CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Accountable Health Communities

Screening, Referral, and Community Alignment to Address HRSNs: Early Lessons from the Accountable Health Communities Model

INTRODUCTION TO THE ACCOUNTABLE HEALTH COMMUNITIES MODEL

The Accountable Health Communities (AHC) Model (2017–2023) aimed to systematically identify and address the health-related social needs (HRSNs) of Medicare and Medicaid beneficiaries through screening, referral, and community navigation services. AHC awardees could participate in either the Assistance Track or Alignment track and awardees included: hospitals, health systems, or health care organizations (19); community-based or social service organizations (2); health plans; university or research organizations (2); health information exchanges (2); and a local health department (1). This resource highlights strategies and lessons learned from awardees' implementation of the AHC Model and findings from an early analysis of the model to provide insight and guidance to other organizations seeking to address HRSNs.[1]

Figure 1. A snapshot of lessons learned from AHC

[1] This work was not intended to be an evaluation of the AHC Model. It aimed to draw insights to inform the design and implementation of similar initiatives and improve efforts to address HRSNs by exploring factors that support or present challenges to navigation. In implementing the AHC Model, CMS also sought to test whether systematically identifying and addressing certain HRSNs would affect health care costs, service utilization, and health outcomes (Center for Medicare & Medicaid Innovation 2022). A separate and ongoing formal evaluation will determine whether AHC Model services affected these outcomes.

LESSONS LEARNED

SCREENING FOR HRSNs

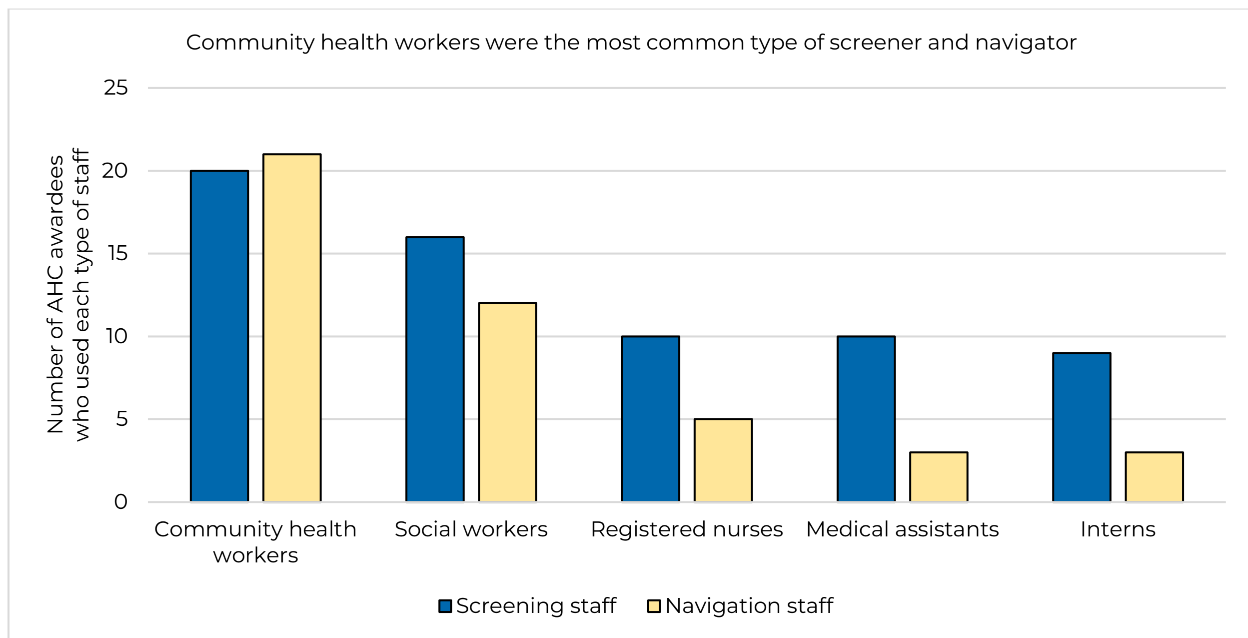
All awardees used the AHC HRSN Screening Tool developed by the Centers for Medicare & Medicaid Services (CMS) to screen eligible patients for five core HRSNs: food insecurity, housing instability, transportation needs, utility needs, and interpersonal violence (safety). See strategies and tips for using the tool in the accompanying guide. Awardees found that staff buy-in, capacity, and flexibility to customize screening workflows were key to effectively integrate HRSN screening in clinical settings.

