HHS Strategic Approach to Addressing Social Determinations of Health: Agency Program, Activity, and Policy Highlights

U.S. Department of Health and Human Services

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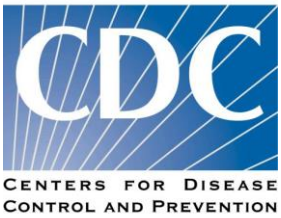
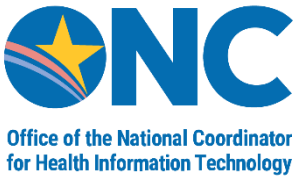
HHS AGENCIES





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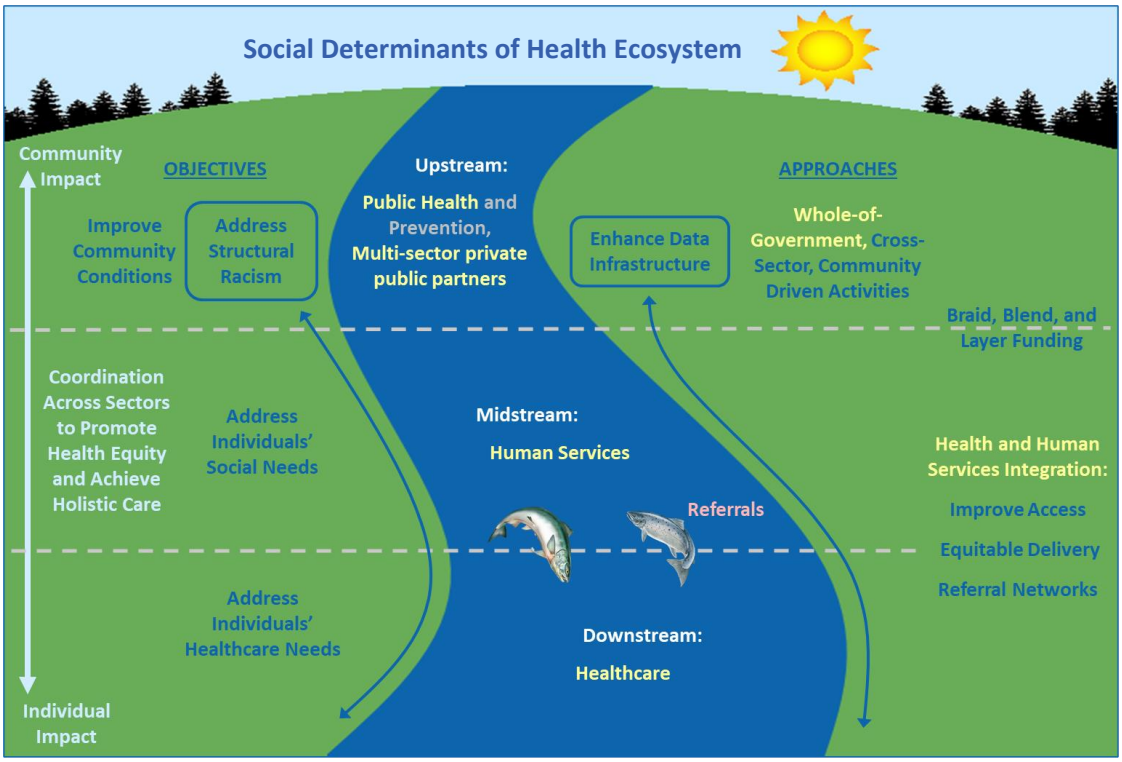
EXECUTIVE SUMMARY

Social determinants of health (SDOH – also referred to as social drivers of health)[1] are estimated to account for as much as 50 percent of county-level variation in health outcomes.[2] SDOH and unmet individual-level health-related social needs (HRSNs)[3] have the potential to impair health and well-being, with a wide-body of research documenting the impact of both SDOH and HRSNs on health outcomes. The U.S. Department of Health and Human Services (HHS) envisions a future in which all individuals, regardless of their social circumstances, have access to aligned health and social care systems that achieve equitable outcomes through high-quality, affordable, person-centered care. As described in Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts, a number of interventions to address SDOH and HRSNs have demonstrated success in reducing barriers to health and well-being, improving health outcomes, and/or lowering health care spending. Addressing these SDOH involves coordinating across multiple sectors and a recognition of the many factors that contribute to disparities in health outcomes.



Note: Adapted from Castrucci B, Auerbach J. Meeting Individual Social Needs Falls Short of Addressing Social Determinants of Health. Health Affairs Blog. January 16, 2019

[1] Social determinants of health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks (Healthy People 2030, https://health.gov/healthypeople/priority-areas/social-determinants-health).

[2] Hood CM, Gennuso KP, Swain GR, et al. County Health Rankings: Relationships Between Determinant Factors and Health Outcomes. American Journal of Preventive Medicine. February 2016; 50(2):129-135. doi:10.1016/j.amepre.2015.08.024

[3] Health-related social needs are individual-level factors pertaining to a person's social circumstances that can affect their health such as their personal finances, housing situation, access to affordable, health nutrition options, and education opportunities.

In April 2022, HHS released three documents in support of HHS' strategic approach to address SDOH. These documents described a three-prong strategy to address SDOH through:

Goal 1: Enhancing data infrastructure;

Goal 2: Improving connections between health and social service providers; and

Goal 3: Engaging in whole-of-government collaborations to implement comprehensive solutions.

In addition, the White House worked in collaboration with HHS and agencies across the federal government to develop the U.S. Playbook to Address Social Determinants of Health ("Playbook") released in November 2023. The Playbook highlights efforts from across the federal government to address SDOH by improving the social circumstances of individuals and communities. In tandem with the Playbook, HHS also released a Call to Action on Addressing Health-Related Social Needs in Communities Across the Nation ("Call to Action"), which calls upon individuals working in health care, social services, public and environmental health, government, and health information technology to partner and work together across silos to address HRSNs through community partnerships to improve the health and well-being of all Americans. The Call to Action lists key actions that partners in different sectors can take to help build a stronger, more integrated health and social care system, with a focus on community care hubs, a type of backbone organization that leverages community capacity and expertise to allow for an efficient, scalable approach to health care and community-based organization (CBO) partnerships to facilitate care coordination and service delivery to address HRSNs.

This report highlights key programs, activities, and policies of HHS' strategic approach, including early accomplishments to date and stories of the on-the-ground impact that these initiatives are making in people's lives. A number of these agency initiatives are also described in the Playbook. The agency activities are organized by the three goals listed above:

- **Goal 1: Enhancing data infrastructure**:
  HHS agencies are building better data infrastructure by advancing SDOH standards to inform research, patient care, and interoperability; they are working with partners in the health care, public health, and social service sectors to use these data to improve care. Building a robust and interconnected data infrastructure to support care coordination and evidence-based policymaking can help us facilitate progress on SDOH and HRSNs and monitor the impact on populations that have been historically marginalized and are often underserved. A strong data infrastructure can help us better identify where there are disparities in health outcomes and social needs that need to be addressed and can help us ensure that HHS programs are addressing those needs in partnership with community leaders.

  Beyond advancing data interoperability standards, to accomplish this goal, agencies are increasing their collection of standardized SDOH data within their programs and working to create interoperable, shareable apps and platforms for health and social care professionals,

organizations, and researchers to access data on individuals' SDOH and HRSNs. HHS is building out our data infrastructure to meet the evolving needs of our health care and social services and support system and research community. As it matures, this infrastructure can support a better understanding of SDOH and HRSNs and help organizations, providers, and payers meet these needs through a more seamless care experience.

- **Goal 2: Improving connections between health and social service providers:**
  HHS is supporting a holistic approach to addressing individual needs that ensures individuals can access appropriate services regardless of their entry point – whether through health insurance, health care, public health, or social services. Improving access to and affordability of equitably delivered health care services and supporting partnerships between health care, social care providers, and other community partners is important to reducing disparities in health status and improving health outcomes for all. Such partnerships are vital to addressing social needs and by extension, improving health outcomes and well-being.

  To accomplish this goal, agencies are supporting partnerships between health and social service providers through a variety of mechanisms, including community care hubs, community health workers, and innovative payment models and policies. HHS is supporting research to identify effective solutions to address adverse SDOH and unmet HRSNs and is putting evidence into action through programs that support language access, food access, employment, and housing, and facilitating closed-loop referrals that ensure individuals' needs are met. These programs and policies can help ensure that individuals are connected to resources that can meet their needs and gain access to services that improve their well-being. The activities being undertaken under Goal 1 will help facilitate these care coordination efforts and evaluations of policies and programs to advance these efforts.

- **Goal 3: Engaging in whole-of-government collaborations to implement comprehensive solutions:**
  HHS is working to improve integration between government agencies that fund the delivery of health care services and social services across the federal government, and with state, local, and tribal and territorial governments. The Department is also working to support actions at the community level that support and sustain systemic interventions through multi-sector partnerships. Whole-of-government approaches, public-private partnerships, and community engagement are necessary in addressing social needs and enhancing population health for all. Similar to addressing the needs of individuals, tackling policy challenges related to addressing SDOH requires a comprehensive approach across federal agencies and levels of government ("whole of government") and the private sector, with an emphasis on working with local community-based efforts to assess local needs, plan development, and service delivery through networks of CBOs.

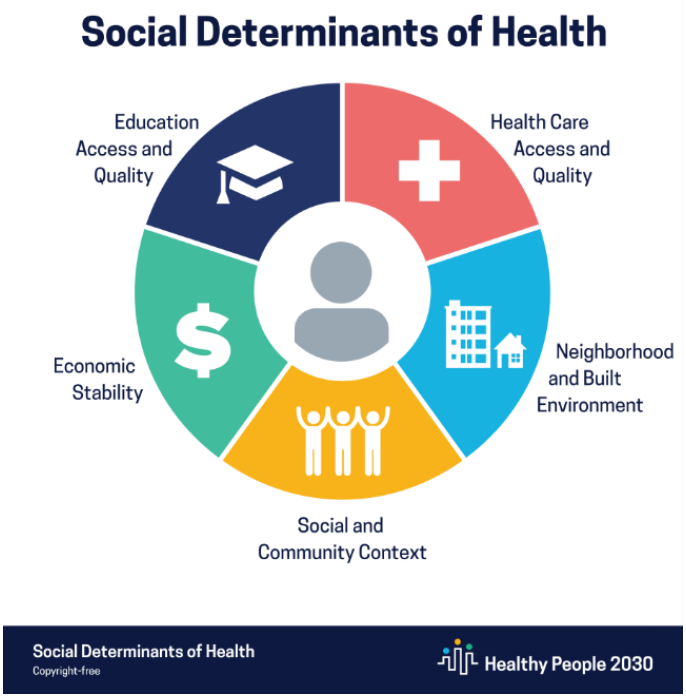
  To accomplish this goal, HHS is collaborating with other Departments across the federal government, including the Department of Housing and Urban Development, the U.S. Department of Agriculture, the Department of Justice, and the Department of Labor, as well as partnering with other levels of government. These partnerships are supporting efforts to

increase housing and food security, increase enrollment in and receipt of benefits, and develop community-driven solutions to improve SDOH. In addition to directly addressing social needs, these efforts will also contribute to the capacity of community-led efforts to coordinate care under Goal 2.

Collectively, these actions represent foundational steps HHS is taking to encourage health care providers to screen and address HRSNs through referrals to social care providers by, among other strategies: aligning payment incentives; advancing electronic patient care record interoperability standards; supporting community-led care coordination infrastructure and partnerships; and improving the performance of HHS' own programs through better data collection and coordination with other agencies.

The goals that this report is organized around, which are reflective of the Department's SDOH work, focus on critical drivers of success for efforts related to addressing SDOH. In addition, agency programs, including those focused on addressing SDOH and HRSN, also measure progress related to the Department's longstanding public health goals to improve the nation's health and well-being as described in the Healthy People 2030 SDOH domains:

- Health Care Access and Quality, focused on increase access to comprehensive, high-quality health care services;
- Neighborhood and Built Environment, focused on creating neighborhoods and environments that promote health and safety;
- Social and Community Context, focused on increasing social and community support;
- Economic Stability, focused on helping people earn steady incomes that allow them to meet their health needs; and
- Education Access and Quality, focused on increasing educational opportunities and helping children and adolescents do well in school.



Measuring outcomes across these domains helps the Department understand the downstream impacts of agency programs.

Agency activities discussed in this report related to each of the Healthy People 2030 SDOH domains are listed below.

