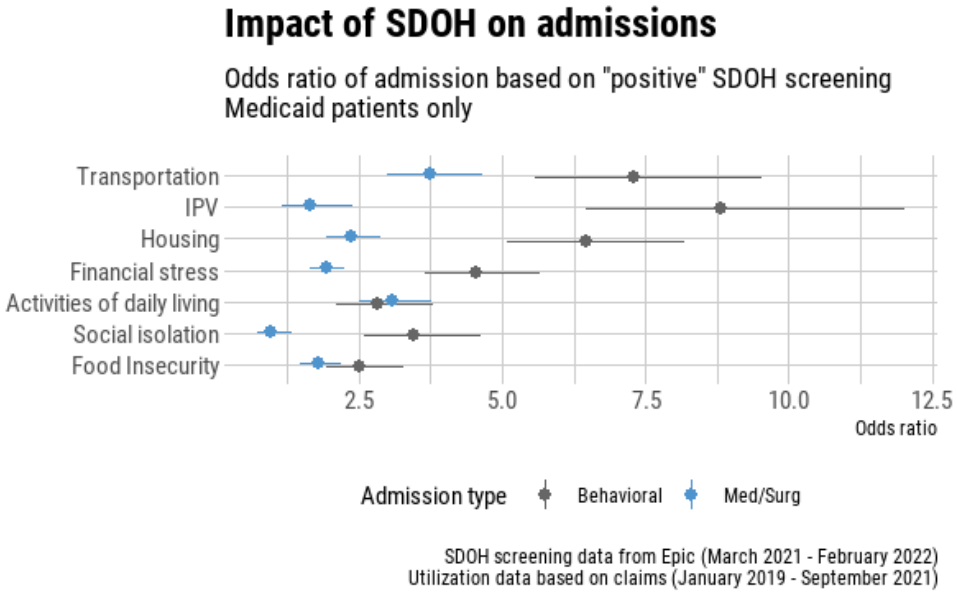


We have some evidence that SDOH needs affect admissions and readmissions





This analysis suggests that a patient with a positive screen for a transportation need is **nearly 4 times** as likely to have experienced a medical/surgical admission and **more than 7 times** as likely to have experienced a behavioral health admission.



RESPONDING TO SOCIAL NEEDS

Integra has a multimodal approach to SDOH

CHWs	CBO Partnerships	Engagement	System Change
			
Well-supported Community Health Worker workforce to build member/patient trust and respond to complex social needs	Create and sustain program partnerships that reach communities and provide specific, high-impact interventions.	Engage with patients, communities, stakeholders, staff, and providers to be effective, agile, collaborative and accountable.	Promote upstream conditions favorable to health & equity, particularly in housing, food, behavioral healthcare access, and primary care.

CHWs

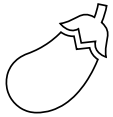
Well-supported Community Health Worker workforce to build member/patient trust and respond to complex social needs

- Integra and its affiliates directly employ 10-20 CHWs, each assigned to one or more specific practices
- CHWs are embedded in the interdisciplinary care team, supported by nurse care manager and social worker colleagues
- CHWs provide direct support to members, and represent Integra in the community

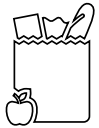
CBO Partnerships

Create and sustain program partnerships that reach communities and provide specific, high-impact interventions.

Integra has service contracts with local community organizations to provide:



Prescription produce



Emergency food supplies

Housing supports

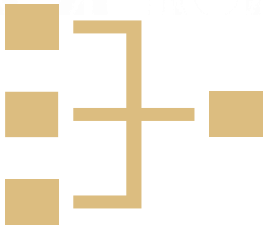
Legal supports

Engagement

Engage with patients, communities, stakeholders, staff, and providers to be effective, agile, collaborative and accountable.

- Actively trying to re-energize our Community Advisory Committee and find ways to directly engage patients and providers

System Change



Promote upstream conditions favorable to health & equity, particularly in housing, food, behavioral healthcare access, and primary care.

- Convened healthcare and homelessness working group
- Seeking ways to contribute to statewide food conversations

Questions we're currently wrestling with …

How do we sustain our CBO partnership contracts?

- When grant/infrastructure funds expire, do these initiatives have an ROI?

Do SDOH referrals to CBOs work?

- Do CBOs actually want to receive referrals this way?
- Can providers really be convinced to use an SDOH referral platform?

What kinds of social needs are health systems responsible for addressing?

- How do we support community actors while respecting their expertise?

Thank you!

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