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VIA ELECTRONIC SUBMISSION: ASPEImpactStudy@hhs.gov

November 16, 2018

The Honorable Alex Azar
Secretary
U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: SCAN Health Plan Comments in Response to ASPE RFI – IMPACT Act Research Study

Dear Secretary Azar:

SCAN Health Plan (SCAN) is pleased to submit comments in response to the Request for Information (RFI) from the Assistant Secretary for Planning and Evaluation (ASPE) on the Improving Medicare Post-Acute Care Transformation (IMPACT) Act. SCAN applauds the U.S. Department of Health & Human Services (HHS) for addressing social risk factors for Medicare beneficiaries, an area that SCAN has been deeply engaged in for many years. The following provides background on SCAN and our responses to the RFI questions.

SCAN Background

Founded in 1977, SCAN is a not-for-profit health plan that serves seniors through Medicare Advantage (MA) plans and institutional, chronic care, and dual eligible special needs plans (SNPs). Approximately 194,000 Medicare beneficiaries are enrolled in SCAN's MA plans in California, making it the third largest not-for-profit MA Prescription Drug (MA-PD) plan in the country. Since 1985, SCAN has specialized in providing comprehensive, high quality care to the most vulnerable Medicare beneficiaries, including those who live with multiple chronic conditions, are eligible for nursing home care, and experience difficulty performing activities of daily living. Members benefit from SCAN's partnerships with health care providers that engage with plan members to provide the right care at the right time, while maximizing beneficiaries' ability to maintain their independence. We are proud that SCAN MA plans have received a 4.5 star rating for plan years 2018 and 2019.

SCAN Responses to RFI Questions

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

SCAN addresses social risk factors affecting Medicare beneficiaries by offering a variety of plans to seniors with different needs. Key strategies for identifying and collecting social risk data include conducting a health risk assessment (HRA), providing comprehensive care management to high need members, and partnering with providers to offer high quality health care. Through our 40+ years of experience, we have learned that in-home culturally sensitive and linguistically appropriate care and services are the keys to addressing social risk factors.

These strategies and others are described in detail in the October 2018 ASPE report, *Addressing Social Determinants of Health Needs of Dually Enrolled Beneficiaries in Medicare Advantage Plans*,¹ in which SCAN is featured as a case study.

Below are examples of SCAN plans and programs that emphasize social risk factors. High need individuals are included in all of our products, although some of them are more focused on dual eligible members who are eligible for benefits from Medicare and Medicaid (called Medi-Cal in California). (Please refer to SCAN's website for information on all of SCAN's programs.)²

- **Dual Eligibles.** Of SCAN's total membership (194,000), our traditional MA plan serves around 40,000 high need beneficiaries, and some have self-selected to enroll in one of our SNPs. These include plans for dual eligibles (D-SNP), in which members enroll in Medicare through SCAN and SCAN coordinates with Medi-Cal to address the needs of those beneficiaries who are dually enrolled for both Medicare and Medicaid benefits. Other SCAN SNPs serve people living in institutions (I-SNP) and those with specific chronic conditions (C-SNP). SCAN's I-SNPs and C-SNPs have a high proportion—around 25 percent—of dually enrolled beneficiaries. Members enrolled in Village Health, one of our C-SNPs, include 85 percent of duals with high needs.

All of SCAN's duals products address social factors, such as access to care in the home, housing, nutrition, social isolation, and others. However, SCAN's most robust and integrated SNP is the Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP). SCAN's FIDE SNP serves approximately 13,000 dually enrolled beneficiaries in Los Angeles, Riverside, and San Bernardino counties, and offers two programs for dual eligibles: *Connections*, which coordinates patients' Medicare and Medi-Cal benefits, and *Connections at Home*, which coordinates and manages patients' Medicare, Medi-Cal, and long-term services and supports (LTSS).

SCAN's FIDE SNP is recognized for providing high quality care to members. It is California's only MA FIDE SNP and rated 4.5 stars by CMS (100 percent of SCAN's FIDE SNP members are in 4.5 Star plans). Additionally, our FIDE SNP model of care achieved a 96.67 percent score for 2018 with no deficiencies; and 99 percent of SCAN's dual members live in community settings, even though 20 percent qualify for nursing home level of care.