Healthy People 2030 SDOH Domain	Illustrative Examples of Agency Programs, Activities, and Policies Related to Domain
Health Care Access and Quality	• AHRQ Social Determinants of Health Database (p. 14) • AHRQ Multiple Chronic Conditions electronic Care Plan Initiative (p. 15) • CDC Community Health Workers for COVID Response and Resilient Communities (CCR) initiative (p. 32) • CDC Racial and Ethnic Approaches to Community Health (p. 59) • CDC Simulation Model of Intervention Linking Evidence to SDOH (SMILES) Project (p. 18) • CMS Innovation Center Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model (p. 18) • CMS Innovation Center Accountable Health Communities Model (p. 33) • CMS Innovation Center Enhancing Oncology Model (EOM) (p. 33) • CMS Innovation Center Making Care Primary (MCP) Model (p. 33) • CMS Innovation Center States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model (p. 33) • CMS Innovation Center Value Based Insurance Design (VBID) Model (p. 37) • CMS Medicaid and CHIP Coordinated Enrollment with Food and Nutrition Service Programs (p. 62) • CMS Medicaid and CHIP Framework for Coverage of Health-Related Social Needs (p. 36) • CMS Medicare Advantage Special Needs Plans (p. 37) • CMS Medicare Shared Savings Program Advance Investment Payments (p. 37) • CMS Medicare Physician Fee Schedule (p. 37) • CMS SDOH Risk Assessment Payment (p. 40) • CMS Quality Measure Reporting and Pay-for-Performance Programs (p. 18) • HRSA Health Center Program Uniform Data System (p. 20) • NIH PhenX Social Determinants of Health Collection (p. 21) • NIH Community Partnerships to Advance Science for Society (ComPASS) Program (p. 43) • NIH Advancing Integrated Models of Care to Improve Maternal Health Outcomes among Women Who Experience Persistent Disparities (p. 43) • OASH Healthy People 2030 (p. 27) • OMH Promoting Equitable Access to Language Services in Health and Human Services (p. 46) • ONC Leading Edge Acceleration Projects (p. 24) • SAMHSA Certified Community Behavioral Health Clinics (CCBHC) (p. 51)

Neighborhood and Built Environment	• ACF Runaway and Homeless Youth Program (p. 29) • ACL Community Care Hubs (p. 30) • ACL Housing and Services Resource Center (p. 55) • CDC Simulation Model of Intervention Linking Evidence to SDOH (SMILES) Project (p. 18) • CDC SDOH Accelerator Plans (p. 56) • CDC Addressing Conditions to Improve Population Health (ACTion) (p. 56) • CDC Racial and Ethnic Approaches to Community Health (p. 59) • CMS Innovation Center Accountable Health Communities (AHC) Model (p. 33) • CMS Innovation Center Value-Based Insurance Design (VBID) Model (p. 37) • CMS Medicaid and CHIP Framework for Coverage of Health-Related Social Needs (p. 36) • CMS Medicaid and CHIP Coordinated Enrollment with Food and Nutrition Service Programs (p. 62) • HRSA Health Center Program Medical-Legal Partnerships (p. 41) • IHS Produce Prescription Pilot Program (p. 42) • NIH Bridge-to-Care Initiative (p. 43) • NIH Advancing Integrated Models of Care to Improve Maternal Health Outcomes among Women Who Experience Persistent Disparities (p. 43) • NIH Pilot Interventions to Integrate Social Care and Medical Care to Improve Health Equity (p. 43) • NIH Social, Behavioral, and Economic Impacts of COVID-19 Initiative (p. 21) • SAMHSA ReCAST: Resiliency in Communities After Stress and Trauma (p. 46)
Social and Community Context	• ACF Regional Anti-Trafficking Initiative Support and Engagement (p. 53) • ACF Runaway and Homeless Youth Program (p. 29) • CDC Simulation Model of Intervention Linking Evidence to SDOH (SMILES) Project (p. 18) • CDC SDOH Accelerator Plans (p. 56) • CDC Addressing Conditions to Improve Population Health (ACTion) (p. 56) • CMS Innovation Center Value-Based Insurance Design (VBID) Model (p. 37) • CMS Medicaid and CHIP Framework for Coverage of Health-Related Social Needs (p. 36) • HRSA Health Center Program Medical-Legal Partnerships (p. 41) • NIH Adolescent Brain Cognitive Development (ABCD) Study (p. 21) • NIH Bridge-to-Care Initiative (p. 43) • OMH Promoting Equitable Access to Language Services in Health and Human Services (p. 46) • ONC Health IT Certification Program (p. 23) • ONC Social Determinants of Health Information Exchange Toolkit (p. 24)

	• ONC United States Core Data for Interoperability (p. 23)
Economic Stability	• ACF Regional Anti-Trafficking Initiative Support and Engagement (p. 53) • ACF Runaway and Homeless Youth Program (p. 29) • ACL Housing and Services Resource Center (p. 55) • CDC Simulation Model of Intervention Linking Evidence to SDOH (SMILES) Project (p. 18) • CDC SDOH Accelerator Plans (p. 56) • CDC Addressing Conditions to Improve Population Health (ACTion) (p. 56) • CMS Innovation Center Accountable Health Communities (AHC) Model (p. 33) • CMS Medicaid and CHIP Framework for Coverage of Health-Related Social Needs (p. 36) • HRSA Health Center Program Medical-Legal Partnerships (p. 41) • IHS Produce Prescription Pilot Program (p. 42) • NIH Bridge-to-Care Initiative (p. 43) • NIH Advancing Integrated Models of Care to Improve Maternal Health Outcomes among Women Who Experience Persistent Disparities (p. 43) • NIH Pilot Interventions to Integrate Social Care and Medical Care to Improve Health Equity (p. 43) • OMH Community-based Approaches to Strengthening Economic Supports for Working Families (p. 63) • SAMHSA Transforming Lives Through Supported Employment Program (p. 47) • SAMHSA Projects for Assistance in Transition from Homelessness (PATH) (p.49) • SAMHSA Treatment for Individuals Experiencing Homelessness (p. 49)
Education Access and Quality	• ACF Runaway and Homeless Youth Program (p. 29) • NIH Bridge-to-Care Initiative (p. 43) • OMH Promoting Equitable Access to Language Services in Health and Human Services (p. 46) • SAMHSA Transforming Lives Through Supported Employment Program (p. 47)

Examples of specific types of outcomes for the populations served by programs focused on SDOH or HRSNs are listed below. These metrics are illustrative and do not represent all outcomes that agencies are using to measure the success of their programs.

Healthy People 2030 SDOH Domain	**Example SDOH and HRSN Metrics Being Measured**
Health Care Access and Quality	• Hospital Readmissions, Inpatient Utilization, and Emergency Department Use • Health Disparities in Chronic Conditions • Preventative Services Utilization • Clinical Quality Outcomes • Everyday Functioning and Health • Child and Adolescent Well-Care Visits • Delay in Progression of Chronic Conditions
Neighborhood and Built Environment	• Number of Individuals Who Identify Housing as a Critical Need • Number of Individuals Stably Housed • Housing Security • Transportation Insecurity
Social and Community Context	• Age-adjusted Morbidity and Mortality • Food Security • Quality of Life • Resolution of Core Needs
Economic Stability	• Financial Status • Stability in Employment and Education
Education Access and Quality	• Stability in Employment and Education

Other outcomes that the Department is tracking as part of Healthy People 2030 are included in the appendix.

These and other actions being taken by HHS, and across the federal government, as well as cross-sector initiatives at the community level, represent important foundational steps toward ensuring that all individuals have equitable opportunities to achieve optimal health and well-being.

HHS agency initiatives to address SDOH and HRSNs are in various stages of implementation, from recently announced policy changes that are in the process of taking effect across the U.S. to agency initiatives that have been integrated into communities and will continue to evolve in the years to come. There are also emerging topics in this area that HHS continues to respond to as their importance becomes better understood. For example, one HRSN not covered in this report but that has garnered increased public policy attention is social connectedness. The Surgeon General's 2023 advisory, *Our Epidemic of Loneliness and Isolation*, drew attention to the importance of this factor in contributing to individual and population health outcomes, and HHS is continuing to explore opportunities to address this challenging topic. The variation in program maturity, availability of resources for program evaluation, and robustness of data collection all affect the degree to which the outcomes of these programs are available now and in the future. As these initiatives mature, HHS will monitor data regarding the impact the programs are making in the lives of millions of Americans to inform future policymaking.

HHS AGENCY SDOH AND HRSN PROGRAM, ACTIVITY, AND POLICY HIGHLIGHTS

Goal One: Enhanced Data Infrastructure

Building a robust and interconnected data infrastructure that supports the collection, exchange, and use of health and health-related data is important to promote care coordination, evidence-based policymaking, and the use of SDOH, HRSN, and health equity data to help identify and eliminate health disparities and improve health outcomes at an individual and population level. A strong, interoperable data infrastructure can enable communities and providers to better identify where there are disparities in health outcomes and social needs that need to be addressed and can help ensure that HHS programs are addressing those needs. HHS agencies are helping facilitate better data infrastructure by working with partners in the health care and social services sectors to advance SDOH standards to improve delivery and coordination of patient care and inform research.

Agency for Healthcare Research and Quality (AHRQ)

Supporting an SDOH Database for Patient Centered Outcomes Research

To assist researchers and others addressing SDOH in identifying geographic areas and population groups that might be of particular concern to them, AHRQ developed an easily linkable SDOH-focused database from a wide array of public data sources to use in patient centered outcomes research, inform approaches to address emerging health issues, and ultimately contribute to improved health outcomes. The database was developed to make it easier to find a range of well documented, readily linkable SDOH variables across domains without having to access multiple source files, facilitating SDOH research and analysis. Variables in the files correspond to five key SDOH domains – social context, economic context, education, physical infrastructure, and healthcare context – and can be linked to other data at three levels of geography.

Accomplishments to Date

An initial SDOH database was developed in December 2020 and was subsequently updated and expanded in July 2022. There have been 36,800 database file downloads, and it has been used in 51 published research articles.

Examples of On-the-Ground Impact

The SDOH database is contributing to a range of efforts to produce data to improve health outcomes. One project, led by the National Institutes of Health's National Institute of Environmental Health Sciences, is integrating environmental, climate-related, and societal data with health outcomes data. The project's overall goal is to create data resources to identify and reduce the health effects associated with environmental or climate-related events and improve patient and population outcomes. This project is developing information that can be used by clinicians, public health officials, and others to

help people stay healthier and safer, taking into account the social environment where people live. The SDOH Database is also a resource for PCORnet®, the National Patient-Centered Clinical Research Network, a Patient-Centered Outcomes Research Institute funded national resource intended to improve the nation's capacity to efficiently conduct patient-centered comparative clinical effectiveness research. PCORnet® Network Partners transform data from everyday healthcare encounters from more than 30 million people across the U.S. each year into a consistent format to enable faster more efficient patient-centered research. The Coordinating Center for PCORnet® is creating and supporting tools to enable linkage to the SDOH Database to make it possible to identify variations in treatments based on social environments and identify more effective methods of tailoring treatments to social circumstances, resulting in safer, more effective, higher quality care. Finally, linking the SDOH Database to the Healthcare Cost and Utilization Project (HCUP) supports research on inpatient and outpatient hospital utilization and outcomes by patient and community characteristics. For example, to identify populations of greatest need by showing that emergency department visits related to substance use disorder vary by patient race/ethnicity and community vulnerability. This information can assist state and local health planners to more effectively allocate resources within their communities to address issues like the opioid crisis, access to mental health care, and maternal morbidity and mortality. For example, the Michigan Value Collaborative used the SDOH database in a regional equity analysis of care for heart failure patients to provide insight into barriers to care that patients may be facing.

Incorporating HRSNs into Electronic Care Plans to Better Address Chronic Conditions

More than 25 percent of Americans have multiple chronic conditions (MCC), accounting for more than 65 percent of U.S. health care spending. These individuals have complex health needs handled by diverse providers, across multiple settings of care. As a result, their care is often fragmented, poorly coordinated, and inefficient. This also makes it difficult for clinicians and patients to engage in comprehensive, shared care planning to address both health and social needs as well as to coordinate care including with community services. Therefore, data aggregation is particularly important and challenging for people with MCC. To address this challenge, the AHRQ and the National Institute of Diabetes and Digestive and Kidney Diseases are developing and testing shared electronic care (eCare) Plan (eCP) data standards and tools designed to aggregate patient-centered data from across various clinical, home- and community-based settings for individuals with MCC. Because addressing HRSNs is central to patient-centered care, developing and implementing data standards for HRSNs is a central component of this work.

Accomplishments to Date

The eCP suite of products developed to date includes two shareable, interoperable eCP apps – one for clinicians and one for patients and their caregivers – as well as a Health Level 7 International (HL7®) Fast Healthcare Interoperability Resources (FHIR) implementation guide. The applications have been developed in alignment with the FHIR implementation guide, using SMART on FHIR technology, enabling integration with any electronic health record (EHR) system. The apps have been developed with user-informed design approaches to foster shared care planning to address health and social needs. The applications can also collect patient surveys and includes the Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE) instrument to identify HRSNs as well as an instrument

to assess caregiver strain. The applications were initially tested at Oregon Health & Science University in 2021, identifying opportunities to enhance their design and functionality. From May 2021 to February 2022, primary care clinicians and patients were recruited for participation in a two-phase user acceptance testing approach. This project demonstrated patients' and clinicians' desires to have patient-reported data available for tracking over time and to find a way to incorporate the generation and review of these data in day-to-day routines and workflows. Based on findings from this first round of implementation and testing, the applications and underlying standards have been refined and enhanced and are undergoing a second, more robust round of testing, which will include aggregation of data across multiple health systems using user-centered design and agile development.

Examples of On-the-Ground Impact

The National Institute of Aging released a Notice of Funding Opportunity for Demonstration Projects to Promote Use of Interoperable Health Records in Clinical Research to develop best practices for collecting and harmonizing medical information from EHRs of older adults and analyzing health conditions through informatics methods. They have awarded two research projects that will build on AHRQ's app and data standards to improve the delivery of person-centered care for people living with MCC. One is Multiple Chronic COnditions: MultiPle dAta SouRcEs (MC COMPARE) through the Oregon Health & Science University (OHSU), which will use the eCP to improve outcomes for people with hypertension and multiple other chronic conditions, including addressing health and social needs. The grant will facilitate the incorporation of disparate data, including social needs like food and housing insecurity, to understand variations in outcomes. OHSU has reviewed the standard codes for SDOH and mapped them internally within one EHR so that they will be available for FHIR. Based upon the eCP data standards the Office of the National Coordinator for Health Information Technology (ONC) has included two new Care Plan Data Elements in United States Core Data for Interoperability (USDCI) v4. By collecting and storing data on HRSNs and supporting shared care planning with patients and caregivers across the health care team, the eCP can serve to help clinicians, practices, and health systems serving Medicaid, Medicare, and the Children's Health Insurance Program (CHIP) to identify and address HRSNs.

Advancing Person-Centered Care Planning for People Living with or at Risk for Multiple Chronic Conditions

The need for person-centered care delivery models that improve care coordination and quality for people living with or at risk for MCC is well-recognized. There is growing recognition of the need for care plans to address SDOH. In addition, racial and ethnic minorities and populations that have been socially and/or economically marginalized are placed at quadruple jeopardy with respect to MCC, as they experience a higher burden of MCC at earlier ages, experience more barriers to accessing care, are at risk for receiving care of lower quality, and lack the resources needed to manage their conditions. Patients with low education, low health literacy, cognitive impairment, and non-English speakers are at particular risk for being overwhelmed by the high burden of treatment, limiting effective management of MCC. Comprehensive, longitudinal, person-centered care planning is designed to meet their needs and can help advance health equity.

Person-centered care plans address physical and behavioral health conditions, as well as HRSNs. Comprehensive, longitudinal, person-centered care planning is an approach to overcome the problem of fragmented care and put the "whole" person's needs and goals in the context of their lives at the center of care delivery across all providers, thereby facilitating better management of MCC. Person-centered care planning models are practiced in some health systems, settings, and populations, such as patient-centered medical homes, accountable care organizations, Medicaid health homes, pediatric complex and special needs populations, and long-term services and supports. The Centers for Medicare & Medicaid Services requires care planning in primary care demonstration projects, including Comprehensive Primary Care Plus and Primary Care First. However, person-centered care planning is not widely practiced. There are many barriers to its use and significant knowledge gaps exist regarding the most effective approaches for its implementation, scale and spread.

