



American Board of Family Medicine, Inc.

Quality Healthcare, Public Trust . . . Setting the Standards in Family Medicine

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The ABFM is pleased to respond to the Request For Information with the general question: *How are providers and health plans serving Medicare beneficiaries working to improve health outcomes for beneficiaries, especially those with social risk factors?*

Below we address your specific questions with references where available. We would be pleased to provide additional information, a demonstration of the mentioned tools, or to discuss.

- Are social risk data being used to target services or provide outreach? If so, how? How are beneficiaries with social risk factors identified?

[We are using the Social Deprivation Index at the census tract level to identify patients from neighborhoods with increased risk.](#)

- Are there especially promising strategies for improving care for patients with social risk?

[Hennepin Health System has several modalities for helping patients with social risk. Their ambulatory ICU provides a robust team of clinicians, social workers, nurses, community care workers, and substance use counselors to a small panel of patients with the highest social risks. They use clinical resources to assure housing stability, family counseling when a loved-one is released from prison, social prescriptions for food banks and farmers markets.¹ Wellmed, a Medicare Advantage plan in Texas filled medications for people who could not afford them, transported patients who had no vehicle, offered health coaches to patients with clinical and social risk factors and had social workers in each clinic.² There are many models but what most of them share is population-based payment, either capitation or supplemental funding above and beyond traditional fee-for-service. A notable emerging example is the North Carolina 1115 waiver, which includes systematic collection of social determinants data, connection through social services and promises statewide practice facilitation social determinants to support implication across all Medicaid recipients.](#)

- How are costs for targeting and providing those services evaluated? What are the additional costs to target services, such as case management, and to provide additional services (e.g., transportation)? What is the return on investment in improved outcomes or reduced healthcare costs?

[Wellmed had 60% lower bed-days than matched comparisons and 50% lower age adjusted mortality after putting nearly 15% of total health spend into their model; both represent large](#)

ROI. Addressing social risk is difficult to address in a randomized, controlled trial. Most models with enhance capacity to address social determinants also have other enhancements, most typically in primary care and population health functions.³⁻⁶ The good news is that most of these have much larger returns than the investments needed.

- What are the best practices to refer beneficiaries to social service organizations that can address social risk factors? Best practices are warm handoffs and local resources. Relationships are key to providing good care—relationships between clinical and social services are just as important as those between patients and care-givers. Vermont realized this and used their Medicare waiver to put behavioral health and social workers in communities as shared clinical resources. Practices that can embed these resources or have them close by can better assure good referrals. Housing vouchers or transitions can be particularly difficult without clinical and community partnerships; it is not enough to refer someone.

- What lessons have been learned about providing care for patients with social risk factors? Caring for social risk factors is not easy. They are not isolated and are often intertwined with behavioral, substance use, and medical conditions. They are also not isolated—their family members often have related problems and household chaos is common. However, they can also be the most rewarding, both in terms of personal impact and in terms of financial savings. Financial savings come from reduced ED and hospital use, but also from reduced police resources, court costs, and incarceration.

Moving up from the clinic level to health systems and making response to social risk a component of the IRS-required Community Health Needs Assessment for non-profit hospitals are important strategies. Health systems are beginning to intervene systematically with CHNAs and interventions (Atrium Health Care, in Charlotte, NC and New Hanover Regional Hospital in Wilmington, North Carolina). Atrium has shown dramatic reduction of ED visits among frequent ED visitors with an intervention including transportation and tagging within a regional integrated EHR.

- What are barriers to tailoring services to patients with social risk factors? How can barriers be overcome?

There are special challenges in rural areas, which often have less infrastructure and less transportation options. They may need more resources in order to hire or build functions not available in their communities. For example, if you look at the Social Risk resource Aunt Bertha, rural areas are often devoid of any identified resources. Vermont's Blueprint for Health is a good example of building shared community resources for patients with social risk factors. Tailoring also means having updated tools for enabling targeted referrals or collaborations. Many of the tools that take stock of and update community-based resources are proprietary, and it would useful to have national (CMS?) support that provides access to them (Aunt Bertha, Community Rx, etc.)

