HHS RFI:
IMPACT ACT, 2018

Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors.

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Social Risk Factors Report
Parkland Health & Hospital System I Community Health Institute

In 2017, Parkland established the Community Health Institute (CHI) with the primary focus on keeping individuals healthy in the community.

Recognizing the importance of the social determinants of health, the CHI supports research and innovation in primary, secondary and tertiary prevention. The CHI has established an intra-organizational Social Determinants of Health Impact Governance Committee that drives system-wide strategic initiatives to address the social determinants through coordination, adoption of best practices, and innovation.

In addition, the CHI has created an inter-organizational Social Impact Action Team that brings a multi-disciplinary group from local hospitals and community based organizations together to identify common public health issues and impact the social needs of our community.

Our commitment to care, compassion and community.

Parkland
Community Health Institute

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GERIATRICS

PROGRAM NAME:	Program Overview	Patient Data / Outcome	Costs / ROI
How is your program serving Medicare beneficiaries, especially those with social risk factors?	Geriatrics encompasses 3 primary service areas in the Parkland ambulatory system and operates as an interdisciplinary practice model: 1. There are 6 Geriatrics clinics located in strategic areas across the county to allow access to seniors near their home; each module has social work support and access to RD, PharmD, and BH services 2. When seniors can no longer "get to the clinic" and are "homebound by Medicare definition", we offer Senior HouseCalls- primary medical visit in the patient home; this service includes social work point of entry to screen all aspects of social, environmental, support needs; NP or MD medical visits, LVN for EKG, lab/urine draws, immunization, wound care; chaplain for end of life and bereavement support. Many patients do not meet the skilled criteria for home health care and this service provides their medical visit regardless of skilled need. 3. Seniors in the "most high risk zip codes areas of Dallas as determined by access related demographic data" are served by Parkland Outreach Services program which provides in-home case management support, van transportation to health and social services visits, health education and health outreach/screening.		Services areas utilize standardized operational metrics that range from cost/visit to program cost. Benchmarking is completed regularly with similar service providers. There are costs related to interdisciplinary geriatric practice that are not incurred in many private settings but are well researched and supported in Geriatric practices and in safety net institutions. In 2015, Senior HouseCalls completed a 5 year retrospective IRB review of the program that included outcomes and cost analysis and showed decrease in ED use for clients. ROI has not been recently reviewed in our area but most systems utilize high cost user data to support special services.

	This program is able to provide strategic efforts to underserved communities; examples: in 2017, we increased screenings for Asian seniors through efforts at Buddhist temples; in 2018, a Quality project involved recontacting Latino seniors due to underuse of our van service. 4. As part of these interdisciplinary programs, we offer in home and dementia caregiver education, Senior Companion program referrals in additional to referrals to all community agencies, case management services for persons with neurocognitive impairment, those over age 85 who live alone, and the unbefriended and additional services that range from Advanced care planning classes to Medicare open enrollment information. 5. The overall Department also provides additional outreach and education in the community ranging from providing fall risk screening or flu drives in senior centers to professional education.		
Are social risk data being used to target services or provide outreach? If so, how?	Social risk factors have driven special services in our safety net health system for many years. In our community health primary care clinics, there are multiple demographic and social indicator questions (detailed in another section) that help drive some of the interdisciplinary referrals, but especially social work involvement with patients. Population health reports/registries have allowed staff to more easily locate and focus on individuals with target concerns that range from frequent ED use, recent		

	hospitalization, and certain high risk conditions like CHF. Geriatrics provides additional phone and outreach contacts with many of these individuals and overbooks face to face visits based on need. Health and social mapping has assisted us in targeting outreach efforts ranging from zip codes target areas for mammograms, colorectal cancer screening, access/transportation issues, flu drives,etc The most common department outreach/screening is Fall Prevention activities focusing on individual and environmental screening and education.		
What are the best practices to refer beneficiaries to social service organizations that can address social risk factors?	Referrals are especially important for our seniors who may have no internet or smart phone access in a world of on line access. Advocating with agencies allowing us to make a direct referral on behalf of the patient as well as allowing us to check in the on the referral status has been significant with this group. Not all agencies can accommodate the volume, variety of languages in our population and we have worked collaboratively to support the translation need. Medicare and Medicaid benefits and eligibility can be difficult to understand and helping individuals understand these processes is important. Senior HouseCalls maintains a log of all patients that helps us remind individuals/families about eligibility renewal dates for QMB, MQMB and Parkland financial screenings; 80% of our Hosuecalls patients have cognitive impairment and remembering and completing deadlines is challenging for them but these financial programs are essential for their service supports in the community.		
What lessons have been learned about providing care for patients with social risk	Flexibilty in scheduling and seeing patients is essential; many caregivers can't miss work and need to bring the senior for care the 1st visit of the day or the last; transport services often bring patients late for		