With the goal of fostering person-centered care planning as standard practice for persons with MCC, AHRQ has awarded a contract through Accelerating Change and Transformation in Organizations and Networks (ACTION) 4 mechanism. The goals of this contract are to:

1) Gather knowledge about the current state of person-centered care planning in practice, including person-centered care planning models in use across diverse health systems, practices, and settings; scale of existing models; implementation barriers and facilitators; and feasible solutions to implementation barriers;
2) Identify innovative, feasible models of person-centered care planning that hold promise for further development, testing, dissemination, and implementation;
3) Identify innovative digital solutions that have been leveraged as tools to support and facilitate the success of implementing person centered care planning in practice;
4) Identify key organizational, policy, payment, technology, cost, and resource requirements for implementing person-centered care planning across diverse health systems, practices, and settings; and
5) Identify key research priorities, strategies, recommendations, and next steps to advance AHRQ's mission of disseminating and implementing person-centered care planning as routine and integral practice in the care of persons with MCC.

Accomplishments to Date

AHRQ is convening a partner roundtable, learning community, and summit to accelerate the uptake of person-centered care planning in diverse settings and population, and to assure that interventions to address the SDOH are identified, considered, and addressed in care plans. This national convening of health system leaders, payers, policymakers, innovators, clinicians, and other frontline health care workers will identify effective strategies as well as research gaps to help assure all people living with or at risk for MCC develop care plans in partnership with their health care teams that address HRSNs as a crucial component of their care to improve health outcomes, reduce inequities, and avert preventable adverse events.

Centers for Disease Control and Prevention (CDC)

Assessing the Long-Term Impact of SDOH Programs on Chronic Diseases

Identifying pathways between SDOH and chronic disease outcomes is important for finding opportunities for programs, practices, and policies to decrease the burden of chronic disease and reduce disparities. The Simulation Model of Intervention Linking Evidence to SDOH (SMILES) project applies a systems science approach to build a simulation model of the interplay of SDOH and their relationship to chronic disease outcomes and related health disparities in order to assess the long-term (e.g., 5, 10, 20, 30 years) effectiveness and cost-effectiveness of programs, policies, or practices that address SDOH. SMILES focuses on five priorities areas: Built Environment, Community-Clinical Linkages, Food and Nutrition Security, Social Connectedness, and Tobacco Free Policies, and examines six chronic diseases: heart disease, cancer, stroke, Alzheimer's disease, diabetes, and chronic kidney disease. Through a multi-user, web-based, 508-compliant public use version of SMILES operating in CDC's cloud environment, SMILES will also allow users to examine the long-term impact of SDOH programs, practices, and policies on disparities in the incidence, prevalence, mortality, and quality-adjusted life years associated with the simulated chronic diseases.

Accomplishments to Date

Since October 2023, CDC has worked to lay the groundwork for building this simulation model, including expanding our prior literature review to identify effective SDOH programs, policies, and practices, planning model risk factor inputs with a focus on highlighting overlapping or shared risk factors among the simulated chronic disease outcomes, and selecting the input population dataset that will be used for the simulation model.

Centers for Medicare & Medicaid Services (CMS)

Establishing Incentives and Requirements to Increase Screening for Health-Related Social Needs

CMS recognizes that integrated information systems and data sharing capabilities at the state, federal, and health care professional level are critical to supporting the evolving role of states in ensuring appropriate, accessible, and cost-effective care for individuals with complex social needs. This data, collected at varying levels across settings and coverage types, helps health care organizations and CMS understand differences in quality of care and utilization – including the underlying reasons for variations in the provision of care to enrollees and disparities in outcomes.

Within the Medicaid and CHIP programs and the Medicare program, CMS has provided flexibilities to enable health care payers, systems, and providers to improve data collection and strengthen their infrastructure to collect and analyze SDOH data.[4] CMS also encourages states to use state and federal

[4] Centers for Medicare & Medicaid Services. SHO #21-001. Re: Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH). Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf

care coordination hubs, such as area agencies on aging or aging and disability resource centers, to ensure alignment and facilitate information exchange across social services.

Beginning in 2023, the CMS Innovation Center's ACO REACH model requires participating entities to collect beneficiary-level information on the demographic and SDOH profiles of the populations they serve. This Health Equity Data Reporting policy has led to provider groups and medical practices integrating the screening and collection of such data into their engagement workflows, often driven by new investments in population health monitoring and electronic medical record capabilities. ACOs are rewarded for these activities as their capabilities are strengthened over time.

CMS has also adopted two quality measures focused on SDOH screening in a number of quality reporting programs including the Hospital Inpatient Quality Reporting (IQR) Program, the Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program (PCHQR), the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program, the Merit-based Incentive Payment System (MIPS), and the End-Stage Renal Disease Quality Incentive Program (ESRD QIP). The Screening for Social Drivers of Health measure assesses whether a hospital, facility, clinician, or group practice implements screening for all patients who are 18 years or older for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. The Screen Positive Rate for Social Drivers of Health measure provides information on the percent of patients 18 years or older on the date of admission who were screened for all five of these HRSNs, and who screened positive for one or more of these HRSNs. Hospitals were able to voluntarily report on these two measures in May 2024 for calendar year 2023 and will be required to report on these measures in May 2025 for calendar year 2024.

In addition, CMS has proposed and finalized a Connection to Community Service Provider quality measure for use in MIPS, which provides information on the percent of patients 18 years or older who screen positive for one or more of five HRSNs (food insecurity, housing instability, transportation needs, utility help needs, or interpersonal safety) and had contact with a Community Service Provider for at least one of their HRSNs within 60 days after screening.

Finally, CMS added Health Equity Confidential Feedback Reports on two claims-based measures, which stratify data on the basis of 1) individuals who are dually eligible for Medicaid and Medicare and 2) race/ethnicity. These stratified results are calculated from data collected by standardized assessments for four provider-types: inpatient rehabilitation facilities, long-term care hospitals, home health agencies, and skilled nursing facilities (SNFs), and ask questions about the need for an interpreter, health literacy, social isolation, and transportation. CMS has also proposed and finalized the Health Equity Adjustment to the Skilled Nursing Facility Value Based Purchasing program to reward high quality care by SNFs that serve a higher proportion of residents who have been disadvantaged, marginalized, and/or underserved by the healthcare system.

Accomplishments to Date

In ACO REACH, participating entities have begun their first round of data submission related to beneficiary-level demographic and SDOH data. Both ACOs and CMS will have greater visibility on the types of HRSNs that are most prevalent in regional populations across the country, which in turn will inform ACOs' plans to develop integrated care models that address such needs (through their Health

Equity Plans, for example) and CMS' ability to create flexibilities and funding schemes that enable providers to holistically care for patients.

Examples of On-the-Ground Impact

In the Innovation Center's ACO REACH model, more than one in five ACOs report partnering with community-based organizations as a key strategy in their Health Equity Plans, leveraging these relationships to meet the HRSN challenges of underserved communities.

Health Resources and Services Administration (HRSA)

Collecting Data to Understand the Impact of Social Risk

In 2022, HRSA-funded health centers served more than 30.5 million people across the nation. Many individuals served by health centers have lower incomes and may have Medicaid or lack health insurance coverage. In addition to providing primary health care services, health centers also connect their patients to resources in the community that address HRSNs, such as food banks. Health Center Program participants are required to submit annual performance data that includes a core set of information, such as data on patient characteristics, services provided, clinical processes and health outcomes, patients' use of services, staffing, costs, and revenues as part of a standardized reporting system known as the Uniform Data System (UDS). In 2019, HRSA added several key SDOH data elements to the UDS to better understand the impact of social risk on individuals served. Gathering information on the prevalence of SDOH among health center patients better informs HRSA's efforts to improve the health and well-being of these patients and the broader communities in which they reside.

Accomplishments to Date

In 2020, HRSA began collecting data on whether health centers are using standardized social risk screening tools and which common social risks patients are screening positive for, in order to support whole-person care. In 2022, an additional indicator was included that focused on the total number of patients screened for social risk factors. The addition of this question supports a broader understanding of the impact of SDOH of patients served by health centers when assessed with an existing question focused on number of patients screening positive for common domains of social risk: food insecurity, housing insecurity, financial strain, and lack of transportation/access to public transportation. In 2022, of the health centers reporting use of a standardized screener to assess social risk, over 65 percent reported using the Protocol for Responding to and Assessing Patients' Assets, Risks & Experiences (PRAPARE) tool. Regardless of screening method, health center patients most frequently screened positive for financial strain (over 19 percent) and food insecurity (over 12 percent). Health centers may address identified SDOH through provision of enabling services that support and assist in the delivery of medical care and facilitate patient access to care, including case management, outreach, transportation, translation and interpretation, health education, and eligibility assistance. In 2022, health centers employed more than 27,400 enabling services full time equivalents (FTEs), including more than 12,300 FTEs as case managers and over 2,300 FTEs as community health workers.

Examples of On-the-Ground Impact

As an illustrative example of how these social needs data are being used in local communities, Valley-Wide Health Systems, Inc., a HRSA-supported health center that serves the local community and migrant workers, launched a transportation service, Valley-Wide Ride, using social needs data from the PRAPARE standardized social risk factors screening tool. This screening tool can be used to understand community needs and identify opportunities for improvements at the policy, payment, and systems levels to achieve better health for communities. To address food insecurity during the COVID-19 pandemic, another HRSA-funded health center, Westside Family Healthcare, piloted a program called Feeding Families. The program supported the health of families who screened positive for food insecurity and had at least one family member with a chronic disease. For one full year, 50 families received fresh food weekly from a home-delivery service and met virtually with a Westside nutritionist and social service coordinator to receive customized education, cooking tools, and recipes.

Additionally, SDOH data inform training and technical assistance products that HRSA develops and delivers to health centers, both nationally and through cohort-based learning collaboratives through HRSA-funded National Training and Technical Assistance Partners (NTTAPs). For example, The Social Determinants of Health (SDOH) Academy is a HRSA-funded virtual training series designed to help health center staff develop, implement, and sustain SDOH interventions in their clinics and communities. Instead of focusing on a single intervention, The SDOH Academy's multiple NTTAPs work together to offer a coordinated curriculum on multiple community based SDOH interventions. During its 2023-2024 series, The SDOH Academy explored strategies and best practices for building and sustaining community SDOH partnerships between health care systems and local communities to support effective referral networks. Expert and peer-led sessions included Moving from Data Collection to Action: Improving Patient Access to SDOH Resources, Fostering a Healthcare Workforce for Today's Social Health Challenges, and Building Bridges between Healthcare Systems and Community-Based Organizations to Address Health Disparities.

National Institutes of Health (NIH)

Building a Robust Data Infrastructure to Support SDOH/HRSN Research

NIH is committed to building a robust and efficient data infrastructure to support the standardization and harmonization of SDOH and HRSN data to comprehensively understand health disparities and the most impactful points of intervention to improve health outcomes. NIH data efforts include those to increase publicly available SDOH data for linkage with health data; standardize SDOH and HRSN measures; and encourage secondary analysis of publicly available health datasets that include SDOH and HRSN measures. The use of SDOH common data elements (CDEs) helps NIH-supported researchers meet the requirements under the 2023 NIH Data Management and Sharing Policy by making data from different studies more interoperable. This policy reinforces NIH's longstanding commitment to making the results and outputs of NIH-funded research available to the public through effective and efficient data management and data sharing practices. Data sharing enables researchers to rigorously test the validity of research findings, strengthen analyses through combined datasets, reuse hard-to-generate data, and explore new frontiers of discovery. Recent examples are described below.

- A lack of standardized, longitudinal metrics of local neighborhood environments has limited opportunities to identify health impacts over time, including the longer-term consequences of COVID-19. To address this limitation, in 2022, under the NIH Social, Behavioral, and Economic (SBE) Impacts of COVID-19 Initiative, the National Institute of Nursing Research (NINR) funded a national data resource project to augment, curate, and disseminate data on the physical, social, and economic characteristics of local neighborhoods across the United States, in the years both before and since the pandemic, from the National Neighborhood Data Archive (NaNDA), so that these data can be readily linked to existing survey data, cohort studies, and electronic health records.
- In 2018, NIH, led by the National Institute on Minority Health and Health Disparities (NIMHD), established the PhenX Social Determinants of Health (SDOH) Collection in the PhenX Toolkit, an open-access resource of standardized measures that investigators can use to select measures, compare results, and combine data from different studies. The collection measures variables across SDOH, social needs, and health outcomes at individual as well as structural levels and expand data protocols to help measure individual as well as structural factors that shape behaviors and health outcomes. The toolkit provides recommended standard data collection protocols for conducting behavioral and biomedical research. In a related effort, as part of an NIH-wide Science Collaborative for Health disparities and Artificial intelligence bias REduction (ScHARe), a set of Core SDOH CDEs was recently endorsed by NIH and published in the NIH Common Data Elements Repository.
- Launched in 2015, the National Institute on Drug Abuse (NIDA)-led Adolescent Brain Cognitive Development (ABCD) Study is the largest long-term study of child health and development ever conducted in the U.S., following nearly 12,000 children from ages 9-10 years until at least young adulthood. The ABCD Study includes the collection of biological, behavioral, and clinical data to understand the impact of SDOH and HRSNs on adolescents and makes the ABCD data publicly available for secondary analysis. The longitudinal design of the ABCD study will allow researchers to understand the long-term implications of study findings.

Accomplishments to Date

In 2020 and 2022, the NIMHD funded an administrative supplement to establish two workgroups to expand the selection of high-quality standard SDOH measures for inclusion in the PhenX Toolkit. This expansion focused on additional high priority areas and measures related to SDOH. As a result, 19 measures were added to the SDOH collection in 2020 and 15 additional protocols were added to the PhenX Toolkit in 2022.

More than 870 scientific papers have been published using data from the NIDA ABCD study on a range of topics, including SDOH and HRSNs. For example, using data from the ABCD study, a 2023 paper found that state-level macrostructural characteristics, such as cost of living and anti-poverty programs, are associated with differences in brain development and mental health outcomes among 9 to 11-year-old youth in the U.S.

