

MINNESOTA MEDICAL GROUPS' COLLECTION AND USE OF DATA ON HEALTH-RELATED SOCIAL RISK FACTORS



OVERVIEW

Improving health equity is a priority for many health care organizations, both in Minnesota and nationally. The COVID-19 pandemic and the social unrest surrounding the death of George Floyd in 2020 drew renewed attention to wide disparities in health outcomes and the need for health care organizations to help identify and address “upstream” factors such as food insecurity and housing that affect health outcomes.

To varying degrees, health care provider organizations already collect data from patients to identify and address health-related social needs. To better understand the current landscape of these activities in Minnesota, in the fall of 2021 MNCM surveyed medical groups about how they collect this type of information from patients and how they use it.

The results of this survey provide information about where there are similarities and differences across medical groups regarding data on health-related social needs and risk factors. The survey results will serve as the foundation for discussions about where there may be opportunities to align data collection practices for health-related social needs and risk factors to improve health outcomes and reduce health disparities.

SURVEY TOPICS

Topics covered by the survey included the following:



Who is screening patients for health-related social needs?



For those not doing any screening for health-related social needs, what are barriers to screening?



Which patients are being screened?



How and when are patients being screened? (e.g., visit type, frequency)



What risk factors are patients being screened for?



Are standardized survey tools being used for gathering data, and if so, which ones?



How are data being used? Is data being shared across entities (e.g., with other health care providers or with social service organizations)?



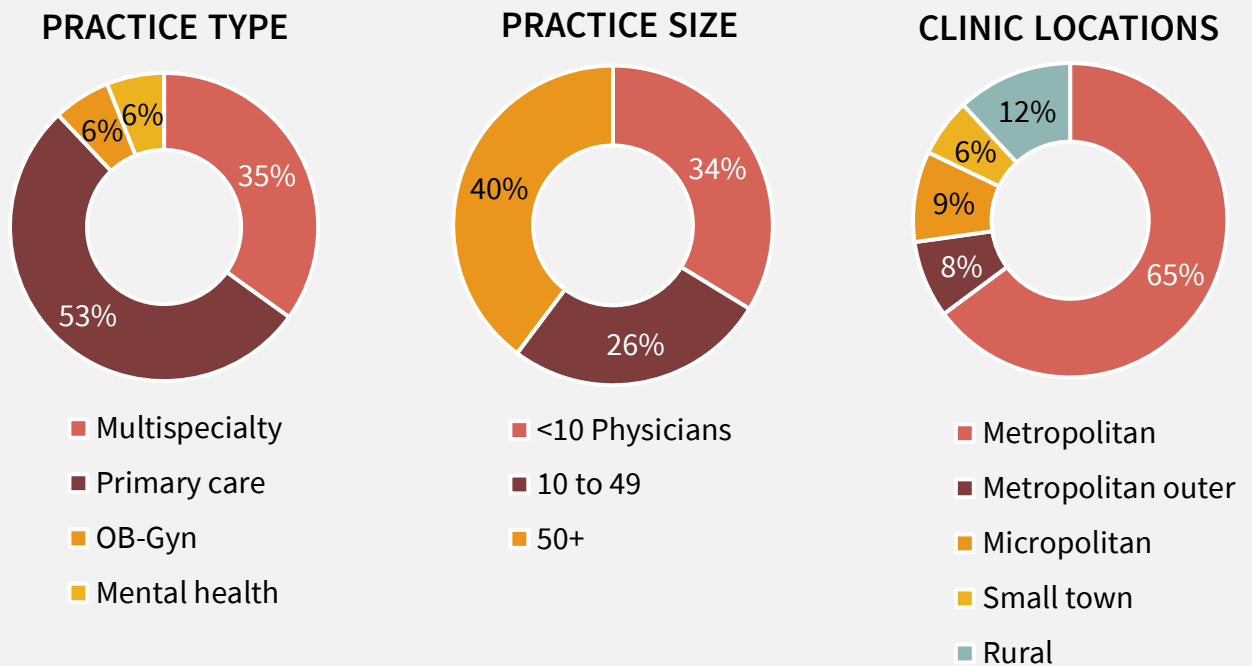
How are data being captured and stored?



