Humana
Healthy Horizons
in Florida

COMMUNITY ENGAGEMENT PROGRAM

2021 Social Needs Gap Closure Pilot Evaluation

Humana Healthy Horizons® in Florida wants to help our members reach their best health, working within states and communities to address the unique dynamics that contribute to the health of our members. *We focus on their whole health so that they can focus on their future.* Our Community Engagement team provides a personalized approach to removing barriers to health by connecting our members to needed resources.

PROGRAM OVERVIEW

As part of a quality improvement initiative, a representative sample (n=80,000) of Humana Healthy Horizons (HHH) members in Florida were contacted via Interactive Voice Response (IVR) to survey members on their health-related quality of life and to offer **those who reported a high number of unhealthy days** (defined as 15 or more physically and/or mentally unhealthy days in the previous 30) a call back from a HHH associate.[1]

During the call, a Community Engagement associate screened the member for mental health and health-related social needs (HRSNs), created a personalized plan for resolving any identified needs through referrals to plan benefits and community resources, and answered questions about accessing health and well-being benefits. The HHH associate documented any gaps and referrals and also made follow-up outreaches to the member to ensure needs were met. If the referral did not close the member's social or mental health "gap in care," additional referrals and follow-up attempts were made.

PARTICIPANT POPULATION

1,035 members completed the initial IVR survey (1.3%)

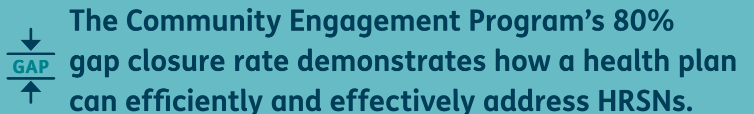
502 eligible for intervention (49%)

401 members with documented gaps closure (80%)

KEY TAKEAWAYS

In the Florida Medicaid population, HRSNs are highly prevalent and frequently co-exist. Of intervention-eligible beneficiaries:

- 86% experienced more than one need
- 69% reported three or more needs



The Community Engagement Program's 80% gap closure rate demonstrates how a health plan can efficiently and effectively address HRSNs.

The insights from this quality improvement initiative will inform HRSN Strategic Plans, Models of Care and Operating Models.

[1] https://www.cdc.gov/hrqol/methods.htm

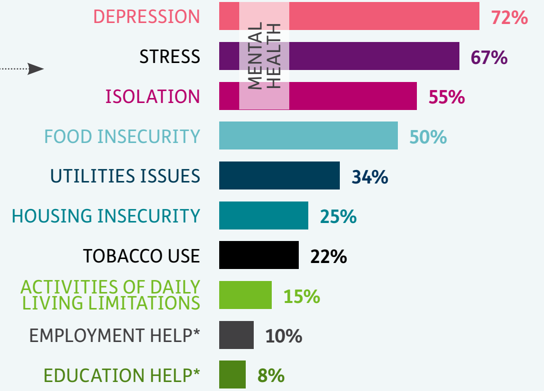
FINDINGS

Mental Health Gaps Most Frequently Reported.

Members were screened for HRSNs and mental health issues using a modified version of the Accountable Health Communities Health-Related Social Needs Screening Tool.[2]

Issues related to mental health were the most frequently reported among the intervention-eligible population while needs among employment and education were the least frequently reported.

Frequency of Social Needs (N=502)



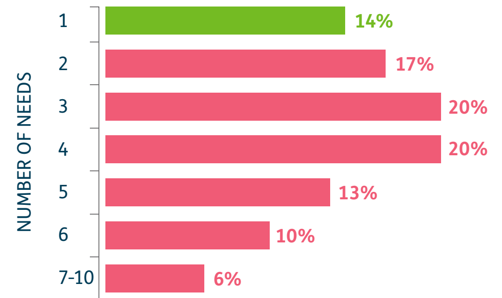
*n < 50

[2] https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf

Intervention-Eligible Members Often Had Multiple Gaps.

86% of intervention-eligible members reported more than one HRSN. 40% reported 3 or 4 needs. As a result, many members in the intervention received more than one referral to plan benefits and/or community resources.

Total Number of HRSNs Per Member (N=502)

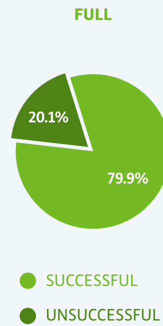


We were successfully able to close gaps for 4 out of 5 members.

A gap was determined to be “closed” when the member reported that the referral was successful and met their need. In most cases, an unsuccessful gap closure was due to loss of contact with the member.

HRSN Resolution Among Intervention-Eligible Members with Identified Gaps (N=502)

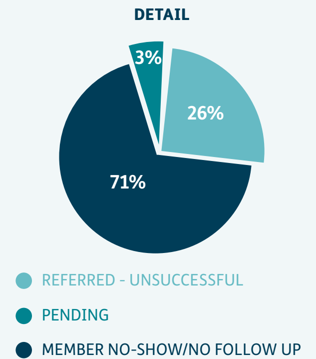
FULL



SUCCESSFUL
UNSUCCESSFUL

Reasons of Unsuccessful Gap Closure (N=101)

DETAIL



REFERRED - UNSUCCESSFUL
PENDING
MEMBER NO-SHOW/NO FOLLOW UP

Gaps related to mental health and isolation had the highest closure rates (≥84%).

In most cases, these needs resulted in a referral to a plan benefit or service.

Gaps that required referral to a community resource generally had the lowest closure rate and often required multiple referral attempts to close.

HRSN Gap Closure Among Intervention-Eligible Members (N=502)