Examples of On-the-Ground Impact

The PhenX SDOH collection is widely used in the extramural research community. To date, 236 publications have cited PhenX protocols, addressing a range of topics, including SDOH and HRSNs. For example, a 2023 paper utilized a PhenX SDOH protocol to create a neighborhood concentrated disadvantage index to investigate its impact on health in a population of adolescents residing in Louisiana. Results showed that neighborhood social environment measures of chronic stress exposure were associated with excess adiposity during adolescence, and relationships were most consistently identified among adolescents living in the most disadvantaged and disordered neighborhoods.

Office of the National Coordinator for Health Information Technology (ONC)

Advancing SDOH Interoperability and the Use of SDOH Data for Improving Health Equity

Advancing the standardized collection of SDOH and HRSN data is important to enabling interoperable exchange and use of these data and involves a collaborative process to establish standards. Structured documentation of SDOH and HRSN in electronic health record (EHR) systems is an important step for enabling users of EHRs to provide holistic, person-centered care, and facilitate exchange and subsequent use of data to address health equity gaps. For settings without an EHR, such as a local food bank or other community-based organizations, the use of standardized, structured SDOH data aligned with non-proprietary, national data standards can support broader integration opportunities with healthcare systems and community partners to facilitate referrals to address HRSNs. ONC advances the development and promotion of SDOH data standardization through various programs and resources in collaboration with federal and non-federal partners. ONC policy and technical resources specific to standards are described below:

- The United States Core Data for Interoperability (USCDI) is a standardized set of health data classes and elements that includes SDOH-related and other health equity related data elements. The USCDI enables the structured exchange of these data to inform clinical decision-making, refer individuals to community resources or social services, and understand barriers to the patient's care.
- The USCDI+ initiative identifies and harmonizes data elements that go beyond the USCDI to meet specific programmatic and/or use case requirements, and provide a roadmap to implementation. USCDI+ is a domain and use-case oriented effort which has overlaps with SDOH data in multiple domains including but not limited to Quality, Behavioral Health, and Maternal Health.
- The ONC Health IT Certification Program ensures that health IT meets technological capability, functionality, and security requirements adopted by HHS, and includes specific standards and functional criteria to support person-centered care, patient engagement, care coordination, and the interoperability of SDOH and equity data.
- The ONC Interoperability Standards Advisory (ISA) is a coordinated catalog of standards and implementation specifications that can be used by different groups to consistently address specific interoperability needs. The ISA includes vocabulary, code set, terminology, content, and structure standards and implementation specifications to support interoperability needs including for SDOH data.

- The ONC Standards Bulletin is a periodically published communications document about ONC health IT standards initiatives.
- The ONC Health Data, Technology, and Interoperability: Certification Program Updates, Algorithm Transparency, and Information Sharing final rule adopted USCDI Version 3 to improve the standardization of electronic health information and advance interoperability within certified health IT systems. The USCDI Version 3 standard includes data elements on patient demographics (such as sexual orientation and gender identity) and SDOH.

Accomplishments to Date

As of 2021, 96 percent of hospitals and 78 percent of office-based clinicians nationally have adopted ONC-certified health IT, which can support the consistent collection and exchange of data elements necessary to support health equity. For example, some ONC-certified products can enable a user to record, change, and access SDOH data, such as financial resource strain, education, stress, depression, physical activity, alcohol use, social connection and isolation, and exposure to violence (intimate partner violence). Additionally, health IT developers can support the collection and exchange of data elements included as part of USCDI Version 2, including SDOH assessments, goals, concerns, and interventions, with applicable vocabulary standards for exchanging these data to address patients' HRSNs.

Examples of On-the-Ground Impact

It is important to capture social needs data in an actionable way so that this information can be used to support shared decision making and address social needs, with the ultimate goal of improving individual and population health. On the ground, hospitals are uniquely situated to help address social needs and mitigate social risk factors by screening for social needs, assisting with transitions of care, and making connections to social service organizations. As noted elsewhere, to promote routine social needs screening at hospitals, the Centers for Medicare & Medicaid Services recently added two social drivers of health measures to the Inpatient Quality Reporting (IQR) program. According to an ONC analysis of data from the 2022 American Hospital Association (AHA) Information Technology Supplement Survey, 83 percent of non-federal acute care hospitals collected data on patients' HRSNs (e.g., transportation, housing, food security), 60 percent received data from outside sources, and many reported using the data they collected internally and received from outside sources for various purposes, including to directly support patient care and make connections to needed resources. ONC analysis furthers understanding of *how* health care providers collect data on patients' HRSNs, which has important implications for whether and how easily those data can be shared and used. In addition, ONC has leveraged data from the Health Information National Trends Survey (HINTS) to better understand patients' perspectives on the collection and use of social needs data, as individuals' comfort with the sharing of their social needs data has implications for patient preferences related to the capture and exchange of potentially sensitive information.

Advancing SDOH Interoperability and the Use of SDOH Data to Support Care Improvement

In order to support care improvements, including integration of clinical knowledge into routine clinical practice, there is a need for data standards and interoperability that support the digitization,

integration, and presentation of new evidence into clinical workflows. ONC has numerous activities underway to advance SDOH interoperability for this purpose, including those focused on innovation and empowering communities to exchange this information and engage in collaborative learning. Two examples include:

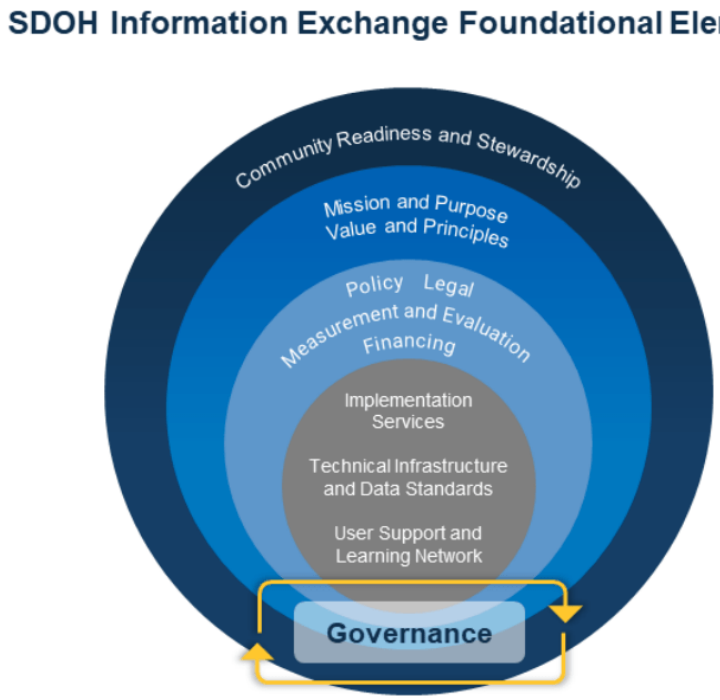
- Leading Edge Acceleration Projects (LEAP) in Health IT program, which tackles the creation of new standards, methods, and tools to improve care delivery and advance research capabilities. Several recent LEAP awardees conducted projects related to SDOH data exchange and registries, application programming interfaces (APIs), and closed-loop referrals. These projects engaged a wide range of interested parties including health IT developers, federally qualified health centers (FQHCs), standards development organizations, community organizations, providers, and many more. Local, innovative LEAP projects inform opportunities for national scale while demonstrating success and feasibility to inform implementation approaches in other communities.
- Social Determinants of Health Information Exchange Toolkit ("ONC SDOH Toolkit"), a practical, on-the-ground resource designed to aid the health IT community in the implementation of initiatives that recognize the importance of using SDOH information. ONC organized a panel of technical experts within the health and human service ecosystem to identify key considerations for interoperability and implementation of SDOH information exchange in communities. This effort informed both the ONC SDOH Toolkit and a series of national SDOH Information Exchange Learning Forum sessions.

Accomplishments to Date

ONC-funded LEAP in Health IT projects, AllianceChicago's "Aligning Housing and Healthcare" and the University of Texas at Austin's (UT Austin) "FHIR-Enabled Social and Health Information Platform" involve SDOH data use and interoperability. AllianceChicago's project leverages HL7 FHIR to enable service providers to integrate and coordinate services to better address SDOH for individuals experiencing homelessness. UT Austin's project demonstrates a comprehensive integrated information system to manage social needs identified in clinical settings through bi-directional information exchange between clinical providers and community-based organizations delivering social care.

ONC has maintained its efforts to support the integration of health and social care information by engaging with its partners and disseminating available resources. The ONC SDOH Toolkit, which was released in February 2023, was developed to support states, payers, community-based services entities, and other partners with the implementation of SDOH-based data exchange within their communities. It includes considerations for applying health IT standards, infrastructure, and interoperability. As of May 2024, the toolkit was downloaded 555 times. Developing the ONC SDOH Toolkit further served as an opportunity to explore the Foundational Elements framework, a conceptual framework to assist the planning, design, implementation, and evaluation processes of SDOH information exchange initiatives, in practice by engaging in peer-to-peer learning. ONC conducted an SDOH Information Exchange Learning Forum Series between March 2022 and June 2023, which engaged 2,416 individuals representing a wide diversity in participants from the field across nine, collaborative, learning sessions accessible online as an ongoing resource. Partners have sustained their interest in opportunities to engage with others who are at various stages of SDOH information exchange, and ONC is continuing efforts to engage and

coordinate with various partners involved in activities to advance SDOH interoperability including HHS programs.



Examples of On-the-Ground Impact

UT Austin created FHIRed-SHIP as an Application Programming Interface (API) enabled platform using the HL7 FHIR standard to integrate a closed loop social services referral system. The system is accessible to People's Community Clinic, a federally qualified health center, through its EHR and it is using the system to leverage SDOH data. A community advisory group member said of the project, "I am quite excited. I am thinking of my client who is diabetic. Without access to proper food, she got into advanced liver damage. Once she goes to her doctor's office and download this app and have her documents and referrals in one place – that's exciting!"

AllianceChicago's Aligning Housing and Healthcare project aims to prototype an interoperable care plan. The specific objectives of the project include understanding and characterizing the elements of a comprehensive care plan bridging the domains of need and services across Heartland Alliance Health, a federally qualified health center, and Chicago House, a community-based Homeless Service organization; piloting test a standards-based, open source, FHIR enabled electronic interoperable care plan accessible to both institutions and the patient; and evaluating the pilot.

Office of the Assistant Secretary for Health (OASH)

Setting Data Driven National Objectives to Improve Equity in Well-Being

Healthy People 2030, led by OASH's Office of Disease Prevention and Health Promotion (ODPHP), sets data-driven national objectives to improve health and well-being over the next decade. In recognition that SDOH have a major impact on people's health and well-being, they are a key focus of Healthy People 2030. Healthy People 2030 establishes a SDOH framework with five domains supported by specific national objectives with targets to be achieved by the end of the decade. Federal agencies, state and local health departments, communities, academics, and public and private organizations draw on the Healthy People 2030 SDOH framework to shape their own plans for eliminating disparities and achieving health equity for their constituent populations. Healthy People 2030 offers SDOH literature summaries and accompanying infographics that provide a snapshot of the latest research related to specific SDOH.

Accomplishments to Date

Healthy People 2030's national objectives provide over 1,100 disparities display charts that communities can use identify populations most impacted by SDOH and direct resources to them.

State and territorial health departments make Healthy People happen every single day across the United States. Each state or territory has a Healthy People State and Territorial Coordinator (Coordinators) who serves as a liaison with the ODPHP. ODPHP works with Coordinators to identify areas of alignment in their work and the Healthy People 2030 goals and objectives. To elevate the health promotion and disease prevention work of health departments as well as the role of Coordinators, ODPHP released a new webpage on Healthy People 2030 in Fall 2023 titled Healthy People in States and Territories. On this page, Healthy People reviews and links to the most recent available version of each state's and territory's improvement plan to highlight how those improvement plans address the Healthy People 2030 Leading Health Indicators (LHIs) affecting communities. In addition to launching the new webpage, ODPHP has met with Coordinators in each Region through 10 technical assistance calls, developed four issues of an internal, quarterly newsletter, and facilitated two networking events in 2023.

To further support utilization of Healthy People 2030 across levels of government and various sectors, in 2023 ODPHP also collaborated with the Association of State and Territorial Health Officials (ASTHO) and the National Association of County and City Health Officials (NACCHO) to develop two publicly available toolkits that detail how Healthy People 2030 can be applied to efforts to develop multisector partnerships:

- Using Healthy People 2030 to Develop Multisector Partnerships (NACCHO)
- Leveraging Healthy People 2030 to Build Non-Traditional Multisector Partnerships (ASTHO)

Examples of On-the-Ground Impact

The Healthy People framework is used in a variety of ways by professionals across all levels of government and outside of government. Popular elements include content from the various topic areas, objectives including the LHIs, benchmarks, data sources, and tools for action. ASTHO fields the ASTHO Profile of State and Territorial Public Health (Profile) survey, which is the only comprehensive source of

information about state and territorial public health agency activities, structure, and resources, including agency use of Healthy People. The most recent Profile was released in December 2023. According to this Profile, 81 percent of state and territorial agencies are currently using Healthy People 2030 in their work. Of those not using the current iteration of Healthy People in their work, many were still using the previous version, Healthy People 2020, but indicated they plan to use Healthy People 2030 to guide their future work. In 2022, the most common uses of Healthy People were in helping to develop State Health Improvement Plans (SHIP) and other assessments and plans such as Preventive Health and Health Services (PHHS) Block Grants, environmental health assessments, and tobacco control plans. ODPHP is currently working with ASTHO to develop a data story that explores specific Healthy People findings in more detail.

Goal Two: Improved Health and Social Services Connections

Improving access to and affordability of equitably delivered health care services and supporting partnerships between health care, social care providers, and other community partners is important to reducing disparities in health status and improving health outcomes for populations that have been historically marginalized and are often underserved. By implementing policies and initiatives that strengthen these connections, HHS is supporting a holistic approach to addressing individual needs that ensures individuals can access appropriate services regardless of their entry point – whether through health insurance, health care, public health, or social services. Such partnerships are vital to addressing social needs and by extension, improving health outcomes.