- For patients with social risk factors, how does patients' disability, functional status, or frailty

affect the provision of services?

It complicates the provision of services because they often have family care-givers or rely on a complex network of support. Family care-givers are typically unpaid and need support of their own. Complex networks rely on community social cohesion which some practices are able to cultivate, but they take resources that are difficult to tie to patient care. For example, Wellmed turned a 100,000 square foot warehouse into the Cisneros Community Center where meals on wheels were provided and personal trainers were available for free, but also where mariachi bands played and pool and chess tables were available for patients to be social and get to know each other.

As part of the second Report to Congress, HHS is requesting information on how providers and health plans capture beneficiaries' social risk. HHS is requesting information on how providers and health plans are collecting and using data on Medicare beneficiaries' social risk factors:

- Which social risk factors are most important to capture?

The PRIME Registry currently serves more than 2500 clinicians in 900 practices in 49 states. The PRIME Registry Population Health Assessment Engine (PHATE) uses the Social Deprivation Index (SDI) to capture and characterize social risk factors for patients and Communities.^{7,8} The SDI includes poverty, nonemployed, percent overcrowded, percent black, less than 12 years' education, rate of no car ownership, renter-occupied housing, high-need age group, and single-mother household. Similar to the Area Deprivation Index, the New Zealand Deprivation Index, and the UK Index of Multiple Deprivation, the SDI used factor analysis to test small-area SDOH measures against outcomes.⁹⁻¹¹ The results are indices predictive of increased cost, utilization, disease prevalence, and mortality. The UK and New Zealand have used their indices to adjust payments for clinical care and social services.¹²⁻¹⁴

- Do you routinely and systematically collect data about social risk? Who collects this data? When is it collected? Is it collected only once or multiple times for a beneficiary? Is it collected consistently across populations (i.e. Medicare beneficiaries, Medicaid beneficiaries, patients receiving specific services, etc.)? What are the burdens of this data collection on plans, providers, and beneficiaries?

We use data collected systematically and routinely by the US Census via the decennial census and the American Community Survey. The Robert Graham Center uses these data to refresh the SDI annually. There is no burden placed on clinicians or practices. The SDI is employed as a Community Vital Sign to convey risk for individual patients, and to evoke a conversation between clinician and patient about their particular risk factors.^{15,16}

- Would standardized data elements for EHRs help you to collect social risk data? If so, how could these data elements be standardized?

The NAM report series raised important concerns about using EHRs as a mechanism to collect social risk data. EHRs already put burden on clinicians to collect scores of other data, many of which have no utility or no direct utility. EHRs shifted work to clinicians that is a poor use of their time and training, and yet most clinics cannot afford to offload this work to people better

suited (and who can be trained to standardize data capture). To avoid offending patients, clinics may guess at patient's social risks rather than ask them for fear of offending or angering them.

- What are barriers to collecting data about social risk? How can these barriers be overcome? Increasing investment/payment so that clinicians can offer referrals or other resources when social risks are discovered makes them more likely to ask and capture those data. The NAM was also clear that providing data from other sources—Social Security, Census, American Community Survey—reduces burden and is often more reliable. They also discuss the role of Medicare in capturing social risk factors at enrollment. A key issue is how to integrate into the training of clinicians. A collaborative of primary care residencies is implementing screening and interventions in their practices. How to do this optimally is still unknown.

- What do you see as promising future opportunities for improving data collection? For using existing or future data to tailor services? The Census Bureau's Center for Administrative Records Research and Administration (CARRA) efforts to link HIE and Registry data with Census/ACS data and improve small-area understanding of social risk and associated outcomes should enhance the availability of reliable data to clinicians and communities. It also increases the likelihood of the previous IOM report recommendations on common data platforms available to primary care and public health.¹⁷

Sincerely,



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