Survey responses are broadly representative of Minnesota's health care landscape

MNCM invited all medical groups in Minnesota that register as part of the Minnesota Department of Health's Statewide Quality Reporting and Measurement System to participate in the survey. As expected, the most robust response was among medical groups that submit data for MNMCM clinical quality measures. The analysis in this issue brief includes responses from medical groups whose practices include primary care, multispecialty, OB/GYN, and mental health. Figure 1 below shows the distribution of responses by practice type, practice size, and geographic locations of their clinic sites. In total, the data in this analysis represents 83 medical groups with 933 clinic locations; these medical groups represent a combined 79 percent of the clinical quality data collected by MNMCM on an annual basis.

FIGURE 1: Who responded to the survey?

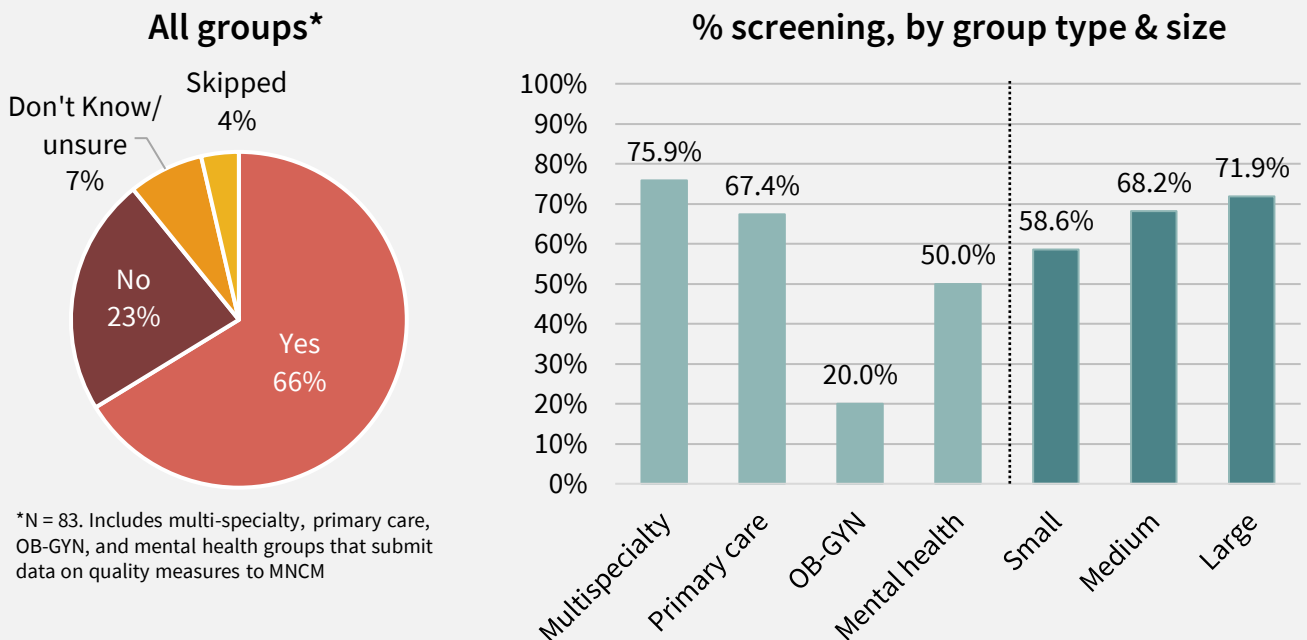


Screening for health-related social risk factors is common; competing priorities and lack of resources are the most common barriers

Two-thirds (66 percent) of the responding medical groups indicated that they routinely screen at least some of their patients for health-related social needs such as food, housing, and transportation. Multispecialty and primary care groups were most likely to report screening (76 percent and 67 percent, respectively). Groups with more than 50 physicians were most likely to report screening for social risk factors (72 percent), but more than half of even the smallest groups reporting doing so (59 percent of groups with fewer than 10 physicians). These results are illustrated in Figure 2.