Administration for Children and Families (ACF)

Disseminating Best Practices to Reduce Youth Homelessness

Addressing SDOH can help create a future in which youth, individuals, and families can live healthy, productive, and violence-free lives, no matter what challenges they face. Innovative programs and services that provide youth and young adults with the support they need to prevent housing instability and homelessness is vital to ensuring that they have the opportunity to reach their optimal health and well-being. Each year, thousands of U.S. youth run away from home, are asked to leave their homes, and/or become homeless. Through the development and coordination of partnerships with youth and young adult service providers, community organizations, youth and young adults with lived experience of homelessness or housing instability, and private and public agencies, ACF's Runaway and Homeless Youth Program (RHY) works with community organizations to implement robust, holistic prevention services tailored for youth and young adults to respond to the diverse needs of youth who are at risk of homelessness and their families. Through the RHY program, ACF supports street outreach, emergency shelters, and longer-term transitional living and maternity group home programs to serve and protect these young people. Through the RHY Training, Technical Assistance, and Capacity Building Center (RHYTTAC) available to grantee agencies, ACF is developing a Training and Technical Assistance Plan aligned with results of the RHY National Needs Assessment and linked to SDOH impacting youth experiencing homelessness and is developing and disseminating training and technical assistance resources to RHY-funded grantees and partners. By increasing the number of training and technical assistance resources available the RHYTTAC will assist RHY-funded grantees in delivering improved services linked to SDOH impacting youth experiencing homelessness and will ultimately improve the well-being of the youth experiencing homelessness.

Accomplishments to Date

As of December 2023, the RHYTTAC has developed and delivered 29 training and technical resources in calendar year 2023 that have been accessed by more than 650 grant recipients.

Examples of On-the-Ground Impact

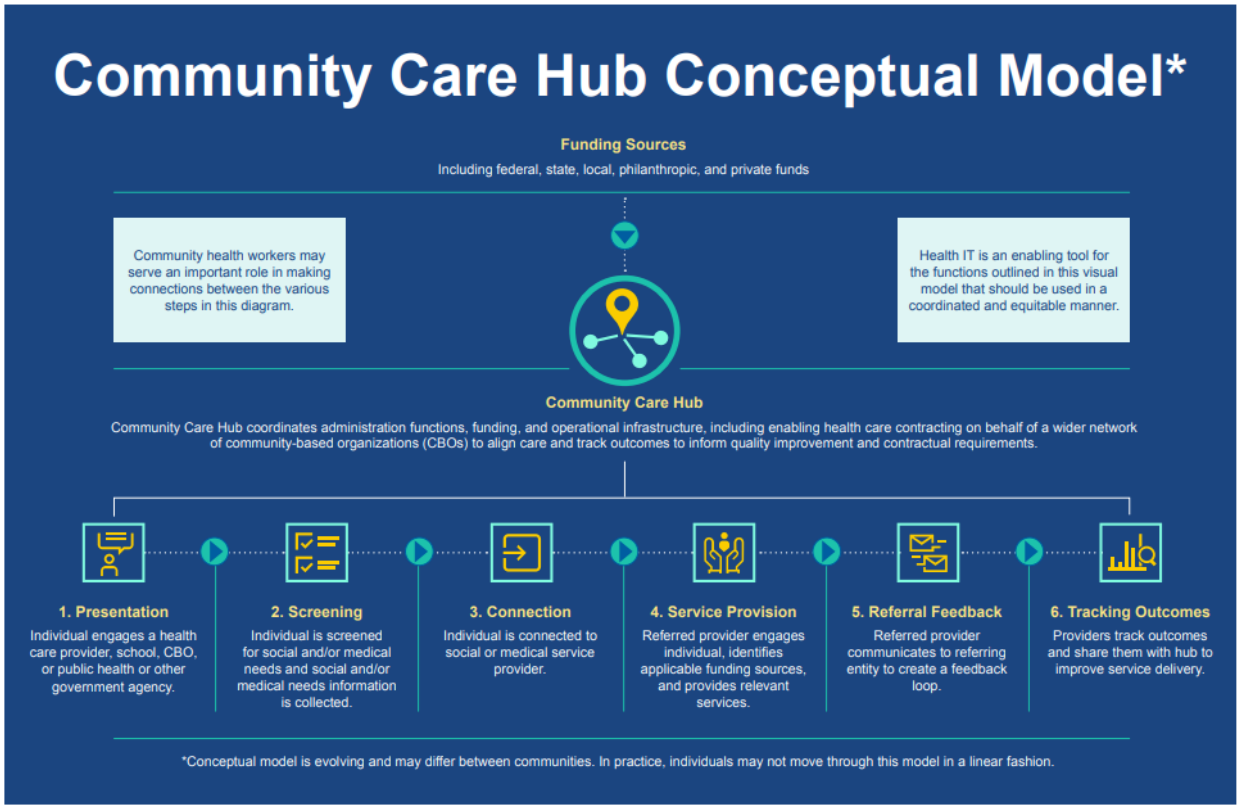
More than 3,000 youth serving professionals have received training and technical assistance resources ranging from topics such as homelessness prevention, human trafficking, understanding bias, and

motivational interviewing, to name only a few. Training and technical assistance delivered to front line, youth serving professionals translates to improved services delivery for youth and young adults at risk of experiencing homelessness.

Administration for Community Living (ACL)

Better Integrating Health and Social Care Systems through Community Care Hubs

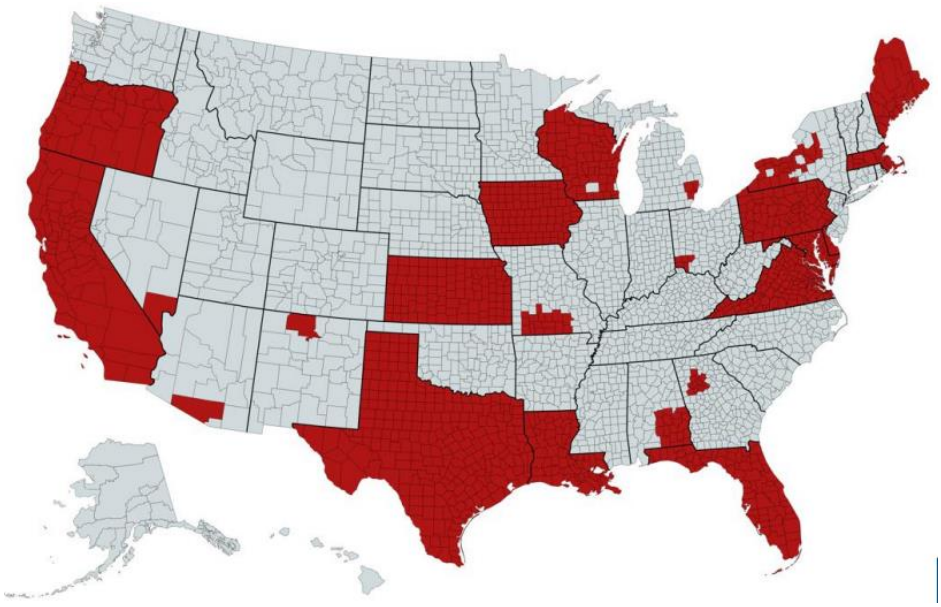
Backbone organizations play an important role in establishing and strengthening partnerships between health care and social service providers. One promising type of backbone organization that plays an important role in promoting an equitable health and social care ecosystem is the community care hub ("hubs" for short), a community-focused entity that supports a network of community-based organizations (CBOs) providing services to address HRSNs. Hubs serve as the bridge between CBOs, health care payers and providers, and public health systems to increase a community's capacity to reach populations who are underserved. They achieve their goals through coordination, financing, and provision of services that address HRSNs. ACL is supporting the development and expansion of hubs serving the aging and disability networks. Building the capacity of hubs nationwide advances ACL's vision of coordinated person-centered care and services for all community members, as this infrastructure can be leveraged to reach populations that extend beyond aging and disability. Through increased partnerships between hubs, their network of CBOs, and health care organizations, hubs seek to address HRSNs, improve health outcomes, and decrease hospital readmissions for individuals receiving services such as care coordination, care transitions, nutrition support, and evidence-based interventions.



Accomplishments to Date

In November 2022, ACL, in partnership with the Centers for Disease Control and Prevention, launched a National Learning Community (NLC) to provide selected hubs with shared learning, information and resource sharing, and technical assistance coordination to build the strength and preparedness of each hub. Fifty-eight organizations representing 32 states, outlined in red in the figure below, participated. Given the success of the first NLC cohort, ACL released a request for applications for the 2023-2024 NLC in October. The second cohort of the NLC included 32 hubs across 23 states and ran from December 2023 through August 2024.

2023-2024 National Learning Community Participants



Through a cooperative agreement for a Center of Excellence to Align Health and Social Care that launched in September 2023, ACL will provide up to 20 sub-awards for a two-year project period to develop and enhance local community care hub infrastructure. The Center will also provide technical assistance to support hub development and sustainability for aging and disability organizations.

Examples of On-the-Ground Impact

Western New York Integrated Care Collaborative (WNYICC) is a community care hub leading a network of eight area agencies on aging, one center for independent living, and 30 CBOs serving individuals of all ages in western and central New York. WNYICC launched a regional project with a large regional Medicare Advantage (MA) plan in 2020 to provide post-discharge home-delivered meals. Under the initial intervention, WNYICC provided a custom, post-discharge home-delivered meals program for hospitalized members that included hot home-delivered meals and medically tailored meals. WNYICC also incorporated patient satisfaction surveys to facilitate member feedback to the health plan. After successful demonstration of organizational capacity, their contract expanded to include health coaching, chronic care management, expanded meal benefit, a social isolation intervention, medical nutrition therapy, and evidence-based programs (including chronic disease, falls, diabetes, and caregiver focused

interventions). Through this partnership in 2022, 695 participants received meals, representing a 70 percent increase in meals compared to 2020 and 2021; 85 percent of participants improved their PHQ-9 or UCLA Loneliness score by 15 percent; 76 percent of participants increased their physical and/or social activity through the program; 57 referrals were made to clinical providers; and 92 percent of participants had their needs resolved in or in-progress as of May 2023. The success of the contract agreement with a major regional MA plan also allowed WYNICC to coordinate with hospital discharge planners and their regional health information organization to receive daily notification of member admissions to solicit referrals and document meal delivery by their network through a centralized data system managed by WNYICC. WNYICC has successfully secured additional contracts with Medicaid managed care plans, other MA plans, commercial plans, and Medicaid long-term care plans. They have integrated with local physician groups and hospitals that are participating in value-based contracts with Medicare and Medicaid to deliver a range of community-based interventions**.** Given CMS' recent SDOH policy activities, including the introduction of new payment and coding for SDOH risk assessment, community health integration, and principal illness navigation in Medicare and the integration of HRSN screening and referral into most Innovation Center models, the need for entities that can serve as clinical-community connectors is expected to increase. The success of this formal CBO network demonstrates the potential for hubs to play a key role in the follow-up to HRSN screening by connecting individuals with HRSNs to responsive services.

Centers for Disease Control and Prevention (CDC)

Community Health Workers Strengthening Community Resilience

Community health workers (CHWs), frontline public health workers and trusted community members, serve as liaisons between health and social service providers and the community to facilitate access to services and to improve the quality and cultural competence of service delivery. Since its inception in August 2021, the CDC's Community Health Workers for COVID Response and Resilient Communities (CCR) initiative has helped to put more trained CHWs in the communities most affected by COVID-19. CCR provides CHWs with the knowledge and skills to support the COVID-19 public health response, deploys CHWs to manage COVID-19 outbreaks and prevent the spread of COVID-19, and engages CHWs to help build and strengthen community resilience to mitigate the impact of COVID-19 by improving the overall health of priority populations in communities. Through increased community outreach and partnership development activities, including health education, screenings, and referrals to health care and social services, CCR seeks to increase access to health care services and adherence to health recommendations and improve overall health outcomes.

Accomplishments to Date

Since August 2021, CDC has awarded grants to 67 local, state, territorial, and tribal entities to train and deploy CHWs to address health disparities among communities hit hardest by COVID-19. CCR-funded programs have hired over 1,000 CHWs and trained over 2,000 CHWs in COVID-19 response efforts. These programs have supported over 5,900 vaccination events, integrated CHWs into nearly 2,000 organizations, developed over 500 new partnerships to enhance CHW efforts, and reached over 16.9 million people with education and messaging. CCR-funded programs have helped connect members of

their communities with needed resources through over 787,000 referrals to health care and social services.

Now in the program's final year, the focus has turned to sustainability. Envision, a national CHW Training and Technical Assistance Center funded by CDC through the Wisconsin Department of Health Services to support CCR programs, convened all 67 grant recipients in April 2024 for a CHW Sustainability Summit. The Summit offered CCR-funded programs the opportunity to showcase their work and strategize together about how to continue CHW programs in the absence of CCR grant funding. Envision is also providing one-on-one assistance to CCR programs on topics including sustainable financing, CHW leadership, and coalition building.

Examples of On-the-Ground Impact

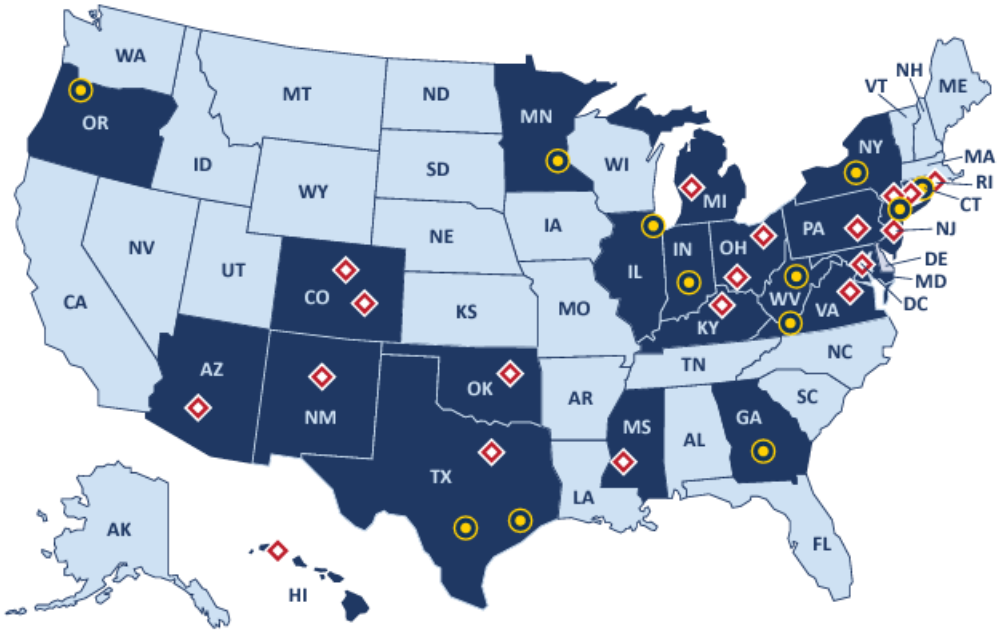
The Health and Hospital Corporation of Marion County, a CCR recipient in Indiana, is using their CCR funding to support a clinic-based CHW program. As part of the program, CHWs screen clinic patients using a SDOH assessment. In the first two years of the program, CHWs within the Marion County program completed over 2,600 of these assessments and supplied 1,136 referrals related to food as medicine and 537 referrals related to safe and stable housing.