factors?	appointments and we don't turn away late patients regardless of presentation time.		
	It is difficult to target who will benefit and who will not benefit to focus limited resources. Staff have personal and ethical principles that focus our attempts on serving everyone regardless of situation and there are individuals who we do not impact. We also believe that intentional screening makes a difference in allowing earlier intervention before obvious issues present. Redundant questions by various disciplines also can yield a benefit as some patients will disclose information to their provider and not the social worker to the nurse but not the doctor, etc		
	Barriers include: Language, literacy, technology, home environment, family/social support can complicate many patient situations.		
	Parkland has a robust language translation network but is difficult to complete hour long cognitive assessments in languages like Urdu and Mandarin via a phone line; we are using a low literacy cognitive screen newly validated that assists with low literacy patients. Cost eligibility and reminders are often sent leveraging technology but many of our patients don't have smart phones and have limited minute phones only; we assist as we can with calling agencies while they are at our locations and allowing them direct access to speak to service providers.		
	Home environments with pest infestations have grown over the last 3 years with rise in bed bugs; we partnered with the City of Dallas and provided a Conference on Bed Buds in 2108 for seniors and professionals but there is no inexpensive solution. We inquire about guns in our homes but still enter homes if guns are not visible or unless there is a report of family violence. We attempt to mobilize family support		

	through family conferences but in some cases, the senior is actually the most stable family member, supporting multiple generations financially and physically.		
Which social risk factors are most important to capture?	Geriatrics most frequently uses these factors: Neurocognitive impairment Living alone and/or with family history of abuse Residence/environment Transportation Income, but most importantly health insurance-coverage, lack of coverage, drug plans Social isolation and social support (formal and informal)		
How is data collected about social risk? (by whom, when, what methods, etc…)	In the community health primary care clinics, there are demographic and social indicator questions completed by business (race, ethnicity, address, gender identification, funding, language) and nursing staff (learning assessment and style, suicide and depression risk, domestic violence) at each patient visit that help drive referrals to the interdisciplinary team as well as provide medical providers information for their encounters/patient history. Medical provider, nurse or social worker in Geriatrics also completes standardized, validated assessment tools for cognition, falls, depression, ADLs, IADLs that further help staff involve the team in care and focus our high risk case management supports. Social workers complete detailed assessments of family and living environment, income/health insurance, and informal and formal support networks. Population health reports/registries have allowed staff to more easily locate and focus on individuals with target concerns that range from frequent ED use, recent hospitalization, certain high risk conditions like CHF. Geriatrics provides additional		

	contacts with many of these individuals and overbooks face to face visits based on need. Health and social mapping has assisted us in targeting outreach efforts ranging from zip codes target areas for mammograms, colorectal cancer screening, access/transportation issues, etc		
What do you see as promising future opportunities for improving data collection?	Interdisciplinary and multidisciplinary approach to care for older adults has long been documented in the literature for enhancing outcomes ranging from quality of life to reduced morbidity/placement to decreased cost. Parkland Geriatrics utilizes the multi-discipline models in several ways: we offer "one stop shop" by providing patients access to social work, RD, PharmD the same day as the doctor appointment, thus increasing their compliance with holistic care while decreasing the cost of transportation for multiple appointments. We also offer multi-discipline programs including Dementia education classes/support for caregivers and Advanced care planning options (English and Spanish). Geriatrics utilizes social and health screens targeted at identifying risk, allowing intervention before disability. Example: screen for fall risk and provide the assistive device before the fall; screen for sensory loss and provide vision and hearing so the individual can continue in social activities; use the medication reconciliation process to determine who can't afford to fill medications and who can't remember to take medication as prescribed. This focus on maximizing function and uncovering syndromes is a hallmark of Geriatrics. Screening for cognition, depression, urinary incontinence, medications, falls, hearing, vision, weight is standard and at least yearly in our practices.		