For groups reporting that they do not routinely screen patients for health-related social needs, the survey asked about the main reasons for not screening. Among the 19 groups that did not screen patients routinely, the most common responses were related to other priorities being more important, barriers related to technology, time, and/or staff resources, and concern about ability to address patients' needs identified by screening.

FIGURE 2: Who is screening for health-related social risk factors?

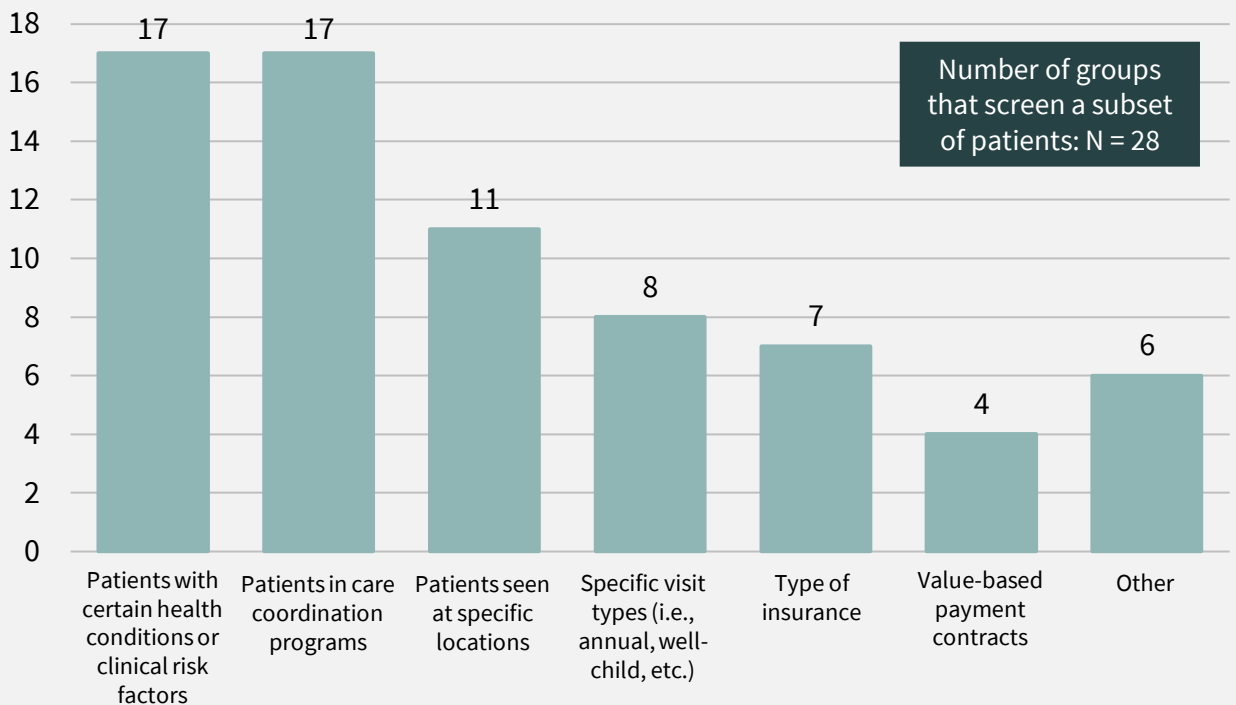


*N = 83. Includes multi-specialty, primary care, OB-GYN, and mental health groups that submit data on quality measures to MNCM

Patient characteristics and visit type are common criteria that determine who is screened

About 42 percent of survey respondents indicated that they screen all patients for health-related social risk factors, but half (51 percent) indicated that they screen a subset of patients. Among those that reported screening a subset of patients, the most common criteria used to determine who is screened included patients with specific health conditions or clinical risk factors, patients in care coordination programs, and patients seen at specific locations; several medical groups noted that screening occurs during specific visit types such as annual physicals and well-child visits (see Figure 3).