- **SCAN Plus.** Another SCAN plan that addresses social risk factors for MA members is SCAN Plus, offered in Los Angeles, Riverside, San Bernardino and San Francisco counties. This plan provides dual eligible members with additional benefits that are not offered by Original Medicare. These include prescription drugs, vision, hearing, dental, acupuncture, chiropractic, podiatry services, as well as transportation, health club membership, home-delivered meals, and a personal emergency response system. SCAN Plus provides care navigation to support members' access to care and community resources. The plan also coordinates members' Medicare and Medi-Cal benefits, even though their Medi-Cal benefits are not enrolled through SCAN.

¹ *Addressing Social Determinants of Health Needs of Dually Enrolled Beneficiaries in Medicare Advantage Plans*. Retrieved on November 10, 2018 at: <https://aspe.hhs.gov/pdf-report/addressing-social-determinants-health-needs-dually-enrolled-beneficiaries-medicare-advantage-plans-findings-interviews-and-case-studies>.

² Please refer to SCAN's website at: www.scanhealthplan.com for additional information.

In addition to the health plan, SCAN offers a community resource agency that serves vulnerable seniors, called Independence at Home (IAH). IAH provides free community and social services to seniors and their caregivers to support them living independently in the home setting of their choice. Since 1977, IAH has managed the largest Multipurpose Senior Services Program (MSSP) in California, which is a 1915(c) Medicaid waiver program, assisting nursing home eligible seniors with health and social risks that put them at risk for nursing home placement. MSSP provides in-home case management and LTSS to close to 1,000 seniors annually. In addition to the MSSP program, IAH offers a variety of programs that address social risk factors and help to maintain living in the community. These include assistance with resource navigation, health education, at-home medication safety and care management, social supports to prevent social isolation, as well as addressing behavioral health. The Insights program, a part of IAH, provides in-home behavioral health counseling to community-dwelling seniors and caregivers.

In addition to offering health plans and programs, SCAN helps providers coordinate care and link to community benefits for their patients. While more providers are becoming interested in addressing social risk factors, many are inexperienced in dealing with social issues and need assistance from plans and other organizations to meet the nonmedical needs of their patients. SCAN is in a unique position because we have a long history of addressing seniors' social needs and our model is based on partnering with providers.

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

SCAN identifies social risk factors, targets services, and provides outreach to its members. Key strategies include conducting a HRA for new and current plan members and providing comprehensive care management to high need members.

- **Health Risk Assessments.** SCAN identifies multiple social risks for members, at various points in time, using a HRA. Social risk is included in the HRA and questions are based on the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) model.³ This assessment uses a screening tool to identify an individual's social and health care needs and to inform the plan's targeting of services. The HRA collects information related to functional status, cognitive status, mental health, physical health, chronic conditions, social risk factors (e.g., whether the individual is living alone, food insecurity), and other domains.

In 2018, SCAN launched an expanded health risk assessment to collect more information related to social risk factors, including education, race, and languages spoken. We also use a modeling approach to identify high-risk individuals for care management activities that integrates pharmacy claims, emergency department utilization, and other relevant information. In addition to HRAs, members' needs are identified through a triggering event such as a hospitalization, outreach to customer service, a physician referral, or self-referral.

- **Comprehensive Care Management.** Another way that SCAN addresses social risk factors is by assessing needs through in-person visits and telephonic care management. Depending on the level of need, as determined by the HRA or other assessments, each SCAN member is assigned a care navigator or a

³ Retrieved on November 10, 2018 at: <http://www.nachc.org/research-and-data/prapare/>.

complex care manager. Care navigators and managers assist enrollees in communicating with their physicians, re-ordering medications, completing health screenings, and making connections to community resources. High need members are assigned to a complex care manager, which is usually a nurse, social worker, or counselor, who conducts telephonic and in-home assessments. Dual members may receive additional assessments to determine if they meet state eligibility criteria for LTSS.

In addition, care managers promote patient engagement and self-management. SCAN members receive personalized coaching to improve treatment and plan adherence, self-management of chronic conditions, and communication with clinicians. Case navigators and managers are trained in motivational interviewing to help members identify and articulate goals that are important to them. They also identify resources (e.g., housing, food, and transportation) that are available in the community through the website Aunt Bertha and facilitate access to services as needed.