SOCIAL WORK (COC)

PROGRAM NAME: Social Work COC	Program Overview	Patient Data /Outcome	Costs / ROI
How is your program serving Medicare beneficiaries, especially those with social risk factors?	For all admitted patients, a psychosocial assessment is completed within 24 hours of admission, which assesses each patient's social determinants of health. In addition, if patients are identified by the interdisciplinary team as needing assistance with psychosocial needs, referrals are made to the case management team for assistance. In the primary care and outpatient settings, patients with identified psychosocial needs are referred to the social worker for assistance. Specific programs are listed below.		
How do you work to identify beneficiaries with social risk factors?	Patients with high ER utilization, homelessness, readmitted in 30 days, and/or those with high risk readmission diagnoses are identified via a track-board in the ESD and interventions are provided accordingly. Social workers also intervene with these patients in the primary care and outpatient settings. In addition to psychosocial assessments, all admitted patients are discussed in daily interdisciplinary huddles to assess for medical and social risk factors that would prevent a successful transition to the next level of care.		
How do you address the needs (medical / social) of beneficiaries?	Once risk factors are identified via the ESD track-board, psychosocial assessment, and/or provider referral, patients are referred to social service agencies, lower levels of care, and any other resource as pertinent. Similarly, in the primary care and outpatient settings, patients are referred to social service agencies and other		

	resources as pertinent.		
Are social risk data being used to target services or provide outreach? If so, how?	Multiple programs target services for those identified via social risk data: Transitional Care Unit (TCU): Through risk analysis created by a partner agency, PCCI, patients with high risk for readmissions are enrolled in the TCU program where patients are closely followed to ensure medication compliance, follow-up appointments are scheduled, and psychosocial barriers are addressed. Acute Response Clinics (ARC): These clinics allow patients who were recently discharged from the hospital or seen in the ER receive prompt follow-up appointments. High ESD Utilizer Program: Patients with more than five ESD encounters in thirty days are tracked on a daily basis. Those with greater than ten ESD encounters receive intensive case management via an interdisciplinary committee to address risk factors driving the patient to the hospital for non-emergent care.	Reduced ESD encounters; increased compliance with outpatient appointments; increased medication compliance Decreased readmissions Decreased ESD encounters; stable housing/shelter; compliance with medical and mental health care follow-up	
What are the best practices to refer beneficiaries to social service organizations that can address social risk factors?	Warm Handoffs A warm handoff must be coordinated by the social worker/case manager between the patient and service organization, to ensure the referral is received by the social service organization and to ensure the patient's compliance with following up on provided referral. Parkland Post-Acute Network Due to social risk factors requiring partnering with social service agencies, Parkland hosts a monthly Parkland Post-Acute Network, with providers across the continuum of care to network and collaborate on resolving system and patient issues. In addition, daily collaboration with community partners is		

	vital for the successful transition of patients into the ambulatory setting.		
What lessons have been learned about providing care for patients with social risk factors?	Patients require warm handoffs across the continuum of care for success and avoid negative cyclical behavior patterns. Increased and continued communication is needed with partner agencies whether a homeless shelter, skilled nursing facility, etc. to ensure patient needs are truly understood as the patient transitions from one setting to another. Patients have complex psychosocial needs with varying levels of support. It is important to engage the patients and leverage all available supports – formal and informal.		
Which social risk factors are most important to capture?	Housing stability, transportation access, medication access, familial/community support, mental health diagnoses and access to care, medical diagnoses and access to care, and food insecurity.		
How is data collected about social risk? (by whom, when, what methods, etc…)	Data reports and tracking are generated from information captured in the Epic electronic medical record. Monthly tracking of patient demographics occurs and includes assessing zip code, patients with established/non-established PCPs, number of homeless patients, number of ESD visits, hospital admissions, and compliance with follow-up appointments.		