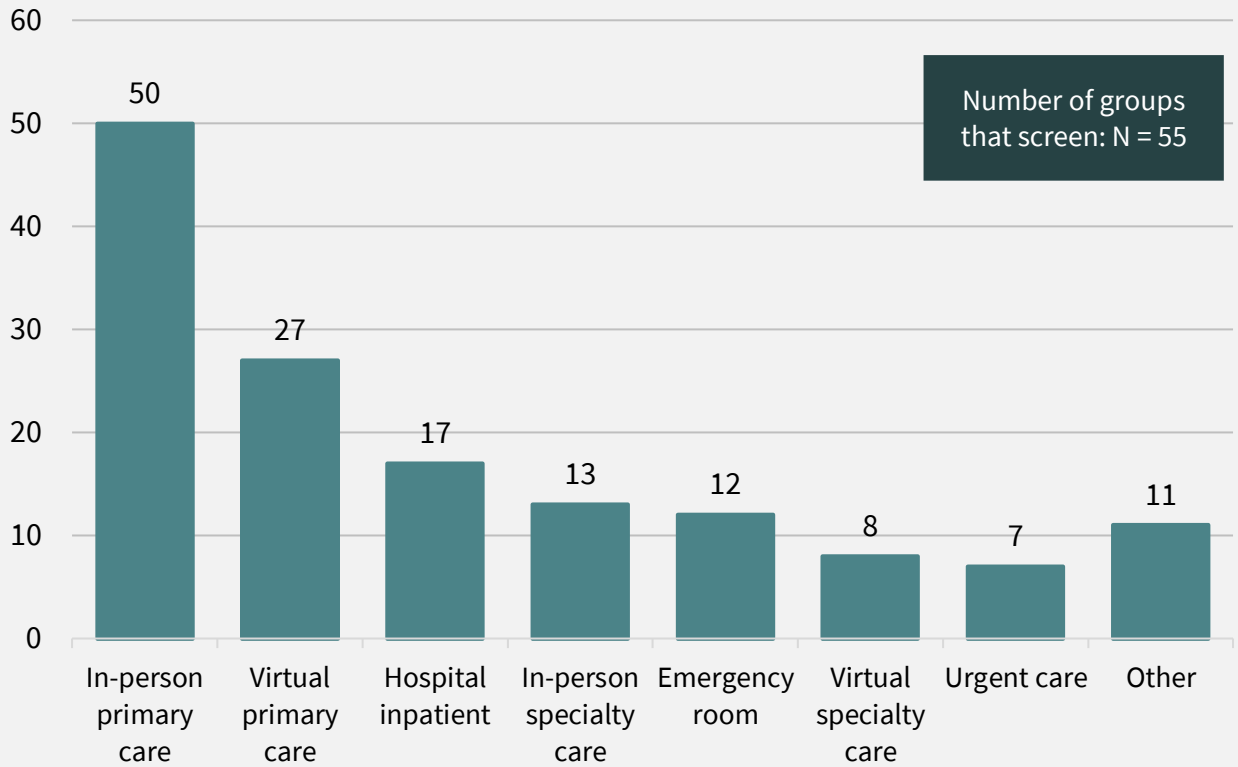
FIGURE 3: Criteria determining for which patients are screened (if not full population)



Screening also varied by type and setting of health care encounters. As shown in Figure 4, survey respondents were most likely to report that screening happens at in-person primary care visits, followed by virtual primary care visits. Survey respondents were less likely to report routine screening during specialty care visits and in hospital and urgent care settings, though it is important to note that not all survey respondents provided these types of care.