SCAN also coordinates LTSS for members in the FIDE SNP. SCAN contracts with a range of community-based organizations and vendors to facilitate the provision of LTSS, including in-home personal care (e.g., assistance with bathing, dressing, and housekeeping), adult day care, meal delivery, and transportation.

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

SCAN is implementing several promising strategies to improve care for patients with social risk factors. Examples include the Connecting Provider to Home Pilot, the Insights program to manage behavioral health, a pilot addressing social isolation, new supplemental benefits (Home Advantage and Returning to Home) to keep people living in their homes safely, and telehealth services.

- **Connecting Provider to Home Pilot.** One promising strategy to improve care and identify social risk factors is SCAN's pilot Connecting Provider to Home, designed to overcome the disconnect that occurs between functioning at home and the picture presented during an office visit. The pilot focuses on improving physical and mental health by engaging patients in their health care, improving doctor/patient communication, providing education, removing barriers, and connecting patients with resources. Culturally and linguistically appropriate social workers and community health workers partner with primary care physicians and care teams to address social determinants of health. To date, the pilot has served nearly 600 patients and worked with six provider groups. Evaluations show that the pilot is improving patient and provider satisfaction as well as reducing emergency room (ER) visits and hospitalizations. Additional information on outcomes is included later in this letter.
- **Insights.** A second strategy is providing behavioral therapy for depression through the Insights program. Insights uses culturally sensitive and linguistically appropriate licensed social workers to conduct cognitive behavioral therapy in members' homes to address anxiety and depression. The program has served nearly 500 individuals over two years. Evaluations show significant improvements in both anxiety and depression following treatment. Additional information on outcomes is included in a later section.
- **Member2Member Peer Program.** A third strategy is Member2Member, an outreach program conducted by peer advocates (SCAN members who are also employees) who work to increase health outcomes for members by encouraging positive health behavior through strengths-based communications and motivational interviewing. Advocates build rapport with members as peers who

can discuss topics like physical activity, bladder control, mental health, and the risk of falling from the perspective of someone who is facing some of the same concerns. They also help members with accessing community resources. Evaluation results will be available in April, but initial reports are positive.

- **Social Isolation.** A fourth strategy is addressing social isolation among community-based seniors. SCAN deployed a pilot program to address issues of isolation and other health problems. The intervention is focused on engaging members through groups in the community and having them participate in physical activity together. Evaluations are still pending.
- **New Supplemental Benefits.** In 2019, SCAN will offer two new supplemental benefits that address social risk factors: Home Advantage and Returning to Home. Both benefits are part of SCAN's health plan, with no additional cost for members.

Home Advantage – includes an annual in-home safety assessment conducted by a licensed Occupational Therapist and a plan for identifying risk from falls or injury and potential hazards in the home. Home Advantage is based on learnings from the CAPABLE model,⁴ which was developed at the Johns Hopkins School of Nursing for low-income seniors to safely age in place. It also includes a follow-up in-home visit from a SCAN care navigator who helps members implement the safety plan and connects them to resources in the community. This benefit is in addition (not a replacement) to Medicare-covered home health services.

Returning to Home – is designed to help with personal care services immediately following a discharge from a hospital or skilled nursing facility. A patient, family member, or doctor can request the program within seven days of being discharged. Specific benefits include:

- o Personal in-home care, which includes up to 4-hour in-home care visits (16 hours total per year) to help with activities of daily living such as, bathing, dressing, laundry, bed linen changing, light housekeeping, caregiver relief, etc.;
 - o Home delivered meals for up to 28 days (84 meals maximum per year);
 - o Instructions for taking prescriptions safely; and
 - o Ongoing personal phone support services from a SCAN care navigator to help with questions about discharge plans, determine what is needed for a safe return home, and coordinate next steps, such as follow-up doctor visits, home health, durable medical equipment, and physical therapy.
- **Telehealth.** SCAN supports telehealth services as a promising strategy for patients and their caregivers who are unable to travel to a doctor's office. However, for telehealth to be a useful tool depends on the patient's ability to use the technology and the type of care needed. In 2019, SCAN is offering a telehealth benefit to its plan members for non-threatening conditions.

