CT Medicaid primary care redesign: What the evidence says

Part 1: Connecting with community services to improve health

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Connecticut Medicaid is considering reforms to primary care delivery and payment. The CT Health Policy Project is collecting evidence from other states and programs to help inform that planning.

A recurring theme of supporting non-medical, community services has emerged in feedback across planning groups. That feedback reflects the evidence that the social circumstances of people's lives contribute far more to their health status than medical care.

DSS has made addressing patients' social needs a main goal of reform.

- "Improve the biopsychosocial health and well-being of our members – especially for our most historically disadvantaged members and in a way that reduces inequities and racial disparities."[1]

DSS's presentations to the Primary Care Program Advisory Committee have outlined plans to connect primary care and social needs[2], including the goal that:

- Providers are expected to fully address member needs and take accountability for member outcomes by providing culturally competent and inclusive treatment, enhancing access, strengthening care coordination, integrating behavioral health care, and better identifying and addressing members' social determinant of health needs"
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DSS's strategy for achieving that goal is:

- "Primary care payment reform will build on this by giving primary care providers the flexibility and incentives to:
    - Identify members' health related social needs
    - Refer members to providers who can help address these needs
    - Assist members in arranging for and obtaining HRSN [health related social need] services"

In Connecticut and nationally ,there is a great deal of interest in connecting primary healthcare with community services to improve health outcomes. **Unfortunately, the published literature doesn't offer much guidance on how to effectively make those connections.**

[1] Primary Care Advisory Committee, 4/6/2023 meeting presentation, Slide 6
[2] Primary Care Advisory Committee, 6/1/2023 meeting presentation, Slide 4

Programs linking primary care and community services are relatively new, vary enormously, and evaluations to date have found disappointing results. Programs differ in important features including defining eligible patients, qualifications and training of case managers and navigators, the range of health and social needs included, and direct assistance vs. only referrals. There are themes in the literature and evidence about what doesn't work.

Connecticut needs to go slowly and carefully in developing a plan. Simply following other states is not likely to work. DSS must screen options, consider Connecticut's context, get stakeholder feedback, pilot, and evaluate options for linkage, learn and revise programs as necessary. **Connecticut must also devote more resources to building community service capacity; referrals to waiting lists are not helpful**. And **any savings, if they occur, must be channeled back to the community services that generated them, rather than to the medical system.**

Findings from the literature:

- Evaluations of both large and small scale programs find little or no impact on health status or community needs met
- No evaluations found any net savings, most programs were very costly
- Screening patients for community service needs and referrals is burdensome on already overwhelmed primary care practices
- Patient engagement varies widely and is often very low in these programs
- Patients and providers often don't see the value in screen and refer programs
- Evaluations of programs and modeling suggest that it will be very expensive to successfully link medical care and community services – **DSS should consider if this is the best use of those resources to achieve the goals**
- There is considerable variation in community service capacity between communities and neighborhoods that must be reflected in implementing any program
- More research is needed

Recommendations from literature:

- Pilot everything, evaluate, and revise
- Consider both provider burden and patient needs
- Provide patients with upstream, targeted, individualized interventions – such as asthma inhalers during wildfire smoke events, healthy food for people with diabetes
- Primary care alone will not be enough for most people to effectively connect to community services
- To be more efficient and effective, rely on Community Health Workers over clinical staff, use trusted messengers to engage members
- Use data on outcomes to identify subpopulations and at-risk patients to target
- Increase spending on community services – referrals to waiting lists are not helpful

Sources:

Parish, W., Beil H., He, F., D'Arcangelo, N., Romaire, M., Rojas-Smith, l., & Haber, S. G. (2023). Health Care Impacts of Resource Navigation For Health-Related Social Needs In The Accountable Health Communities Model. *Health Affairs*, 42(6), 822-831.
https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.01502
An evaluation of CMMI's Accountable Health Communities, to address social determinants of health across 32 communities, found little impact on health outcomes. The programs relied on screening high-risk patients for community service needs, referrals, and navigation assistance. Some programs included creation of community and medical care providers coalitions to advance quality improvement. There was some limited evidence of lower ED visits for Medicaid and fee-for-service Medicare members, however no statistically significant change in other health outcomes or in health spending. According to the authors, "Collectively, findings provide mixed evidence that engaging with beneficiaries who have health-related social needs can affect health care outcomes."