FIGURE 4: Types of encounters at which patients are screened



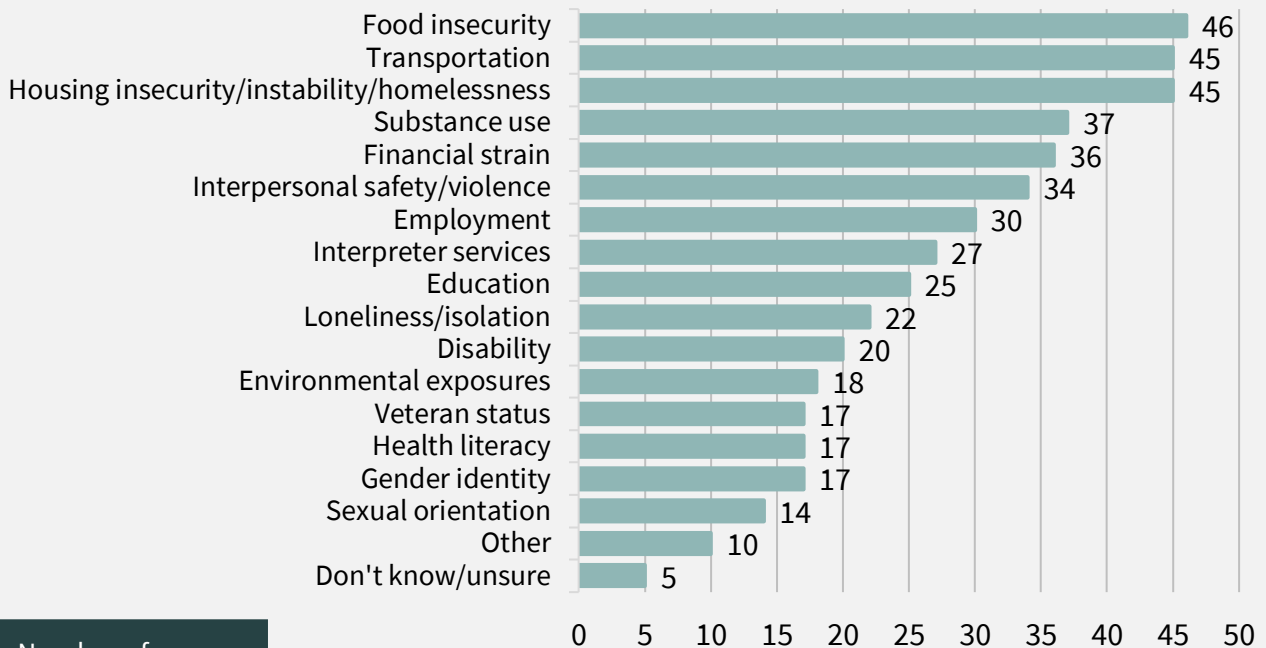
Providers are screening for a broad range of health-related social risks

Among groups that routinely screen for health-related social risks, a wide range of risk factors are encompassed in current screening. Food insecurity, transportation, and housing issues topped the list, followed by substance use, financial strain, interpersonal safety, and other factors (see Figure 5). When asked to indicate up to three topics that their medical group has prioritized to help support patients, food insecurity, housing, and transportation topped the list, followed by substance use, need for interpreter services, financial strain, and other factors (Figure 6).



Most medical groups reported using standardized survey tools, or a combination of standardized and customized or “homegrown” tools, for screening. However, many respondents reported being unsure of exactly which standardized tools are being used, sometimes indicating that they use tools that are built into their electronic health record systems but that they don’t know which survey questionnaire is built in to the EHR. Among specific standardized tools that respondents reported using, the PRAPARE tool from the National Association of Community Health Centers¹ was cited most, followed by the Accountable Health Communities Health-Related Social Needs Screening Tool.²