Centers for Medicare & Medicaid Services (CMS)

Testing New Strategies to Address HRSNs

Based on emerging evidence that addressing HRSNs through enhanced clinical-community linkages can improve health outcomes and reduce cost, the CMS Innovation Center developed the Accountable Health Communities (AHC) Model to address a critical gap between clinical care and community services in the current health care delivery system. From 2017-2023, the AHC Model provided support to 28 community bridge organizations covering 328 counties in 21 states across two tracks. Together with their clinical partners, AHC bridge organizations conducted over 1.8 million screenings of people with Medicare, Medicaid, or both across widely varied clinical settings from big emergency departments to community health fairs. Nearly 40 percent of patients screened reported at least one HRSN and were referred to community services. The AHC Model demonstrated that conducting HRSN screening at scale was both appropriate and feasible for individuals enrolled in Medicare and Medicaid.

Accountable Health Communities Model Participants



In addition to testing whether the systematic HRSN screening of eligible beneficiaries across CMS programs would impact utilization and health care costs, this model tested the effectiveness of navigation to community resources as a tool to address HRSNs for a group of individuals with high health care utilization. Over 75 percent of those eligible accepted navigator help to access services and that acceptance did not differ by program enrollment, type of need, or sociodemographic characteristics.

While this model ended in 2023, in 2021 the CMS Innovation Center committed to diffusing key lessons from AHC throughout Innovation Center models, incorporating HRSN screening and referral into new model tests and facilitating coordination with social service providers into existing and future model tests. Since 2021, the Innovation Center has launched multiple models that include support for addressing HRSNs in part through providing navigation to community-based resources. As of 2024, six currently operating Innovation Center models require HRSN screening for unmet needs: Integrated Care for Kids (InCK), Maternal Opioid Misuse (MOM), Kidney Care Choices (KCC), Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH), Value-Based Insurance Design (VBID), and the Enhancing Oncology Model (EOM). In addition, five recently announced models may also require screening and referral when they launch: Making Care Primary (MCP), Innovation in Behavioral Health (IBH), States Advancing All-Payer Health Equity Approaches and Development (AHEAD), Guiding an Improved Dementia Experience (GUIDE), and the Maternal Health Model (TMaH). Collectively, these 11 models focus on diverse populations across a range of providers, health plans, and care settings.

EOM aims to promote whole-person, patient-centered, equitable care for cancer patients receiving chemotherapy treatment. The model includes a monthly per-beneficiary-per-month payment to participating oncology practices that supports furnishing enhanced services to patients in an effort to facilitate care transformation through better coordination and management of patient cancer care, including, but not limited to, identifying and addressing HRSNs such as food insecurity, housing instability, and transportation, and facilitating linkages to follow-up services, referrals, and community resources. The Innovation Center is also supporting community-clinical connection in primary care. Primary care practices in the MCP Model will receive Enhanced Services Payments that enable them to deliver the care coordination and other key services that are integral to high quality, person-centered care. This includes identifying and addressing HRSNs and connecting patients to community supports and services. These payments will be adjusted by social risk as well as clinical indicators.

Several Innovation Center models are adjusting certain payments to facilitate provision of high-quality, person-centered care to all beneficiaries. For example, the ACO REACH Model includes a financial benchmark adjustment for participating ACOs serving a disproportionate number of underserved beneficiaries. This increased funding for underserved beneficiaries is also intended to support more targeted wraparound services, often provided by community-based organizations, to address HRSNs that affect patient health and cost. States that participate in the newly announced AHEAD Model will pursue equitable outcomes for beneficiaries through multiple mechanisms, including using social risk adjustment of hospital and primary care provider payments to increase resources available to care for underserved populations.

To facilitate HRSN screening and referral in accordance with best practices, CMS makes available learning and other technical supports to all model participants. By embedding screening across the Innovation Center model portfolio, CMS is gaining insight into the prevalence of HRSNs among program members across different programs (e.g., Medicaid and Medicare), geography, and populations. This new data will inform future CMS and model participant strategies to address HRSNs and reduce associated disparities.

Accomplishments to Date

The AHC Model provided approximately 1.2 million screenings and more than 160,000 beneficiaries accepted navigation assistance. Among those who completed 12 months of navigation, over a third had at least one HRSN resolved. The model reduced emergency department visits among Medicaid and Fee-for-Service (FFS) Medicare beneficiaries in the model's Assistance Track with an eight percent reduction in emergency department visits among FFS Medicare beneficiaries and a three percent reduction in emergency department visits among Medicaid beneficiaries. In addition, there were statistically significant reductions in the percentage of beneficiaries receiving treatment for respiratory illness among Medicaid beneficiaries in the Assistance Track and FFS Medicare beneficiaries in the Alignment track, and measures of asthma complications and respiratory illness were both directionally suggestive of improvements in health outcomes for Medicaid and FFS Medicare beneficiaries in the Assistance Track. Although initial evaluation reports show that navigation alone did not increase beneficiaries' connection to community services or HRSN resolution, qualitative interviews indicate that it may have altered beneficiary behavior in ways that changed health care utilization and stakeholders and advisory

board members noted that the model helped bridge the "two worlds" of clinical care and community services through alignment activities. Two additional AHC evaluation reports are forthcoming.

In addition, through learning opportunities, Innovation Center participants have shared strategies to minimize potentially duplicative screenings, improve data sharing, build referral relationships with community-based organizations, and analyze the relationship of HRSN trend data with other metrics such as clinical conditions. For example, technical assistance related to HRSN screening is part of the VBID model's Health Equity Incubation Program. Integrating screening and referral into Innovation Center models has also spurred the creation of community-clinical partnerships and other infrastructure that can be leveraged for the benefit of people enrolled in CMS programs. Ultimately, these efforts support CMS and model participants in better understanding and addressing beneficiaries' food insecurity, transportation concerns, housing instability, among other needs.

Examples of On-the-Ground Impact

An AHC Navigator worked with a patient at AMITA Health who frequently visited the emergency department for issues associated with the same wound. The Navigator assisted the patient in setting up an appointment with the specialist who could provide the ongoing care the patient needed. The Navigator also walked the patient step-by-step through the process of setting up transportation to the initial appointment. The Navigator followed up with the patient the next day to ensure that the patient had everything he needed for the outpatient visit. The patient successfully attended the appointment and no longer returned to the emergency department for care.

Addressing Health-Related Social Needs through Medicaid Payment Policies

Medicaid provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, older adults, and people with disabilities. The program is one of the largest payers for health care in the United States. Medicaid is jointly funded by states and the federal government and is administered by states, according to federal requirements.

CMS recently released a framework for states outlining opportunities to address HRSNs using existing Medicaid authorities. By addressing HRSNs, state Medicaid and CHIP programs can help their enrollees stay connected to coverage and access needed health care services, and supplement – but not supplant – existing local, state, and federal supports. CMS supports states in addressing HRSNs through multiple Medicaid and CHIP authorities and mechanisms. These initiatives include coverage of clinically appropriate and evidence-based HRSN services and supports; care delivery transformations, including improvements in data sharing; and performance measurement to create accountability for HRSN screening and connecting to needed supports as part of successful care management. For example, services offered under this framework can, depending on Medicaid authority, include services and short-term housing for individuals with specific clinical conditions who are transitioning out of places such as congregate settings, homeless shelters, the child welfare system, and a range of other options to transition more people out of homelessness. States have also provided nutrition counseling and education, medically tailored meals, and pantry stocking for individuals with certain clinical needs.

Accomplishments to Date

As of January 2024, CMS has approved section 1115 demonstrations in eight states that cover certain evidence-based housing and nutritional services designed to mitigate the negative health impacts of unmet HRSN. Together, these flexibilities and accompanying safeguards to protect program and fiscal integrity comprise a framework for coverage of HRSN, complementing but not supplanting existing social services, that states can use to improve consistent access to needed care, health outcomes, and health equity among Medicaid beneficiaries. As a condition for approval of HRSN services, states have been and will be required to ensure provider payment rates in primary care, obstetrics care, and care for mental health and substance use disorders meet minimum thresholds, or commit to improving those payment rates. This condition of approval reflects that connections to care can only be successful if beneficiaries have timely access to health care providers. As the purpose of section 1115 demonstrations are to demonstrate and evaluate state-specific policy approaches to better serving Medicaid populations, states must adhere to systematic monitoring and robust evaluation requirements, including performance reporting on quality and health equity measures.

Examples of On-the-Ground Impact

California's CalAIM initiative, approved under a section 1115 demonstration and a section 1915(b) waiver, provides Enhanced Care Management (ECM) to select members with complex needs to coordinate their health and health-related care, including social services. One member, Frank, struggled with opioid addiction and has been experiencing homelessness for four years. After a visit to the emergency department, Frank was referred to ECM. Working with this ECM care manager at a nearby food bank, they developed a plan for him to see his mental health provider, adjust his medication, follow up with his primary care provider, and secure safe, supportive housing.

Addressing Health-Related Social Needs through Medicare Payment Policies

CMS has recently finalized several policy changes within the Medicare program to increase coordination and collaboration across health and social service providers to help identify and address enrollees' HRSNs within the Medicare program, including Medicare Parts A, B, C, and D, and Innovation Center models. Payment for services covered by the Medicare program is made under the Physician Fee Schedule, along with other annual regulations. These annually updated payment rules specify what services Medicare pays for and what health care professionals who are enrolled as Medicare practitioners can bill for. In the 2024 Physician Fee Schedule, which went into effect January 1, 2024, CMS made several policy changes related to SDOH to improve the connections between health and social services for Medicare enrollees. Specifically, CMS will now pay separately for Community Health Integration (CHI), SDOH risk assessment, and Principal Illness Navigation (PIN) services to account for resources when clinicians involve certain types of auxiliary personnel such as community health workers, care navigators, and peer support specialists in furnishing medically necessary care. Although these types of auxiliary personnel have been able to perform services under the supervision a billing physician, this is the first time that Medicare coding and payment have been specifically designed to describe services involving community health workers, care navigators, and peer support specialists. CMS has also finalized that community health workers, care navigators, peer support specialists, and other such auxiliary personnel providing these services may be employed by community-based

organizations (CBOS) if there is the requisite supervision by the billing practitioner for these services, similar to other care management services.

CHI and PIN services involve a person-centered assessment to better understand the patient's life story, care coordination, contextualizing health education, building patient self-advocacy skills, health system navigation, facilitating behavioral change, providing social and emotional support, and facilitating access to community-based social services to address unmet SDOH needs. Specifically:

- CHI services are to address unmet SDOH needs that affect the diagnosis and treatment of the patient's medical problems.
- PIN services are to help people with Medicare who are diagnosed with high-risk conditions (e.g., dementia, HIV/AIDS, cancer) identify and connect with appropriate clinical and support resources. These services also include peer support specialists to better support individuals with behavioral health conditions like severe mental illness and substance use disorder.

Within the Medicare Shared Savings Program, eligible new Accountable Care Organizations (ACOs) entering the program can receive Advance Investment Payments (AIPs). AIPs help provide an opportunity for less well-resourced ACOs inexperienced with performance-based risk Medicare ACO initiatives to build the infrastructure needed to succeed in the Shared Savings Program and promote equity by holistically addressing beneficiary needs. Additionally, the amount of AIPs that ACOs are eligible for varies depending on the number of individuals who are dually eligible or residing in areas with higher deprivation as referenced by the Area Deprivation Index (ADI). Among other investments, ACOs can use AIPs to address HRSNs. AIPs may also be used by ACOs to partner with entities including CBOs to meet these goals.

Medicare Advantage (MA), a Medicare option under which CMS contracts with private insurance companies to offer Medicare benefits, covers more than half of eligible Medicare beneficiaries. In MA, the types of services addressing social needs are often paid through supplemental benefits, which MA plans have the flexibility to offer, including special supplemental benefits for the chronically ill (SSBCI). CMS increased Medical Loss Ratio (MLR) data requirements to collect more detailed information on spending on categories of supplemental benefits, expanded encounter data collection for MA plans to report beneficiary-level data on the use of supplemental benefits, as well as introducing new MA reporting requirements to collect plan-level data on plan spending, out-of-pocket spending, and utilization of supplemental benefits. For 2025, CMS has also finalized rulemaking to require MA plans to demonstrate through relevant acceptable evidence how proposed SSBCI impacts health, and must notify enrollees when they are eligible for a supplemental benefit, including SSBCI, that has not been used by midyear.

Within MA, special needs plans (SNPs) are available to individuals who are dually eligible for both Medicare and Medicaid, individuals with one or more chronic conditions, and individuals who live in the community but need the level of care a facility offers or live in a facility for at least 90 consecutive days. These SNPs include care coordination services and tailor their benefits, provider choices, and list of covered drugs to best meet the specific needs of the groups they serve. CMS has finalized a requirement for SNPs to include one or more questions on housing stability, food security, and access to transportation in their health risk assessments beginning in 2024. All SNPs must complete enrollee

health risk assessments at enrollment and annually. Including these questions in SNP health risk assessments will help better identify the risk factors that may inhibit SNP enrollees from accessing care and achieving optimal health outcomes and independence and enable SNPs to take these risk factors into account in enrollee care plans.