Renaud, J., McClellan, S.R., DePriest, K., Witgert, K., O'Connor, S., Johnson, K.A., Barolin, N., Gottlieb, L. M., De Marchis, E. H., Rojas-Smith, L., & Haber, S.G. (2023). Addressing Health-Related Social Needs Via Community Resources: Lessons from Accountable Health Communities, *Health Affairs*, 42(6): 832-840.
https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.01507
Another evaluation of CMMI's Accountable Health Communities found that connections to community services in the program were not productive. According to the authors, "Survey findings indicated that navigation—connecting eligible patients with community services—did not significantly increase the rate of community service provider connections or the rate of needs resolution, relative to a randomized control group." "When connections were made, resources often were insufficient to resolve beneficiaries' needs. For navigation to be successful, investments in additional resources to assist beneficiaries in their communities may be required."

Centers for Medicare and Medicaid Services, Center for Medicare & Medicaid Innovation, RTI International. (2023). *Accountable Health Communities (AHC) Model Evaluation, Second Evaluation Report*. https://innovation.cms.gov/data-and-reports/2023/ahc-second-eval-rpt
Independent evaluators of Accountable Health Communities (AHCs) programs found that over 77% of patients agreed to navigation, but connections were not productive. Two thirds of members were not connected to community services and their health-related social needs (HSRNs) were not resolved. "Beneficiaries experienced four key challenges to using community services: lack of transportation, ineligibility for services, long wait lists, and lack of community resources." Authors also noted that meeting members' needs required community resources beyond primary care. "Interviewed beneficiaries indicated AHC navigation was one of several strategies used to resolve HRSNs. Beneficiaries also relied on resources unrelated to the AHC Model, including family, friends, and caseworkers to address their needs." "There were no statistically significant changes in primary care provider visit rates or follow-up visits and ED use after hospital discharge for either Medicaid or FFS [fee-for-servce] Medicare beneficiaries".

Basu, S., Berkowitz, S. A., Davis, C., Drake, C., Phillips, R. L., & Landon, B. E. (2023). Estimated Costs of Intervening in Health-Related Social Needs Detected in Primary Care, *JAMA Internal Medicine,* 183(8):762-774. https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2805020
The study modeled costs to provide primary care–based screening and referral protocols, food assistance, housing programs, nonemergency medical transportation, and community-based care coordination and found they are prohibitive. Models predicted costs averaging $60 per member per month. Only $5 of that cost is for the referral and follow up system. Of the $60, only $27 is potentially federally funded.

Palakshappa, D., Scheerer, M., Semelka, C. T., & Foley K.L. (2020). Screening for Social Determinants of Health in Free and Charitable Clinics in North Carolina. *Journal of Health Care for the Poor and Underserved*, 31(1):382-397. https://pubmed.ncbi.nlm.nih.gov/32037338/
Clinics' major barrier to screening patients is not enough personnel.

Gold, R., Kaufmann, J., Cottrell, E. K., Bunce, A., Sheppler, C. R., Hoopes, M., Krancari, M., Gottlieb, L. M., Bowen, M., Bava, J., Mossman, N., Yosuf, N., & Marino, M. (2023) Implementation Support for a Social Risk Screening and Referral Process in Community Health Centers. *NEJM Catalyst Innovations in Care Delivery*, 4(4).
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10161727/
Technical assistance and coaching for clinic staff improved screening during the intervention but rates fell back to earlier levels after the intervention ended. There was no difference in referral rates either during or after the intervention.

Gottlieb, L. M., Adler, N. E., Wing, H., Velazquez, D., Keeton, V., Abigail Romero, A., Hernandez, M., Vera, A. M., Caceres, E. U., Arevalo, C., Herrera, P., Suarez, M. B., & Hessler, D. (2020). Effects of in-person assistance vs personalized written resources about social services on household social risks and child and caregiver health: A randomized trial, *JAMA Network Open*, 3(3): e200701. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2762502
The study found some evidence that in-person assistance and follow up in addition to written information was more effective than written information alone.