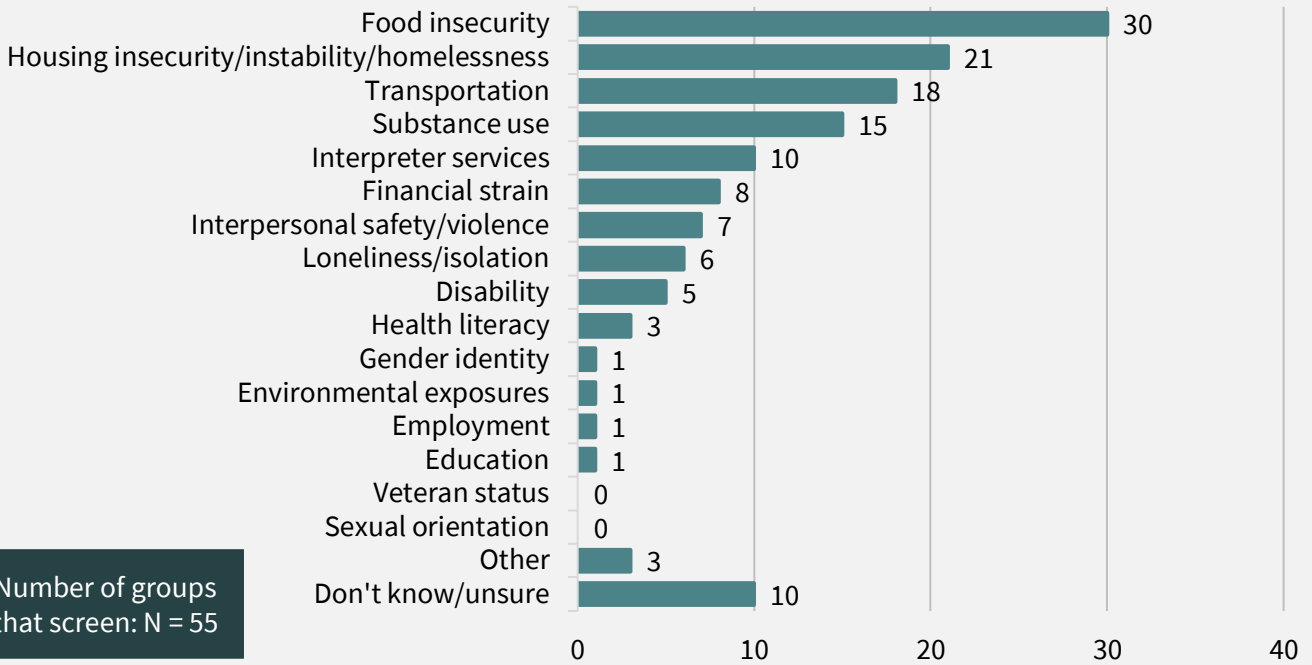
FIGURE 5: Which health-related social risk factors are captured?



Number of groups that screen: N = 55

1 <https://www.nachc.org/research-and-data/prapare/>
 2 <https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf>

FIGURE 6: Which health-related social risk factors are medical groups prioritizing to help support patients?