- **Cultivating staff buy-in.** Awardees emphasized the effect of HRSNs on patients' health when speaking to staff about the importance of screening. They also identified staff within their organizations, for example a clinical or executive leader, to act as AHC champions who helped spread the message internally. This in turn helped foster an organization-wide commitment to person-centered care that acknowledged the role of non-medical service coordination and reinforced the importance of identifying and addressing HRSNs. Engaging staff in developing and tailoring screening workflows to their sites' context further helped buy-in and implementation as workflows were tailored to staff needs.
- **Integrating screening into existing workflows.** Many awardees integrated screening into existing intake or discharge workflows. For example, awardees included HRSN screening questions with the paperwork that patients filled out in the waiting room or during discharge, or they asked HRSN screening questions while collecting insurance information. The model allowed awardees to screen patients via a variety of screening modalities (e.g., paper, laptop/tablet, phone, text), and this flexibility made it easier for awardees to set up workflows and helped them reach patients. For example, many awardees screened patients online or over the phone during the COVID-19 pandemic.
- **Managing staff capacity.** Recognizing often limited clinical staff capacity and competing priorities, awardees used dedicated or cross-trained staff, most commonly community health workers (CHWs), to increase clinical sites' capacity to screen patients. In fact, community health workers were the most common type of screener and navigator (see Figure 2). In some cases, awardees found that hiring dedicated screening staff increased clinical site participation by reducing burnout among existing staff. Awardees noted that patients were more willing to engage in screening when staff reflected the demographics of the patient population, a consideration when hiring new screening staff.
- **Investing in screening staff.** Awardees tailored their staffing models to fit the needs of different clinical sites and provided training and support, such as peer learning opportunities, screening scripts, and training on trauma-informed and motivational interviewing techniques. For example, some awardees used Plan-Do-Study-Act cycles to refine scripted introductions to screening or text messages and found that using welcoming language and customizing the wording for specific sub-populations, such as elderly patients, fostered trust and increased patients' participation in screening.

Preparing for implementation: Lessons from AHC Awardees

- Engage community-based organizations and clinical partners early to begin establishing relationships and involve partners in planning to build trust.
- Allow ample time to re-configure existing data systems or set up new ones to track screening, referral, and navigation cases. Create strategies to ensure data quality.
- Consider needs for additional staff or outside vendors, for example, for a closed-loop referral system or additional IT staff for data system support.
- Plan for sustainability from the outset, for example, by planning early how to track measures of success such as cost savings, reduced emergency department use, or resolved HRSNs among patients.

Figure 2. Types of screening and navigation staff in the AHC Model, by number of awardees



Note: Awardees partnered with multiple clinical sites who sometimes employed different staff and awardees' staffing models changed over the course of the model. Therefore, the total number of awardees represented here is greater than 28.

REFERRAL AND NAVIGATION

Referrals to community-based resources and navigation to assist patients with accessing resources both sought to address patients' pervasive and complex HRSNs. However, resolving patients' HRSNs was difficult. Early analysis of preliminary AHC Model program data showed that as the total number of needs increased across all HRSN types, the likelihood that all case needs were resolved decreased. Furthermore, compared with other HRSN types, the likelihood of a case having all or one of its needs resolved was consistently lower for each additional housing or safety need.[2]

- **Engaging patients.** To address challenges around patient engagement, awardees identified strategies to help build patient trust to help patients feel more comfortable working with AHC staff who were assisting with navigation. Awardees developed empathetic scripts and set up warm handoffs between staff to engage patients and help them feel at ease working with awardee staff. Using hybrid staff that act as both screeners and navigators created consistency for patients, improved patient follow up and increased patient trust. By training staff to use trauma-informed and motivational interviewing techniques when interacting with patients, awardees found patients were more likely to follow through to receive services. Additionally, cases where navigators spent as little as 15 more minutes with patients were more likely to have all HRSNs addressed. On average, navigators spent 36 minutes with patients. However, the optimal amount of time to spend with patients remains unclear.[3]
- **Managing staff turnover and caseloads.** Managing staff turnover and navigation staff caseloads was challenging for awardees, in part because of how many people accepted navigation services and due to the complexity of patients' HRSNs. Awardees hired additional staff and provided professional and personal supports to navigators such as mental health benefits and opportunities for peer learning to combat turnover. Awardees also used data to align navigation caseloads with staff capacity. For example, one awardee identified overburdened navigators by

[2] Navigation staff kept a record (also called a case) for each patient to document the HRSNs identified, the navigation services provided, and the outcomes of navigation services (such as whether beneficiaries' needs were resolved, left unresolved, or otherwise).

[3] Note: Time spent with a navigator could include conducting a personal interview and action plan and time spent on follow-up and other activities.

reviewing weekly reports from their appointment technology platform and adjusted caseloads as needed. Individual navigators used spreadsheets or downloaded lists of upcoming appointments to stay organized and manage their work. Additionally, CMS provided group and one-on-one technical assistance around screening and navigation to awardees to help them cultivate strategies to improve workflows and staff training.

  - Early analysis of the AHC Model also showed that navigation staff type impacted needs resolution, finding that employing CHWs to support navigation was a promising strategy for improving needs resolutions. Cases where patients had at least one navigation contact with a CHW (42.5% of cases) resolved a higher proportion of HRSNs associated with their case than patients who received navigation without CHW contact.