⁴ Retrieved November 10, 2018 at: https://nursing.jhu.edu/faculty_research/research/projects/capable/index.html.

4. 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?

SCAN evaluates all of its programs to determine their quality outcomes, effectiveness, cost, and return on investment. Below are examples of SCAN programs that address social risk factors and show positive health outcomes.

- **Connecting Provider to Home Pilot.** SCAN's evaluation of the Connecting Provider to Home Pilot indicates health improvements and lower costs. Evaluating two rounds of data, including a controlled match, found a statistically significant decrease in ER visits and hospitalizations and a positive return on investment. Additionally, there were improvements in glycated hemoglobin (A1C) with a statically significant reduction in A1C scores for diabetic members in the program. This reduction was especially pronounced for people whose diabetes was uncontrolled. Metrics on patient and provider satisfaction were also positive.
- **Insights.** SCAN evaluated the use of in-home cognitive behavioral therapy provided by social workers to seniors with depression. The program led to members' improvements in depressive symptoms as measured by the PHQ-9 (a depression screening tool). Client depression levels decreased from 11 to 5 in the PHQ-9 while anxiety dropped from a 12 to a 6 in the Geriatric Anxiety Scale. Program results were equally significant across client's race, ethnicity, and preferred language.
- **LTSS/Care Management.** SCAN found that frail seniors in its FIDE SNP who received LTSS had a 20 percent reduction in the hospitalization rates among frail dually enrolled members receiving care management services compared to individuals who were similar in complexity. This evaluation, which includes a pre/post comparison of hospitalizations, emergency department visits, and other outcomes, has consistently found positive effects from care management.

In addition, SCAN compares scores on HEDIS measures for each plan to scores from other California plans and national averages. From SCAN internal documents, we confirmed that our SNPs performed at or above the national average on measures related to blood pressure control for patients with hypertension (HTN), colorectal cancer screening, medication reconciliation post discharge, and three measures related to care for older adults (assessment for pain, functional status, and medication reconciliation).

5. What are the best practices to refer beneficiaries to social service organizations that can address social risk factors?

Several best practices used by SCAN to address social risk factors include:

- **Person-Centered Care Management.** Using a person-centered approach to address high need patients' health and social needs is another SCAN best practice. This means moving beyond the medical model and taking into consideration what matters most to patients, such as supporting their quality of life and function; minimizing the burden on family; addressing concerns about role changes and illness stigma; and acknowledging uncertainty, hopes, fears and spiritual concerns.

Additionally, care managers meet patients in their homes to determine social needs. For example, if a care manager discovers that a patient's main concern is finding affordable housing or getting enough food to eat, then taking care of health concerns may be an afterthought for the patient. SCAN care managers focus on the whole person and connect them to community-based services to help meet their needs. Lastly, care is culturally and linguistically appropriate. Hiring staff from local communities who speak the same language as the patient, who understand the resources available, and who know how to identify and remove barriers in a culturally appropriate manner is key to achieving rapport, trust, and outcomes.

- **Closing the Loop on Care.** Another best practice is that SCAN focuses on closing the care loop by working with high need members to help them put their treatment plans into practice. This is important because many providers write prescriptions and make treatment recommendations for their patients, but are unaware of what happens to them after they leave the office, unless they return for another appointment.

SCAN's approach is to work with members to develop goals and care plans that include identifying social support and care navigation needs, discussing personalized goals, needs, and preferences matched against personalized treatment options, and adjusting for variables that may impact appropriate treatment selection. Once interventions are implemented, the focus is on efficacy of the intervention and continuous improvement of the plan of care.

For high need members, regardless of the type of MA contract, SCAN emphasizes the right to self-determination, care management, coaching and navigation on benefits, health care utilization, and community resources. For example, upon enrollment, each dually enrolled member is assigned to a Personal Assistance Line (PAL) navigator, who is bilingual (Spanish and English). The PALs are well-trained in customer service and able to answer questions about Medicaid benefits, identify community resources through the website Aunt Bertha, and make referrals. This person stays with the member as their personal assistant for care to ensure that care is delivered and outcomes are achieved.