Trenton Health Team. (2023). *How Do Community Resource Referral Platforms Work for Social Service Organizations?* https://sirenetwork.ucsf.edu/sites/default/files/2023-03/SIREN%20HARP%20Webinar%2003-01-23.pdf
An evaluation of an online community resource directory with electronic referral functionality across the community of Trenton, NJ found that enthusiasm for the resource was much greater than eventual use. Staff rated the value of the resource as low. A communications strategy, a hub for referrals, tailored trainings, and monthly use reports had no impact on use. Staff faced several barriers to adopting the resource and using it regularly. Interestingly, staff valued the resource directory more than electronic referrals. Tools developed to meet very specific needs had higher adoption (e.g., Mercer County Food Finder, Baby Item Inventory). Staff had negative reactions to financial incentives to use the resource.

Brown D. M, Hernandez E. A., Levin, S., De Vaan, M., Kim, M., Chris Lynch, C., Roth, A., & Brewster, A. L. (2022). Effect of Social Needs Case, Management on Hospital Use Among Adult Medicaid Beneficiaries: A Randomized Study. *Annals of Internal Medicine*, 175(8):1109-1117. https://pubmed.ncbi.nlm.nih.gov/35785543/

A very useful and relevant study. 58,000 adult patients in Contra Costa County, CA at high-risk for healthcare use were either provided 12 months social needs case management or assigned to a control group. "Each patient's risk for avoidable hospitalization was predicted by a risk model that incorporated 91 variables, including demographics, health care use history, clinical diagnoses, behavioral indicators, and social risk variables." Patients in the intervention group were assigned to a case manager for holistic coordination of social and health needs including screening, development of a patient-centered care plan, and "supported patients' progress on goals through coaching, help with applications for public benefits, referrals to social services, assistance communicating with health care providers and social service agencies, and direct access to resources managed by CommunityConnect (cell phones, emergency housing funds, and legal aid)."

"In-person case managers came from various professional backgrounds, including public health nurses, housing specialists, substance abuse counselors, mental health clinicians, and social workers, and had target caseloads of 85 to 90 patients. In-person patient assignments aligned patient needs with case manager expertise. All telephonic case managers, who had target caseloads of 250 to 350 patients, were community health workers."

The evaluation found $317 per person cost savings in avoidable ED visits and hospitalizations. Unfortunately, total savings of $3.4m did not cover the program costs of $22.4m or $1,880 per patient-year. Savings only covered 17% of program costs.

In addition, only 40% of the intervention group engaged with the program. "Those who were female, were Black, had a history of recorded health problems, and had no history of detention were more likely to engage with the program."

Beidner, L., Razon, N., Lang, H., & Fraze, T.K. (2022). "More than just giving them a piece of paper": Interviews with Primary Care on Social Needs Referrals to Community-Based Organizations. *Journal of General Internal Medicine,* 37(16):4160–4167. https://pubmed.ncbi.nlm.nih.gov/35426010/

Researchers interviewed healthcare administrators responsible for social care efforts in their organization. Respondents agreed that social need referrals are an essential part of the practice. However, they need to limit the burden on care teams, ensure referrals are customized for patients, and close the loop on referrals to ensure needs are met. Challenges cited include keeping up to date referral resource lists, aligning referrals with patient needs, and measuring the effectiveness of referrals. Respondents reported inconsistent buy-in and use across staff, trouble integrating with EMRs, misalignment with other organizations, and making it a management priority for resources/time is a challenge.

Some promising case studies:

Drabo, E. F., Eckel, G., Ross, S. L., Brozic, M., Carlton, C. G., Warren, T. Y., Kleb, G., Laird, A., Porter, K. M. P., & Craig, C. E. A. (2021). Social-Return-On-Investment Analysis Of Bon Secours Hospital's 'Housing For Health' Affordable Housing Program. *Health Affairs*, 40(3): 513-520. https://pubmed.ncbi.nlm.nih.gov/33646873/
A hospital-developed affordable housing program saved money with a return on investment of $1.30 to $1.92 for each dollar invested.

Seligman, H., Lyles, C. L., Marshall, M. B., Prendergast K., Smith, M. C., Headings A., Bradshaw, G., Rosenmoss, R., & Waxman, E. (2015). A Pilot Food Bank Intervention Featuring Diabetes-Appropriate Food Improved Glycemic Control Among Clients in Three States, *Health Affairs*, 34(11):1956-1963. https://pubmed.ncbi.nlm.nih.gov/26526255/
Providing healthy food to people with diabetes through food banks lowered HbA1c levels, increased fruit and vegetable consumption, medication adherence, and self-efficacy. The program also provided blood sugar monitoring, referrals to primary care, and self-management support.