VCARE

PROGRAM NAME: VCare	Program Overview	Patient Data / Outcome	Costs / ROI
How is your program serving Medicare beneficiaries, especially those with social risk factors?	Parkland Health and Hospital System, a public safety net entity, serves a large vulnerable population of uninsured patients. Many of these patients with complex health and social needs frequently use the Emergency Department (ED) as a portal of care. The Value Based Care (vCare ©) Program was developed to re-design primary care delivery upstream to improve the wellbeing of the overall patient population while avoiding excessive downstream utilization, including unnecessary ED visits. In launching this program, Parkland had a unique opportunity for integrating care within its Population Health Program since it consists of both an 800 bed tertiary care hospital and a large network of Community Oriented Primary Care (COPC) Clinics.	The initial vCare © patient cohort, enrolled in January 2017, has demonstrated early success with high impact outcomes. This patient cohort (n = 15) had an aggregate baseline of 1.68 ED visits per patient per month ratio (June – December 2016). By May 2017, significant improvement in this cohort was demonstrated with 0.67 ED visits per patient per month ratio - a reduction of 1.01. To date, more than 96 patients are enrolled in vCare ©. From an individual perspective, one vCare © patient, who had nearly 100 ED Visits within one calendar year, consistently has had "0" ED visits per month, is gainfully employed, renting his own apartment and regularly keeping his primary care visits. Now that vCare © has demonstrated "proof of concept",	Please see Case exemplar in Attached CMS Powerpoint – Slide # 9 and 10 and in Attached Second CMS Powerpoint Slide#9.

		Parkland is re-engineering its entire Population Health Program by designing multidisciplinary team-oriented personalized care across all of its COPC sites.	
How do you work to identify beneficiaries with social risk factors?	Social Worker Conducts an Intake Social Determinants of Health Risk Assessment.		
How do you address the needs (medical / social) of beneficiaries?	The Multidisciplinary vCare Team consists of a primary care provider and registered nurse who address the health care needs of the vCare patient while the social worker addresses the health care related social needs of the patient. Patient progress/status is reviewed jointly by the multidisciplinary team on a weekly basis.		
Are social risk data being used to target services or provide outreach? If so, how?	Yes, As Stated Above.		
What are the best practices to refer beneficiaries to social service organizations that can address social risk factors?			The expanded vCare program includes use of standardized health-care related social needs risk assessment tools for the purpose of identifying and stratifying levels of risk, titrating individualized applications of evidence based practice

			guidelines based on risk stratification, and monitoring remediation of risk within and across patients.
What lessons have been learned about providing care for patients with social risk factors?	Parkland Health and Hospital System, a public safety net entity, serves a large vulnerable population of uninsured patients. Many of these patients with complex health and social needs frequently use Emergency Departments (ED's) as portals of care. In addressing Parkland's mission for improving health and wellbeing within the community, Parkland leaders across several departments embarked on initiatives providing "Better, Smarter, Healthier" care for High ED Utilizer patients resulting in reduction in unnecessary ED visits and admissions at the acute care point of service. These groups included Complex Care within the ED, Value-Based Care (vCare©) in the primary care clinics and Faith Health Initiative in the community. Using a Care Optimization and Standardization Initiative (COSI) performance improvement methodology, programmatic accomplishments and individualized patient-centered care improvements were initially achieved. As these multidisciplinary teams proceeded to advance, they recognized opportunities to strengthen *intra-organizational collaboration* for intensifying each program's uniquely distinct approaches while *collectively leveraging* resources to further *impact* health and wellbeing in the community. This inspired inauguration of the *High ED Utilizer Affinity Group* including the original High ED Utilizer groups along with Parkland's Behavioral Health		

	Department and Community Health Institute. The Affinity group meets monthly engaging in dynamic bi-directional collaboration. As the Affinity group's progress accelerated, leaders further recognized opportunities for advancing *inter-organizational collaboration* with other healthcare systems and community based organizations (CBO's) to *collectively leverage inter-organizational* resources within an integrated network of health and social services for the highly vulnerable across Dallas County. This *Collaborative Coalition* encompasses dynamic navigation involving health service delivery across multiple healthcare organizations as well as CBO coordination addressing homelessness, food insecurity, and post-incarceration community re-entry. The *Coalition* is launching innovative multi-faceted initiatives expected to significantly *impact community health* upstream advancing population health where it begins rather than waiting for downstream detection of disease and chronic illness.		
Which social risk factors are most important to capture?	Early pilot participation in the CMS Accountable Health Communities (AHC) Grant using the CMS developed Health Care Related Social Needs Screening Tool has demonstrated the top three social risk factors for the Parkland Patient Population to include: food insecurity, transportation needs, and housing.		
How is data collected about social risk? (by whom, when, what methods, etc…)	**QUANTITATIVE** Using pre-test/post-test methods, Healthcare Driven Measures are subjected to analysis across organizations participating in this *Coalition* including: Access to Care, Same Day Clinic Visits, ED Visits,		

Observation Stays, Hospital Admissions, Hospital Readmissions, Patient/Family Experience, Total Cost of Care.