- **Health Risk Assessments.** Another SCAN best practice is assessing individuals' health risks, including social risk factors. Using a screening tool to identify an individual's social and health care needs to inform the plan's targeting of services is best practice, especially if the HRAs collects information related to functional status, and social risk factors (e.g., whether the individual is living alone, food insecurity, etc.). This data is difficult to obtain through other means such as diagnosis and procedure codes.
- **Transportation Services.** SCAN provides its members (99 percent) with a transportation benefit to enable them to travel to and from medical appointments.
- **Alternative Pain Management.** SCAN provides its members (over 99 percent) with chiropractic and/or acupuncture benefits to reduce pain and help prevent opioid addiction.
- **Medication Adherence by Telephone.** Through a telephonic program, bilingual care managers provide support to SCAN members and reduce barriers to medication adherence.
- **In-Home Palliative Care.** SCAN uses an in-home palliative care model with an outside organization to provide palliative care for members.

6. What lessons have been learned about providing care for patients with social risk factors?

Lessons learned, based on SCAN's experience with providing care for patients with social risk factors, include: 1) people with high needs may require a human connection to meet their health goals; 2) people with chronic conditions may not have the coping skills necessary to follow a treatment plan without assistance; and 3) physicians may not have the time to address patients' social risk factors during an appointment, resulting in treatment plans that are based on limited information.

- **Human Connection.** First, many patients with significant health and social needs require a human connection to meet their health goals and treatment plans. For example, providers may ask patients to use specific technology and equipment to help with health conditions (e.g., iPads, iPhones, oxygen tanks, etc.) that they do not understand how to use. Some patients benefit from repeated instructions on how to use technology, and without this, the equipment is not used and health conditions may not improve. In addition, some people will never learn how to use certain technology because of a variety of barriers. Without in-person linguistically and culturally appropriate outreach, these barriers go unnoticed and unaddressed and alternative more appropriate interventions are not implemented.

An example is Mrs. W., an 85-year-old low-income member with end-stage congestive heart failure who lives alone. Her provider ordered her an electronic scale and a tablet to track her weight. Vision and balance issues make it impossible for her to step onto the scale without assistance of another person and read the scale, plus she does not have a way to keep the tablet charged. After an in-home visit from a social worker and community health worker, she and her care team decided to get a different scale and develop a manual way for her to track her weight and share it with her doctor.

- **Coping Skills.** Second, some patients with social risk factors lack adequate coping skills to successfully navigate the health system and find community-based services on their own. An example is a woman named Sue who enrolled in Insights, which addresses seniors' and caregivers' barriers to accessing mental health care. Sue is a 71-year-old monolingual Korean speaker and the primary caregiver for her younger sister with Alzheimer's. She was experiencing stress due to caregiving and depression from the loss of her adult son. After receiving Insights interventions, including regular cognitive behavioral therapy and coping strategies such as routines, problem-solving, and journaling, her mental outlook improved. Sue felt she had more confidence to handle difficult situations and a better relationship with her sister.
- **Limited Information.** Third, many physicians have limited time to spend with patients and are not able to ask questions about social risk factors. Even when physicians collect data on social risks, they may have limited awareness of the community-services for patient referrals. For example, Mr. E is a senior who was living in a mini RV with no running water, cooking facilities, or electricity. He had multiple ER and hospital admissions due to chronic obstructive pulmonary disease, HTN, cancer, depression, chronic pain, and more. After being connected to community resources that provided housing, behavioral health services, food pantry, personal care, meal prep, and transportation, Mr. E's health greatly improved. He has not had any further ER or hospital visits and now follows a treatment plan.

To alleviate these issues, SCAN recommends that providers use standardized HRAs to capture social risk factors. Providers who are not aware of external resources to make referrals to patients should partner with organizations to help them develop patient-centered care to address social risk factors, rather than focusing

solely on medical issues. For example, it is important that high need seniors are assessed in their homes to identify risk factors and community-based services that can help them.

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

Barriers to tailoring services to patients with social risk factors include a lack of protocols that incorporate social risk identification and interventions, a lack of incentives and reimbursement for providers, and a lack of available community-based support systems. First, as mentioned earlier, providers should use different protocols to target social risk factors for high need populations, such as seniors and people with disabilities. Second, providers are not paid for addressing social risk factors. Additional incentives and reimbursement or a realignment of incentives would encourage physicians to pay more attention to patients' social needs. Third, providers must be aware of, and their systems must enable the use of existing codes available for social risk factors, such as the ICD-10 code for homelessness and CPT II codes for screenings and interventions.