- **Tracking referrals and managing community resources.** Awardees used a list of community resources to determine where to refer patients for assistance. Frequent shifts in resource availability made it challenging to keep these lists up to date, particularly during the COVID-19 pandemic. Awardees found effective strategies for keeping the inventories current were to have a dedicated staff person update the list by regularly calling, checking community-based organizations' websites and social media, and to partner with local 2-1-1 directories. Some awardees found that using a closed-loop referral platform, that health systems and community-based organizations participated in, helped navigators determine if patients had received the assistance they needed.
- **Collaborating with Community-based Organizations (CBOs) on referral processes.** CBOs often had limited staff and technical capacity, which sometimes discouraged CBOs from participating in referral systems as they are often asked to participate in multiple referral systems that don't align or interface well with existing case management or reporting systems. Partnering with CBOs in a collaborative planning process to design referral processes and select and secure funding for a data-sharing system could help gain CBO trust, buy-in, and increase the likelihood of CBO participation.

COMMUNITY ALIGNMENT

Awardees encountered challenges in creating and fostering partnerships with community-based organizations and found it difficult to resolve patients' needs once identified. However, over the course of the model, awardees were able to identify strategies to better engage community members and align community resources in supporting HRSN resolution. To increase capacity to address HRSNs, partners must align across sectors and meaningfully engage community members, because health systems do not have the expertise or resources to resolve HRSNs alone.

- **Building multisector partnerships.** Alignment track awardees were required to establish multisector advisory boards to help ensure that community services were available and responsive to patients' needs. Awardees cited several strategies as critical to building and maintaining advisory boards, including investing time to build relationships and establish infrastructure, sharing data at advisory board meetings to help focus and motivate members to work together, and fostering consensus around common goals. For example, one awardee created a food insecurity order in their electronic health record so that providers could prescribe food to patients, and

Health equity in the AHC Model

- Early analysis of preliminary AHC Model program data revealed that cases for American Indian/Alaska Native patients were significantly less likely to have HRSNs resolved than cases for non-Hispanic White patients. Furthermore, cases for male patients were significantly less likely to have needs resolved than cases for female patients.
- AHC awardees completed annual Disparities Impact Statements that described health disparities in their communities. A 2022 article found awardees focused on serving multiple minority and underserved populations and used a variety of innovative strategies to improve health equity through the model. Read the full article to learn more.
- AHC awardees used AHC data to identify disparities and illuminate health inequities in their communities. In turn, AHC data drove discussion and decision making about the allocation of community resources. Learn more about health equity strategies from the AHC Model here.

simultaneously worked with their community partners to expand access to produce so that those orders could be fulfilled.

- **Engaging community members.** Some awardees found success cultivating shared input and participation between community members and representatives from various organizations with respect for differences in communication styles and power dynamics. One awardee that successfully engaged community members in AHC work used strategies such as the following:
  - Structuring meetings to encourage interaction between community members and other organizations
  - Offering professional development opportunities
  - Providing free transportation, childcare, and food for in-person meetings
  - Compensating and preparing community members for participation

  Another awardee recruited people to serve as community advisors by reaching out to people who received navigation services, distributing flyers in places that program recipients frequented such as transit stations and community centers, and recruiting through cultural and faith-based community organizations.

BEYOND THE AHC MODEL

CMS and AHC awardees continue to build on the model's infrastructure to address HRSNs.

- **Sustaining AHC activities.** Most awardees expanded HRSN screening, referral, and navigation to more patients than those eligible under the model, which was limited to Medicaid and Medicare beneficiaries. Since AHC Model funding was not indefinite, awardees needed to create new partnerships and find new funding sources to expand the scope of their work beyond AHC. For example, some awardees worked with payers to establish value-based care models to support their work while others used internal funding to continue their screening, referral, and navigation work.
- **Aligning with Medicaid.** Some awardees are partnering or aligning with state Medicaid agency priorities and coverage mechanisms to continue and expand efforts to identify and address HRSNs. State Medicaid agencies can benefit from awardees' experience enhancing data exchange and collection across sectors and partners; engaging and incentivizing health systems and providers in HRSN screening and community service navigation; identifying gaps and building capacity in community resources; providing effective, community-based, and culturally concordant care; and advancing health equity by engaging patients and communities.
- **CMS' strategies for integrating AHC lessons into other models and programs.** Lessons learned from the AHC Model continue to inform requirements, options, and incentives for HRSN screening and referral in other CMS models and programs. For example, the AHC Model experience informed requirements to identify, measure, and address health disparities in the ACO Realizing Equity, Access, and Community Health (REACH) Model and contributed to the development of two quality measures related to HRSN screening that CMS added to the Hospital Inpatient Quality Reporting Program in 2022. Additionally, the AHC Screening Tool has become one of the most widely used HRSN screening tools and CMS secured Logical Observation Identifiers Names and Codes (LOINC) panel and question codes for the tool to improve interoperable data sharing.

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