In addition to considering the Healthcare Driven Measures identified above, a normalized ratio based on consideration of "Opportunity" ED Visits was developed in Parkland's vCare© Program and has been favorably reviewed by CMS in June 2017. This ED Visits Per Patient Per Month Ratio will be utilized as a program evaluation outcome measure across Parkland High ED Utilizer Affinity Group participants and will be shared with all participating *Coalition* healthcare systems for consideration.

Multi-organizational data regarding volumes and characteristics of ED visits will be analyzed across all participating *Coalition* healthcare organizations using a Regional Master Patient Index (REMPI) Limited Data Set available from the Dallas Fort Worth Hospital Council (DFWHC) Data Registry.

Given that the ultimate purpose of this Coalition is to improve the health and wellbeing of the Dallas County community, the Regional Health Partnership 9 Community Needs Assessment (CNA) (2018) is being utilized for baseline assessment of the community's overall health with longitudinal tracking on an annual basis to determine improvements in measures within CNA Strategic Priority domains: Capacity/ Access, Chronic Disease, Care Coordination/Preventive Care (including ED Utilization), Behavioral Health (including Mental Health and Substance Use Disorder) and Infant/Maternal Health.

QUALITATIVE

In addition to quantitative data, consideration of individual case studies/exemplars will provide rich

contextual information as well as most importantly furnish insight into the "voice of the patient". These case exemplars will be studied at the individual level as well as subjected to further qualitative analyses using Grounded Theory Method of Content Analysis to identify common categories and themes to further inform development of patient-centered interventions.

OUTCOMES

Quantitative Analysis of Healthcare Driven Measures is being conducted using pre-test/post-test methods to demonstrate collective impact of Parkland's High ED Utilizer Affinity Group including Complex Care, vCare© and Faith Health Initiative. Parkland is proposing multi-organizational analysis of this data among participating *Coalition* members.

The initial vCare © patient cohort, enrolled in January 2017, demonstrated proven success with high impact outcomes. This patient cohort (n = 15) had an aggregate baseline of 1.68 ED Visits Per Patient Per Month Ratio (June – December 2016).   By May 2017, significant improvement in this cohort was demonstrated with 0.67 ED Visits Per Patient Per Month Ratio – a statistically significant reduction of 1.01. To date, more than 96 patients have enrolled in vCare ©. Data for the second vCare© patient cohort (April – August 2017) is undergoing analysis. Preliminary results indicate an even lower baseline pre-intervention ED Visits Per Patient Per Month Ratio with significant reduction in the post-intervention ratio.

Preliminary results of REMPI DFWHC Registry data indicate that a discrete sub-population of patients (n

	= 80) are the Highest ED Utilizers (>30 ED Visits During 12 Months) receiving ED services across two to three of DFWHC healthcare organizations. This recent information provides even greater impetus for advancement of the *Coalition*. Although preliminary results are quite compelling, further data sharing data across healthcare organizations awaits finalization of a Memorandum of Understanding. Comprehensive analysis of <u>Regional Health Partnership 9 Community Needs Assessment (CNA)</u> (2018) is being conducted. Early results are profound indicating that excessive alcohol consumption occurred in 17 percent of the total adult population in Dallas County in 2018. Detailed CNA analysis is being provided as the *Coalition's* baseline measurement. <u>Qualitative Analysis</u> of individual and group level patient case study data is being conducted for both baseline and post-intervention analysis.		
What do you see as promising future opportunities for improving data collection?	Integrated Comprehensive Health and Social Care Electronic Record such as that which is being developed by EPIC.		

ACUTE RESPONSE CLINIC (ARC)

PROGRAM NAME:	Program Overview	Patient Data / Outcome	Costs / ROI
How is your program serving Medicare beneficiaries, especially those with social risk factors?	The acute response clinics (ARC) provide timely acute care access for patients who are being discharged from the Emergency Department (ED), Urgent Care-ED and Inpatient units; who will otherwise be at risk for readmission, or cycling back through the ED.	FY2017 – 3,345 Medicare patients were seen by the ARCs	
How do you work to identify beneficiaries with social risk factors?	The ARC nurses are responsible for completing the screening for suicidal risk, violence, and psychosocial components at each visit.		
How do you address the needs (medical / social) of beneficiaries?	The ARC physicians provide the medical care needs and when risk factors are identified the patients are referred to the social workers for assistance.		
Are social risk data being used to target services or provide outreach? If so, how?	Through risk analysis created by a partner agency, PCCI, patients with high risk for readmissions are enrolled in the Transitional Care Unit (TCU) program where patients are closely followed to ensure medication compliance, follow-up appointments are scheduled, and psychosocial barriers are addressed.		
What are the best practices to refer beneficiaries to social service organizations that can address social risk factors?	The social workers complete an assessment and based on the identified needs they make the appropriate referrals to social service organizations.		
What lessons have been learned about providing care for patients with social risk factors?	Patients have complex needs with different levels of support and this affects their ability to keep appointments and continue with follow up care.		
Which social risk factors are most important to capture?	Transportation access, medication access, housing needs, food insecurity and financial resources.		
How is data collected about social risk? (by	The data is being captured in our Electronic		