Fourth, providers often do not close the care loop for high need individuals. Providers see patients and make treatment recommendations, but do not know what happens to them afterward. A feedback system would help ensure that individuals receive appropriate community resources and that the services are directed to those most in need. Finally, SCAN is concerned that as large health plans begin using small community organizations to manage social risk factors, it could lead to fewer community-resources available for seniors who are not enrolled in large plans. As community resources become part of the health care ecosystem, they need more support with technology and funding in order to meet the needs of Medicare beneficiaries with social risk factors.

8. For patients with social risk factors, how does patients' disability, functional status, or frailty affect the provision of services?

Patients' disability, functional status, and frailty must be considered when addressing social risk factors. Factors such as patient ability, provider practices, and patient trust can affect the provision of services. For example, not every person benefits from digital solutions. Although telehealth must be a part of the solution, digital solutions can be problematic for people who are homebound and do not have anyone to assist them with the technology.

In addition, as mentioned previously, providers should use different protocols to assess various populations and a person-centered approach to determine and address individual social risks. Finally, building relationships and trust with some high need patients may take time before they accept social services. Some high needs individuals may not trust treatment recommendations made to them by physicians, plans, and community organizations, especially if they were promised services in the past that did not materialize.

9. 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?

The most important social risk factors to capture are data on housing, nutrition, transportation, isolation, living alone, and access to affordable medications and health providers. SCAN has routinely collected data on social risk factors through the HRAs for the SNP programs and now collects this information from the HRAs from all of our programs. In addition to the HRAs, data are collected at point of sale, and at doctors' offices when patients fill out health forms. We recommend that social risk data is collected in partnership with other public data sources like Social Security and local municipalities to have complete information for each patient. However, we understand that current HIPPA rules prevent some data sources from being shared.

Collecting data can be burdensome for providers, patients, and plans. For providers, collecting social risk data can be frustrating if they do not have a clear path for what to do with the information or knowledge of community-based services for patient referrals. Patients are burdened by data collection because they are often asked to provide the same information over and over about their health conditions, and do not know why the data are being collected. For plans, data collection can be difficult because some patients are reluctant to provide personal information because of concerns about privacy and how the data will be used. Integrating data and promoting greater interoperability among health systems would ease some of these burdens.

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

SCAN supports standardized data elements for EHRs to collect social risk data for consistency and accuracy across plans and providers. Specifically, we recommend using the PRAPARE model for standardization. PRAPARE is a national effort to help health centers and other providers collect the data needed to better understand and act on their patients' social determinants of health. The PRAPARE assessment tool consists of a set of national core measures as well as a set of optional measures for community priorities. It was informed by research, the experience of existing social risk assessments, and stakeholder engagement. It aligns with national initiatives prioritizing social determinants measures proposed under the next stage of Meaningful Use, clinical coding under ICD-10, and health centers' Uniform Data System.⁵

11. 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?

Barriers to collecting social risk data include: 1) providers are not coding for social risks even when there are codes available, e.g., homelessness; 2) providers are not reimbursed for collecting data on social risk factors; 3) providers do not have a clear path for what to do with the data collected; and 4) members of the public are not often aware of the importance of providing data on health equity factors to providers and plans.

⁵ Text retrieved on November 10, 2018 at: <http://www.nachc.org/research-and-data/prapare/>.

The current focus on social determinants of health in the medical community, the inclusion of social risk factors in EHRs, the aggregation of community resources in on-line data bases, and the growing interest in community health workers and other in-home care coordination and management are all very promising. Ensuring that laws and regulations allow for appropriate sharing of data and that new data analytic models use social risk factors will greatly improve data collection and the ability to tailor services.

SCAN Health Plan appreciates your interest in addressing social risk factors for Medicare beneficiaries and improving health outcomes for people with complex health conditions. We look forward to partnering with you in the future on this important work.

Sincerely,

A handwritten signature in black ink, appearing to read "Eve Gelb". The signature is fluid and cursive, with the first name "Eve" written in a larger, more prominent script than the last name "Gelb".

Eve Gelb
SVP, Health Care Services
SCAN Health Plan