CMS also announced the extension of the CMS Innovation Center's Value-Based Insurance Design (VBID) Model, which tests a broad array of complementary MA health plan innovations, to 2030. The VBID Model is designed to reduce Medicare program expenditures, enhance the quality of care for beneficiaries, and improve the coordination and efficiency of health care service delivery. Changes in the model's design encourage an even greater focus on addressing HRSNs, such as food insecurity, safe living environments, and transportation access. Beginning in Calendar Year 2025, some of these changes include:

- Requiring Medicare Advantage Organizations (MAOs) participating in the model to offer supplemental benefits to address HRSNs in at least two of three areas: food, transportation, and housing insecurity and/or living environment.[5] Those benefits would be targeted to meet enrollees' medical needs and could include benefits such as meals beyond a limited basis, transportation to medical appointments, air conditioning units to support enrollees in areas experiencing extreme heat, and housing assistance. Other flexibilities, including the ability to offer reduced cost sharing for Part D drugs, will remain a core part of the model.
- Introducing a new flexibility for MAOs to address HRSNs in socioeconomically disadvantaged areas, using the ADI to identify the targeted areas, to direct benefits to enrollees in underserved communities. While existing VBID Model flexibilities have allowed for a focus on HRSNs, current targeting criteria (namely Part D low-income subsidy and dual-eligible status) are based on income, and therefore, miss enrollees who still may be relatively disadvantaged, and have HRSNs, but do not qualify for these programs.
- Requiring additional beneficiary-level data collection to heighten CMS's understanding of how enrollees are using supplemental benefits and their impact on enrollees.

Accomplishments to Date

CMS had 19 newly formed ACOs that will receive AIPs join the Shared Savings Program beginning January 1, 2024, and these 19 ACOs will receive more than $20 million in AIPs to support their ability to care for underserved populations. ACOs receiving AIPs are required to use AIPs to invest in health care infrastructure, staffing, and providing accountable care for underserved beneficiaries. These 19 new ACOs are hiring community health workers, utilizing health assessment and screening tools, and implementing quality improvement activities, such as case management systems, patient registries, and electronic quality reporting. For additional information on how ACOs will use AIPs, please reference the Public Use File.

In 2023, CMS released guidance outlining the screening instruments MA SNPs must use to meet the new requirement to screen for housing stability, food security, and access to transportation in enrollee health risk assessments. In addition to allowing MA SNPs to use any existing state-required screening instrument that includes questions in the required areas, the guidance requires selecting questions from

[5] MA plans currently have the option to cover services and items that address HRSNs through supplemental benefits.

validated, health information technology encoded screening instruments. This will help standardize the information SNPs are collecting about enrollees' housing, food, and transportation needs.

Unique to the VBID Model, certain benefits addressing HRSNs may be targeted to MA enrollees based on socioeconomic status – that is, beneficiaries eligible for Part D low-income subsidies or, in territories, Medicaid – and/or chronic condition status. In plan year 2024, 8.7 million targeted enrollees are projected to be offered additional supplemental benefits, reduced co-payments, and/or rewards and incentives that are anticipated to improve health and equity by meeting medical and social needs – such as food and transportation.

Adjusting Health Care Payments to Account for Costs Associated with Addressing SDOH

Building on the lessons learned from CMS Innovation Center models, Medicare is now paying for SDOH risk assessments starting January 1, 2024. These assessments acknowledge and identify instances where practitioners may allocate resources and time towards evaluating SDOH factors that could potentially impact their patient care capabilities. Practitioners can assess patients in the SDOH domains of food insecurity, housing insecurity, transportation problems, and utility difficulties, as well as other SDOH domains of their choosing. Additionally, as part of the Calendar Year 2024 Physician Fee Schedule, CMS finalized the integration of SDOH risk assessments into the annual wellness visit as an optional supplementary component, entailing an extra payment. Patients will not be subject to coinsurance or deductibles when this assessment is conducted alongside the annual wellness visit. Furthermore, CMS has finalized the coding and payment structure for SDOH risk assessments administered during evaluation and management visits (including hospital discharge and transitional care management) or behavioral health visits.

Also of note, within the Fiscal Year 2024 Inpatient Prospective Payment System (IPPS) final rule, CMS finalized payment policies to adjust the severity level of a set of SDOH codes related to homelessness to address the resource intensity required to address the full needs of patients experiencing this HRSN. IPPS payment is made based on the use of hospital resources in the treatment of a patient's severity of illness, complexity of service, and/or consumption of resources. Generally, a higher severity level designation of a diagnosis code results in a higher payment to reflect the increased hospital resource use. After review of a data analysis of the impact on resource use generated using claims data, CMS finalized a change to the severity designation of the three ICD-10-CM diagnosis codes describing homelessness (e.g., unspecified, sheltered, and unsheltered) from non-complication or comorbidity (NonCC) to complication or comorbidity (CC), based on the higher average resource costs of cases with these diagnosis codes compared to similar cases without these codes.

Accomplishments to Date

The CMS policy changes and models being tested will support the connection of millions of Medicare and Medicaid enrollees with local services to address their HRSNs. Providers making those connections will be compensated for their services. As data become available, research and evaluation activities will be critical to inform future policymaking. For example, as SDOH diagnosis codes are reported, CMS plans

to continue to analyze the effects of SDOH on severity of illness, complexity of services, and consumption of resources.

Health Resources and Services Administration (HRSA)

Facilitating Legal Supports to Assist Health Center Patients with Their SDOH Needs

Medical-legal partnerships (MLPs) enable health care providers to incorporate the expertise of lawyers to help clinicians, case managers, and social workers address SDOH and HRSNs. While some social needs can be addressed through the provision of social services, others are connected to federal, state, and local policies that require legal information and expertise. Through a cooperative agreement with the National Center for Medical-Legal Partnerships, HRSA is supporting health centers to establish MLPs that facilitate health center patients' access to patient-centered legal services that can help them address HRSNs that are barriers to optimized health outcomes.

Accomplishments to Date

In 2022, HRSA-funded health centers served more than 30.5 million people across the nation. Roughly 160 health centers have established partnerships with MLPs, representing one-third of all health care organizations with such partnerships. Through these partnerships, health centers establish eligibility for and facilitate access to community-based legal services that can support their patients in addressing a variety of needs, including seeking reasonable accommodations for disabilities in the workplace, addressing occupational safety and health issues of agricultural workers, and addressing issues faced by individuals who are justice-involved as they re-enter communities.

Examples of On-the-Ground Impact

When a four-year-old screened positive for lead poisoning months after moving into a new home with a federal Housing Choice Voucher, a nurse practitioner at Erie Family Health Centers, a HRSA-supported health center in Chicago, IL, requested an inspection of the home and lead-based paint hazards in the home were discovered. At the time, the Department of Housing and Urban Development's standards were four times the CDC's reference value standard, which meant that the local housing authority was not required to take action and they chose not to do so, despite evidence that the elevated blood lead level was causing neurological problems. The family was also unable to move before the end of a lease. The nurse practitioner at the clinic referred the family to the clinic's MLP, which was able to work with the city's housing authority to allow the family to move. The MLP also ensured that the new home was screened for lead and that any hazards were abated before the family moved in. While the child's lead levels decreased, she had permanent neurological damage from the lead poisoning. To help the family deal with these long-term impacts, the MLP helped them obtain special education services, as well as public benefits.

Indian Health Service (IHS)

Testing Strategies to Reduce Food Insecurity and Increase Dietary Health in Tribal Areas

American Indian and Alaska Native (AI/AN) people are disproportionately impacted by food insecurity when compared to non-Native people. They are also more likely to live in areas with low or no access to fresh foods than any other racial or ethnic group. About one in four Native people experience food insecurity, compared to one in nine Americans overall. The higher rates of food insecurity amongst AI/AN people are worsened by water insecurity, environmental pollution, and historical loss of land and forced relocation, all of which have negatively impacted traditional healthy food practices**.**

Produce prescription programs have been shown to increase access to nutritious foods in communities at risk for food insecurity. These programs help meet the needs of individuals and families experiencing food insecurity and diet-related health problems by making fruit and vegetables more readily available to communities in need. Interventions have included developing the infrastructure to implement and maintain a produce prescription program that fosters ongoing collaboration with one or more tribal, federal, or urban health care facilities and local markets, organizations, and services that provide fresh fruits and vegetables and/or traditional foods (stores, markets, farmers, mobile unit, etc.). Additional interventions include implementing a nutrition education program that teaches program participants about proper nutrition and the impact it has on disease risk reduction and overall health. Nutrition education programs also include information on cultivation and preparation for consumption of traditional foods.

The IHS Produce Prescription Pilot Program (P4) aims to improve health outcomes by developing sustainable, community-specific approaches to reducing food insecurity and improving overall dietary health by increasing access to fruits, vegetables, and traditional foods. The goal of P4 is to demonstrate and evaluate the impact of produce prescription programs on AI/AN people and their families, and to identify best practices.

Accomplishments to Date

In 2023, IHS awarded a total of $2.5 million of grant funding to five tribes and tribal organizations to implement a produce prescription program in their communities. The grantee programs began their implementation plans in the fall of 2023. The IHS P4 support team has been conducting one-on-one, monthly meetings with each grant program since late August, and monthly cohort meetings since October. The monthly meetings have given the grantees an opportunity to share their stories and discuss successes and challenges in implementing their produce prescription program.

Produce Prescription Pilot Program Grantees

Examples of On-the-Ground Impact

During the first year of the P4, each grant program has developed unique and creative ways to address their community's priorities and utilize available resources to implement their programs. For example, grantees have shared that they have incorporated food sovereignty and traditional foods into their programs by partnering with Indigenous farmers in their communities. Additionally, grantees have implemented nutrition education programs to teach participants the importance of healthy eating and to increase access to Registered Dietitians for individual counseling sessions. Some programs have implemented cooking classes focusing on traditional foods and intergenerational participation.

National Institutes of Health (NIH)

Funding Research to Identify Effective Interventions to Address SDOH and HRSNs

NIH supports research to identify effective solutions to address adverse SDOH and unmet HRSNs to reduce health disparities and advance health equity. Below is a selection of recent NIH activities and accomplishments that illustrate the NIH's commitment to advancing research to understand and address SDOH and HRSNs.

- To advance solution-oriented science on health disparities and health equity research, the NIH Common Fund launched the Community Partnerships to Advance Science for Society (ComPASS) Program. The goals of ComPASS are to 1) develop, deploy, and evaluate community-led health equity structural interventions that leverage partnerships across multiple sectors to reduce health disparities and 2) develop a new health equity research model for community-led, multisectoral structural intervention research across NIH and other federal agencies. ComPASS

also seeks to increase diversity and inclusion in research by cultivating community trust and partnerships, building research capacity among the community and relevant partners, and enhancing community organization competitiveness for future funding.

ComPASS Program Components

- In 2023, the National Institute of Nursing Research (NINR) issued the Bridge-to-Care Initiative, to support intervention research that leverages healthcare-community partnerships to address HRSNs at the individual or family level or SDOH at the community level.
- In response to the national maternal health crisis, in 2022 and 2023, NINR issued the Advancing Integrated Models (AIM) initiative to support research to advance the implementation and expansion of interventions, policies, and programs, focused on the provision of supportive care throughout the pregnancy continuum, among populations who bear a disproportionate burden of adverse pregnancy outcomes.
- A new research initiative was launched by the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) in 2023: Pilot Interventions to Integrate Social Care and Medical Care to Improve Health Equity. This funding opportunity will support pilot and feasibility trials to test interventions that screen for and address social risks during a healthcare visit. NIDDK intends to commit $1.2 million in fiscal year (FY) 2024 to fund three awards.

Accomplishments to Date

In FY 2023, ComPASS funded a Coordination Center and community-led health equity structural interventions (CHESIs). The interventions are located in all 10 HHS regions and will intervene on structural factors across five SDOH domains: 1) Neighborhood and Built Environment; 2) Economic Development; 3) Social and Cultural Context; 4) Nutrition and Food Environment; and 5) Community Health Care Access and Quality. In FY 2024, ComPASS intends to fund five Health Equity Research Hubs. The Coordination Center and Hubs will provide research training and capacity building in planning, implementation, and dissemination of health equity structural interventions. Recipients of these resources and support will include backbone organizations funded to conduct structural intervention research through the CHESI awards. Resources and materials developed through the ComPASS Program will be open access with the aim to serve backbone organizations beyond those that are funded. Over a five-year period, NIH will invest approximately $200 million dollars in supporting community-led structural intervention research.

Community Partnerships to Advance Science for Society (ComPASS) Award Locations

Under the Bridge-to-Care Initiative, NINR funded four research projects totaling more than $5 million in 2023. These healthcare-community partnerships will, for example, utilize electronic health record-based functionality to support clinic-community linkages for individuals with social risks; engage school-based community health workers in rural areas to support student school attendance; and link access to medications for Opioid Use Disorder care between jails and referral clinics. The Bridge-to-Care funding opportunity was reissued in December 2023, for which NINR intends to commit $4 million dollars in FY 2024 to fund four to six awards.

Under the AIM Initiative, NINR funded eight projects in 2022 and four projects in 2023, totaling approximately $10 million over five years. One project will implement and evaluate an integrated, multilevel maternity care home model that incorporates maternity care navigation, benefits navigation, social work, doula, and mental health resources. Another project focuses on evaluating the impact of integrating community-based patient navigation into maternal care for Black women to improve maternal health outcomes by meeting social needs, decreasing stress and discrimination, and increasing timely care utilization.

Examples of On-the-Ground Impact

Among other important findings, recent NIH-funded research on HRSNs has found: food insecurity is significantly associated with poorer sleep in a racially/ethnically diverse U.S. sample; an unconditional cash transfer intervention for 1,000 mother-infant dyads experiencing poverty improved toddlers' consumption of fresh produce (although it was not found to improve reports of their child's health, sleep, or health care utilization); unmet social needs were common among caregivers of children presenting to a pediatric emergency department in Utah, especially among Spanish-speaking caregivers; among a cohort of 846 adults with Medicaid, those with mental illness diagnoses had higher odds of

experiencing food insecurity; and food insecurity was associated with higher odds of developing a future binge-eating disorder among participants of the Adolescent Brain Cognitive Development study.

Office of Minority Health (OMH)

Enhancing the Availability of Language Services in Health Care Settings

Individuals who have difficulty communicating in English may need an interpreter or document translation to access healthcare. HHS is working to improve communication with those with limited English proficiency (LEP). For example, OMH is providing awards through an initiative called Promoting Equitable Access to Language Services in Health and Human Services (PEALS) to develop new ways to enhance the availability of language services in health care settings. Awardees serve as demonstration sites that identify and implement innovative strategies to enhance language access services through: (1) policy development and implementation; (2) technology utilization; (3) education for individuals with LEP; and (4) education for providers, including medical support staff. Through this initiative, OMH expects to identify evidence-informed practices to increase the availability of language services in healthcare setting and reduce health disparities among people with LEP.