Number of groups that screen: N = 55

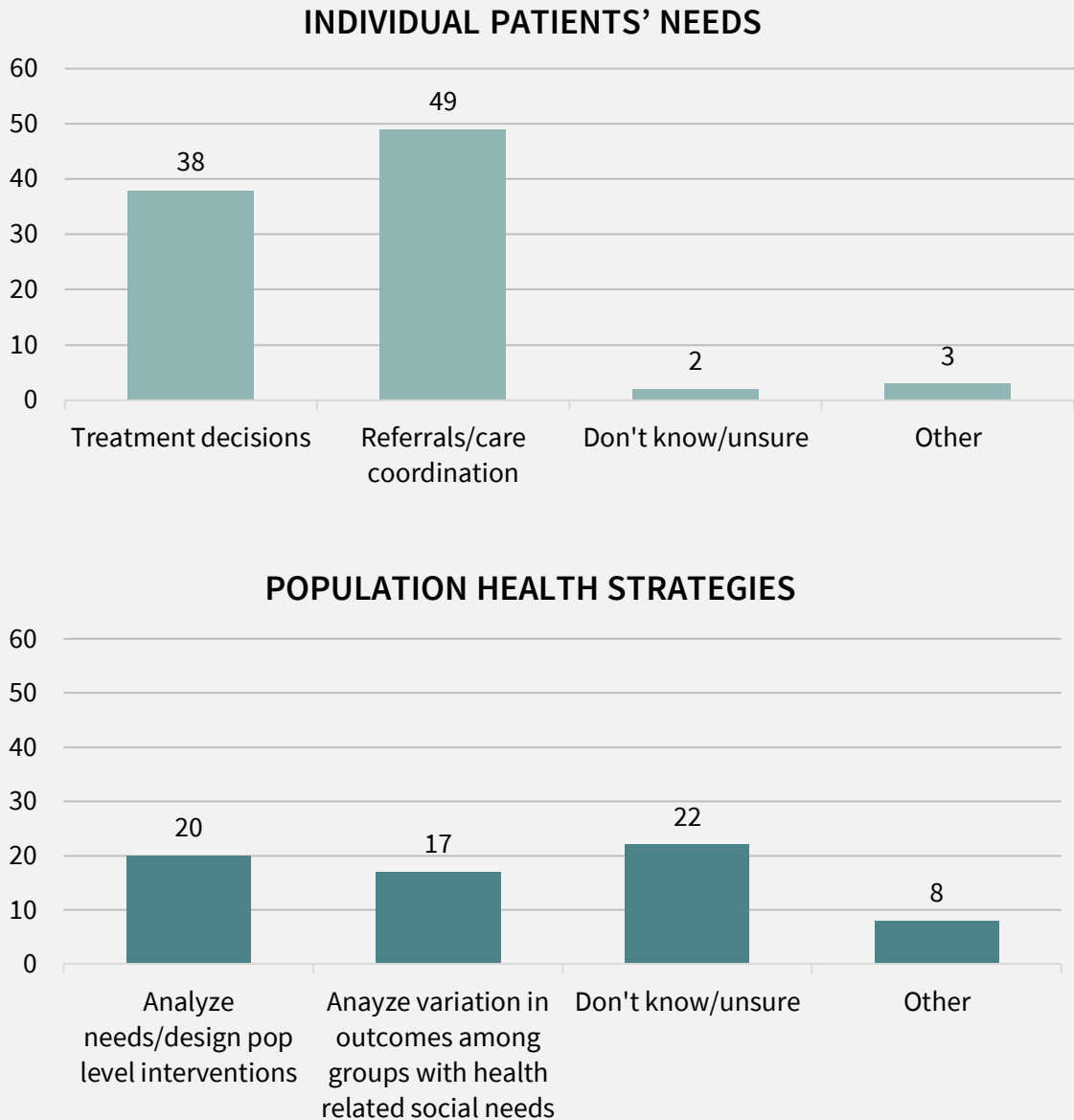
Data are used to address both individual and population health needs, but sharing across organizations is limited

Among medical groups that routinely screen patients for health-related social risks, the most common use of this information is to inform treatment decisions and referrals or care coordination for individual patients. However, a substantial share of respondents also reported using patient-reported data on health-related social risks to support population health strategies, such as designing population-level interventions or analyzing variation in outcomes within their patient populations (see Figure 7).

Although screening is fairly common, it appears to be much less common that these data are being shared between health care organizations or between health care providers and payers, though some medical groups did report sending/receiving data with other health care providers and with payers. It was somewhat more common for providers to report sending data to nonmedical providers like social service agencies, but less than half of the medical groups that reported screening patients for social risks indicated that they send data to these organizations.



FIGURE 7: How are data used by medical groups to address health-related social needs?



Data are typically collected by clinical staff or community health workers/care coordinators, and stored in structured fields in the electronic health record

Understanding how data are collected and stored by medical groups that screen patients for health-related social risk factors is important to inform potential future efforts to standardize and aggregate data. Among medical groups that reported screening for social risk factors, most indicated that clinical staff are responsible for collecting data, with a substantial share also indicating that community health workers or care coordinators collect this information.

Most commonly, questions are asked verbally and answers are entered into the EHR by clinical staff or CHW/care coordinators; several medical groups also reported having patients fill out paper questionnaires that are later entered into the EHR by staff, and several reported that patients complete surveys electronically with responses stored in the EHR.

Most but not all survey respondents that screen for health-related social risks indicated that they store these data in structured fields in their electronic health record, which makes it easier to query, extract, and analyze for follow-up.

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