whom, when, what methods, etc....)	Medical Record (EMR) by our clinical and social work teams.		
What do you see as promising future opportunities for improving data collection?	The development of an electronic process in the EMR that also captures the social risk factors.		

BEHAVIORAL HEALTH & PSYCHIATRY

PROGRAM NAME:	Program Overview	Patient Data / Outcome	Costs / ROI
How is your program serving Medicare beneficiaries, especially those with social risk factors?	We provide a Psychiatry ER, Extended Psychiatry Observation, Psych Specialty Outpatient Clinic, Integrated Psychiatry, Consult Liaison Psychiatry Services, Psychiatry Inpatient Unit, and a RIGHT Care team. and identify those social risk factors upon assessment.		
How do you work to identify beneficiaries with social risk factors?	We have an expansive number of social workers in behavioral health departments assessing patients for these social risks all across Parkland.		
How do you address the needs (medical / social) of beneficiaries?	We connect them with resources to aid with food, prescriptions, transportation, counseling, social support resources. It is a standard of care to provide care coordination.		
Are social risk data being used to target services or provide outreach? If so, how?	PCCI information		
What are the best practices to refer beneficiaries to social service organizations that can address social risk factors?	In addition to our social workers, PCCI developed a technology to assist patients in connecting to resources local to their communities. Another best practice is the RIGHT Care Team. We address patients mental and social needs in the community. LOOP BACK		

	ANALYTICS		
What lessons have been learned about providing care for patients with social risk factors?	Patients with mental health issues need housing, stable support, access to medication, food and transportation.		
Which social risk factors are most important to capture?	Housing, support, financial stability, transportation		
How is data collected about social risk? (by whom, when, what methods, etc...)	Pulled from the EHR		
What do you see as promising future opportunities for improving data collection?			

FAITH-HEALTH

PROGRAM NAME:	Program Overview	Patient Data / Outcome	Costs / ROI
How is your program serving Medicare beneficiaries, especially those with social risk factors?	Parkland's Faith Health Program is the convener and member of the DFW Faith Health Collaborative, a collaboration between the four: Baylor, Methodist and Children's. Although,	As of 2018, we began companioning patient with trained volunteers as Faith Health Community Caregivers, which are volunteers from local faith communities. It is our goal to evaluate these metrics in this fiscal year.	We will analyze the ROI in this fiscal year and determine the impact and effectiveness of our Faith Health Program.
How do you work to identify beneficiaries with social risk factors?	Currently, we have started talks with Pieces Iris to work with the Accountable Healthy Communities Grant. This program provides our partnered faith communities to document and track social risk factors, and work with the patient to eliminate or mitigate the social risk. We also utilize a Faith Health Caregiver Monthly Report, maintain monthly continuing education where we discuss patient barriers and are available to our partners 365 days of the year.	It is our goal to evaluate these metrics in this fiscal year.	It is our goal to evaluate these metrics in this fiscal year.
How do you address the needs (medical / social) of beneficiaries?	The needs are addressed by way of the DFW Faith Health Collaborative. We are four major hospitals and over 80 faith based community communities with far reaching resources. When a patient has a	It is our goal to evaluate these metrics in this fiscal year.	It is our goal to evaluate these metrics in this fiscal year.

	need we reach into the resources of the hospital and faith communities.		
Are social risk data being used to target services or provide outreach? If so, how?	Yes. Our Faith Health Community Caregivers encounter social risk daily, and provide navigation and accompanying to those services if/when needed.	It is our goal to evaluate these metrics in this fiscal year.	It is our goal to evaluate these metrics in this fiscal year.
What are the best practices to refer beneficiaries to social service organizations that can address social risk factors?	We have found the best practices to refer patients to social services organization is through companionship. The patient population we service are highly isolated and lonely, while managing	It is our goal to evaluate these metrics in this fiscal year.	It is our goal to evaluate these metrics in this fiscal year.
What lessons have been learned about providing care for patients with social risk factors?	We have learned Dallas County has a lacks solutions around homelessness, income equality and affordable housing.	It is our goal to evaluate these metrics in this fiscal year.	It is our goal to evaluate these metrics in this fiscal year.
Which social risk factors are most important to capture?	Faith Health realizes the most important social risk factors to capture are: 1) Isolation/Loneliness 2) Housing arrangements 3) Income 4) Literacy Level 5) Food Access	It is our goal to evaluate these metrics in this fiscal year.	It is our goal to evaluate these metrics in this fiscal year.
How is data collected about social risk? (by whom, when, what methods, etc…)	Data is collected about social risk with our Faith Health Caregiver Monthly Report.	It is our goal to evaluate these metrics in this fiscal year.	It is our goal to evaluate these metrics in this fiscal year.
What do you see as promising future opportunities for improving data collection?	In the near future, we will utilize the Iris platform and EPIC.	It is our goal to evaluate these metrics in this fiscal year.	It is our goal to evaluate these metrics in this fiscal year.

FOR REFERENCE

REQUEST FOR INFORMATION:

IMPACT ACT Research Study: Provider and health plan approaches to improve care for

Medicare beneficiaries with social risk factors

Section 2(d) of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 calls for the Secretary of Health and Human Services (HHS), acting through the Assistant Secretary for Planning and Evaluation (ASPE), to conduct a study evaluating the effect of individuals' socioeconomic status (SES) on quality measures and measures of resource use under the Medicare program. The first component of the required work, a 2016 Report to Congress,2 focused on socioeconomic information currently available in Medicare data.

This request for information is part of the second component, which expands the analyses by using non Medicare datasets to quantify SES, and will be completed no later than October 2019 as required by the authorizing legislation. Following up on ASPE's first Report to Congress, **HHS is interested in how plans and providers serving Medicare beneficiaries:**

- **Identify beneficiaries with social risk factors**
- **Approaches plans and providers have used to address the needs of beneficiaries with social risk factors**
- **Evidence regarding the impact of these approaches on quality outcomes and the total cost of care**
- **Disentangle beneficiaries' social and medical risks and address each**

There is growing recognition that social risk factors – such as income, education, race and ethnicity, employment, housing, food, community resources, and social support – play a major role in health. Despite ongoing efforts, significant gaps remain in health and in life expectancy based on income, race, ethnicity, and community environment.

At the same time, the health care system is increasingly moving towards higher levels of provider accountability for the quality, outcomes, and costs of care. Value-based or alternative payment models, which tie payment to the quality and efficiency of health care delivered, are in place in nearly all Medicare settings, including in hospitals, outpatient settings, and post-acute facilities. In many ways, beneficiaries with social risk factors may benefit the most from value-based purchasing programs and other delivery system reform efforts, since improved care coordination and provider cooperation will be of the highest utility to the most complex beneficiaries with the most care needs.

In the 2018 Medicare payment rules, CMS solicited comments on when and how the Medicare program should account for social risk in quality measures and programs.

The definition of social risk provided by the National Academies of Science, Engineering, and Medicine (NASEM) under contract to ASPE is being used for this request.

These social risk factors include:

1. Socioeconomic position (income, wealth, insurance status, education, occupation, food insecurity)
2. Race, ethnicity, and community context (race and ethnicity, language, nativity, acculturation)
3. Gender (gender identity, sexual orientation)
4. Social relationships (marital/partnership status, living alone, social support)
5. Residential and community context (physical environment, housing, and social environment)

In the first Report to Congress, ASPE found that beneficiaries with social risk factors were also medically complex. As part of the second Report to Congress, ASPE is looking at additional measures of medical risk, including disability, functional status, and frailty, and the interaction of medical and social risk.

Overall Question

How are providers and health plans serving Medicare beneficiaries working to improve health outcomes for beneficiaries, especially those with social risk factors?

Delivery of services

HHS is interested in understanding services targeted to Medicare beneficiaries with social risk factors. The 2016 Report to Congress found that providers that disproportionately cared for beneficiaries with social risk factors tended to perform worse than their peers on quality measures. However, in every setting, be it hospital, health plan, ACO, physician group, or facility, there were some providers that served a high proportion of beneficiaries with social risk factors who achieved high levels of performance.

To better understand these findings, ASPE asked the NASEM to identify best practices of high performing hospitals, health plans, and other providers that serve disproportionately higher shares of socioeconomically disadvantaged populations and compare those best practices to practices of low performing providers serving similar patient populations. The NASEM determined that the following six practices show promise for achieving high levels of performance for beneficiaries with social risk factors:

1. Commitment to health equity: Value and promote health equity and hold yourself accountable
2. Data and measurement: Understand your population's health, risk factors, and patterns of care
3. Comprehensive needs assessment: Identify, anticipate, and respond to clinical and social needs
4. Collaborative partnerships: Collaborate within and across provider teams and service sectors to deliver care
5. Care continuity: Plan care and care transitions to prepare for patients' changing clinical and social needs
6. Engaging patients in their care: Design individualized care to promote the health of individuals in the community setting

ASPE also contracted with RAND to conduct interviews and case studies with Medicare Advantage (MA) plans to understand how the plans address dually enrolled beneficiaries social and health needs. High performing, high-dual and special needs plans (SNP) were found to implement multi-pronged

approaches and strategies. Through this work, we developed a taxonomy for MA plans addressing social needs that includes strategies and interventions that focus on:

1. Needs identification and targeting
2. Care management and coordination
3. Directly addressing social needs
4. Integration of Medicare and Medicaid

HHS is requesting information on how providers and health plans are implementing these approaches and principles for Medicare beneficiaries with social risk factors. HHS is also interested in approaches beyond the NASEM principles and health plan taxonomy that work to improve care for Medicare beneficiaries with social risk factors.

- **Are social risk data being used to target services or provide outreach? If so, how?**
- **How are beneficiaries with social risk factors identified?**
- **Are there especially promising strategies for improving care for patients with social risk?**
- **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?**
- **What are the best practices to refer beneficiaries to social service organizations that can address social risk factors?**
- **What lessons have been learned about providing care for patients with social risk factors?**
- **What are barriers to tailoring services to patients with social risk factors? How can barriers be overcome?**
- **For patients with social risk factors, how does patients' disability, functional status, or frailty affect the provision of services?**

Data

As part of the second Report to Congress, HHS is requesting information on how providers and health plans capture beneficiaries' social risk. The Medicare program captures limited information on beneficiary social risk, but there is potential for additional information to be collected by health plans or providers at the point of care. In particular, the NASEM identified electronic health records (EHRs) as a potential source of social risk data.7 In earlier work, a separate NASEM committee recommended that certain social and behavioral health domains be collected in EHRs.8

ASPE also contracted with NORC to conduct a qualitative study of EHR vendors' incorporation of social determinants of health in EHRs.9 Among the 6 vendors interviewed, all were incorporating social determinants of health into their systems in response to client demand, although the type of product varied greatly across the vendors.

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?**
- **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?**
- **Would standardized data elements for EHRs help you to collect social risk data? If so, how could these data elements be standardized?**
- **What are barriers to collecting data about social risk? How can these barriers be overcome?**
- **What do you see as promising future opportunities for improving data collection? For using existing or future data to tailor services?**

Submitting Comments

Comments will be received until November 16, 2018.

Submit electronic comments via email to ASPEImpactStudy@hhs.gov

Note to commenters

This RFI is issued solely for information and planning purposes; it does not constitute a Request for Proposal, applications, proposal abstracts, or quotations. This RFI does not commit the Government to contract for any supplies or services or make a grant or cooperative agreement award. Further, HHS is not seeking proposals through this RFI and will not accept unsolicited proposals. Responders are advised that the U.S. Government will not pay for any information or administrative costs incurred in response to this RFI; all costs associated with responding to this RFI will be solely at the interested party's expense. Not responding to this RFI does not preclude participation in any future procurement or program, if conducted. It is the responsibility of the potential responders to monitor this RFI announcement for additional information pertaining to this request.

Please note that HHS will not respond to questions about the policy issues raised in this RFI. HHS may or may not choose to contact individual responders. Such communications would only serve to further clarify written responses. Contractor support personnel may be used to review RFI responses. Responses to this RFI are not offers and cannot be accepted by the Government to form a binding contract. Information obtained as a result of this RFI may be used by the Government for program planning on a non-attribution basis. Respondents should not include any information that might be considered proprietary or confidential. This RFI should not be construed as a commitment or authorization to incur costs for which payment would be required or sought. All submissions become Government property.