Accomplishments to Date

OMH has provided more than $4 million per 12-month budget year in grants to 11 organizations to establish one or more policy and program demonstrations. The project period for the PEALS initiative is September 30, 2022 to September 29, 2025. Data on short term outcomes from Year 1 of the initiative, including the number of new and revised policies developed and the number of individuals with LEP participating in the demonstration project activities, are pending.

Examples of On-the-Ground Impact

Thomas Jefferson University (TJU), a PEALS awardee, shared stories via YouTube from a community member in Camden County and a provider from Jefferson Health East that completed the awardee's medical interpreting course. Both the community member and provider commented that TJU's strategy of incorporating telenovelas as a teaching tool was very effective. They reported that the intriguing drama and characters encouraged their completion of the various sections of the course. The community member also noted his next step was to pass the certification to become a medical interpreter thanks to TJU.

Substance Abuse and Mental Health Services Administration (SAMHSA)

Supporting the Resilience of Individuals Exposed to Violence

Trauma results from an event, series of events, or set of circumstances experienced as physically or emotionally harmful or life threatening by an individual or community and has lasting adverse effects on the individual's functioning and mental, physical, social, or emotional well-being. Communities that have

experienced trauma related to community violence or civil unrest are often the communities experiencing long-term accumulated trauma related to discrimination, poverty, and other adverse SDOH. However, there are evidence-supported strategies to mitigate the impact of these exposures by promoting healing, recovery, and resiliency, as well as strategies to build on the abilities of service providers to support these communities in a trauma-informed way. Programs with these aims are likely to be successful in supporting the resilience of young people in those communities, which leads to long term positive impacts both for the individuals and the community.

Established in 2016, SAMHSA's ReCAST (Resiliency in Communities After Stress and Trauma) program supports efforts in communities that have experienced civil unrest, community violence, and collective trauma within the previous 24 months. ReCAST grantees are guided by a community-based coalition of residents and stakeholders, in partnership with other entities, such as health and human service providers, schools, institutions of higher education, faith-based organizations, businesses, state and local government, law enforcement, and employment, housing, and transportation services agencies. Through these community-based coalitions, ReCAST grantees build a foundation to strengthen the integration and cultural responsiveness of mental health services and other community systems to address the effects of trauma and other SDOH, such as law enforcement practices, employment, and housing policies.

Accomplishments to Date

In FY 2023, the ReCAST grantees trained 14,441 individuals, reached 198,445 community members with mental health messaging addressing trauma-informed practices, and provided evidence-based mental health-related services to 15,922 individuals. In addition, because of ReCAST, 1,421 organizations have collaborated on shared resources and coordinated mental health services to provide resilience and equity in communities that have recently faced civil unrest.

Examples of On-the-Ground Impact

SAMHSA's ReCAST program grantee, Louisville-Jefferson County Metro Government in Louisville, Kentucky, has started a new supportive housing initiative to help public housing residents maintain their housing placements. This grantee was approached by Louisville Metro Housing Authority to partner on a supportive housing project aimed at strengthening the integration of behavioral health services to address the SDOH of the Metro Public Housing residents. These behavioral health and case management services will provide vulnerable residents with both concrete needs, including links to resources for food, workforce development, transportation, as well as the skills to maintain their housing and avoid eviction and risk of homelessness.

Helping People with Serious Mental Illness Gain and Retain Employment

People with serious mental illnesses (SMIs) have many strengths, talents, and abilities that are often overlooked, including the ability and motivation to work. While 70 percent of adults with SMIs have a desire to work and consumers and families consistently identify finding and keeping jobs as a top priority, they often face significant barriers to finding and keeping jobs. Supported employment, an approach to vocational rehabilitation for people with SMIs, can help people with SMI participate in the

competitive labor market by helping them find meaningful jobs and providing ongoing support from a team of professionals. Supported employment occurs within the most integrated and competitive settings that provide individuals with SMI opportunities to live, work, and receive services in the community. SAMHSA's Transforming Lives Through Supported Employment Program (SEP) supports state and community efforts to refine, implement, and sustain evidence-based supported employment programs and mutually compatible and supportive evidence-based practices, such as supported education, for adults with SMI or co-occurring mental and substance use disorders.

Accomplishments to Date

In FY 2022 and FY 2023, 879 persons received services through SAMHSA's SEP. Of the total persons served, National Outcome Measures data is available with multiple time-points on 477 unique individuals. Of the total unique individuals served, there was an overall increase on all SDOH variables, including:

- A 153 percent increase in those either employed or enrolled in school or a job training program;
- A 51 percent increase in those enrolled in school or a job training program;
- A 224 percent increase in those currently employed;
- A 48 percent increase in those remaining in the community rather than requiring inpatient care or residential treatment;
- A 52 percent increase in those with a stable place to live; and
- A 15 percent increase in those reporting that they were socially connected.

SAMHSA's Center for Mental Health Services held a National Policy Academy on Supported Employment for Transition Age Youth in May 2023 with participation from seven states: Illinois, South Carolina, Alaska, Oklahoma, Utah, Mississippi, and Ohio. The states met for three days with SAMHSA, its federal partners, and national subject matter experts to develop a plan to align their supported employment services with evidence-based practice for transition age youth and to effectively utilize federal funding to expand their vocational rehabilitation services for this age group. SAMHSA is supporting the seven states through a Learning Collaborative as they implement their plans.

Examples of On-the-Ground Impact

SAMHSA's SEP program grantee, CarePlus New Jersey, shared that "Michael" joined the Employment Matters program in February 2020. At the time he was working at a job that he was unhappy with and wanted to gain alternative employment. Throughout his time in the program, Michael's objectives were to gain employment and develop social skills. Michael worked with the benefits counselor in the program to gain SNAP benefits, which allowed him to make steps towards becoming more independent. He also became more comfortable speaking to staff independently without the support of his parents. Through his hard work and determination, Michael landed a sales associate position at a chain department store. He reports that during his performance reviews, he received comments such as "great employee" by his supervisor. Michael maintained his employment at the store for months while searching for a higher paying position.

Because of the ongoing support offered at the Employment Matters program, he was able to land a higher paying position at an e-commerce company in June of 2021, which he still holds to this day. At

one point he was working at both positions, but ultimately decided to put all his energy into his employment at the e-commerce company. Through his work with the Employment Matters program, Michael has gained food security through SNAP benefits and gainful employment which are helping him work towards independent living. Through his employment journey Michael has also gained a positive network of friends in his coworkers, learned valuable job searching skills that will aid him in his future endeavors, and made positive strides toward developing communication skills.

Achieving Housing Stabilization for People with Serious Mental Illness

On a single night in 2023, roughly 653,100 people were experiencing homelessness in the United States.[6] It is estimated that 21 percent of individuals experiencing homelessness have a serious mental illness (SMI).[7] Mental illness affects individuals' abilities to maintain stable relationships, perform daily living activities, and maintain stable employment. Symptoms of mental disorders also often cause individuals to become estranged from family members and caregivers, leaving them without a support system. As a result, as compared to those without mental illness, individuals with a mental illness are more likely to experience homelessness and experience homelessness longer than the rest of the homeless population. As reported by the Office of National Drug Control Policy, approximately 30 percent of people experiencing chronic homelessness have a serious mental illness (SMI), and around two-thirds have a primary substance use disorder (SUD) or other chronic health condition. Stable housing is a critical component of recovery for individuals with behavioral health conditions.

SAMHSA's Treatment for Individuals Experiencing Homelessness (TIEH) program provides comprehensive, coordinated and evidenced-based services for individuals, youth, and families with a SMI, serious emotional disturbance, or co-occurring disorder who are experiencing homelessness or at imminent risk of homelessness (e.g., people exiting jail or prison without a place to live). Programs engage and connect individuals to behavioral health treatment, case management, and recovery support services; assist with identifying sustainable permanent housing by collaborating with homeless services organizations and housing providers, including public housing agencies; and provide case management that includes care coordination/service delivery planning and other strategies that support stability across services and housing transitions. With this program, SAMHSA aims to further expand opportunities to improve access to and delivery of coordinated, comprehensive mental health services and improve housing stability.

In addition, SAMHSA's Projects for Assistance in Transition from Homelessness (PATH) program, a formula grant supporting 56 grants to the 50 states, the District of Columbia, Puerto Rico, Guam, American Samoa, the United States Virgin Islands, and the Northern Mariana Islands, funds community-based outreach and engagement, case management, assistance with accessing housing, mental illness and substance use disorder treatment services, and other supportive services for individuals with SMI or a co-occurring disorder (COD) who are experiencing homelessness or at imminent risk of homelessness.

[6] The U.S. Department of Housing and Urban Development, Office of Community Planning and Development. The 2023 Annual Homeless Assessment Report (AHAR) to Congress, Part 1. https://www.huduser.gov/portal/sites/default/files/pdf/2023-AHAR-Part-1.pdf

[7] The U.S. Department of Housing and Urban Development, 2023 CoC Homeless Populations and Subpopulations. https://files.hudexchange.info/reports/published/CoC_PopSub_NatlTerrDC_2023.pdf

Each state PATH grantee is able to direct funds to sub-grantee local homeless services providers based on their assessment of need and service capacity. PATH outreach workers are specialized in engaging those who are most vulnerable in their communities and least likely to seek out services on their own, engaging in the extended trust building often necessary but also often not billable under many conventional funding sources such as insurance.

Accomplishments to Date

In FY 2023, 39 percent of individuals served by the TIEH program reported that they had a stable place to live at their six-month reassessment, an increase from 14 percent at intake, and 35 percent of individuals served by the program reported being homeless in the past 30 days at their six-month reassessment, compared to 62 percent at intake. During FY 2023, 70 percent of individuals reported a decrease in psychological distress, compared to 55 percent at intake.

In FY 2023, PATH providers offered essential services in over 400 communities to support outreach workers and mental health specialists who engaged with over 100,000 individuals living with SMI or a COD and were homeless or at imminent risk of becoming homeless. All of those contacted were offered referrals to appropriate local services, and over 58,000 were eligible and accepted enrollment into PATH services, receiving ongoing services and supports.

Examples of On-the-Ground Impact

SAMHSA's TIEH program grantee, the University of Arkansas for Medical Sciences, shared that "Kim" and her daughter, "Kelly," relocated to Little Rock from Florida in 2020 to take care of Kim's sick mother, only a month before the pandemic hit. When Kim was no longer able to stay with her mother, she was left without a stable home and hit many roadblocks trying to find jobs and resources during the height of the pandemic. Kim bounced between different friends' houses but struggled to find somewhere safe and secure. A friend directed Kim to Our House, a TIEH grantee, for resources as a single mom to a young daughter facing homelessness. She was able to get connected to the Home Together program, which builds provider capacity to assist both mothers of young children and pregnant people who have a SMI or co-occurring SUD with long term housing outcomes. Kim and her Home Together case manager, "Paula," quickly worked together in their first week to explore housing resources and connect Kelly to our children's clinic—in partnership with Arkansas Children's Hospital—to be seen for all her necessary screenings. Kim was fortunate to quickly get a housing voucher so that she could find affordable housing. After moving into an apartment, Kim faced many challenges throughout the next year before landing in her current home, but Paula was there to support and guide her all the way.

Through it all, Kim and Paula worked closely together to focus on mental health supports, getting childcare for Kelly in Our House Little Learners program, and evolving her work experience into a long-term career. Working with the Home Together program helped Kim transform her mindset to think about how to make sustainable choices for her family that will result in a well-balanced life. Kim is now working in a long-term care facility, no longer using a housing voucher and is starting nursing school at University of Arkansas - Pulaski Technical College this summer. Kelly is excelling in Little Learners, especially by working with Home Together-funded children's therapist to establish a strong foundation

of social and emotional skills. Kim has learned to prioritize her own self-care by having a therapist and remaining mentally balanced through all the obstacles she faces.

PATH outreach workers have also shared successes in helping individuals achieve stable housing. Mary had spent most of her waking hours for multiple years on the same park bench. She wore brightly colored scarves and headphones along with layers of clothing that included dresses and long underwear, skirts, pants, and jackets. No one knew much about Mary because she would get up and move if anyone came too close. And if someone became too insistent, Mary would leave her bench and not return for days. No one knew where she went during those times. PATH outreach workers kept trying to find a way to break through her fear and distrust. They brought her sunscreen and insect repellant, sandwiches, hot coffee, and blankets when the temperature dipped dangerously low. Over and over again, they brought offers of housing, services, and safety. After multiple years and many seasons of life-threatening weather something finally clicked and Mary agreed to accept help from a PATH worker. After spending a month in the hospital, she moved into an emergency respite bed at the local shelter, and subsequently found her a subsidized, non-time-limited apartment with connections to case management and other supportive services where she was able to live comfortably and safely.

Another individual, Sam, was first met with during a Point-in-Time Count, which counts sheltered and unsheltered people experiencing homelessness on a single night in January, at which time he was observed to be sleeping under a bridge. A PATH outreach worker helped connect Sam with medical care for health issues, providing mental health support to attend, and supported Sam in applying and obtaining a Bridging Rental Assistance Program (BRAP) housing voucher. However, due to the client's rental and criminal history, Sam was unable to find housing with his BRAP voucher. The PATH worker persisted and supported Sam in applying and obtaining a Shelter Plus Care housing voucher. They searched together for apartments that would accept the voucher until Sam successfully moved into an apartment where he is currently living successfully.

Transforming Community Behavioral Health Systems

Many individuals with behavioral health conditions do not receive the help they need. When they do try to access services, they often face significant delays and/or have limited access to services. Too often, services are incomplete and uncoordinated. People who receive services, such as medication or psychotherapy, often do not get other supports they need, such as crisis management, supported employment, supportive housing, and care for co-occurring physical health problems.

In 2014, Congress created a new approach to addressing these issues by creating the Certified Community Behavioral Health Clinics (CCBHC) model. CCBHCs were established to transform community behavioral health systems, provide sustainable funding for robust community outpatient mental health treatment, and provide comprehensive, coordinated behavioral health care. CCBHCs are required to serve anyone who requests care for mental health or substance use, regardless of their ability to pay or place of residence. CCBHCs must serve people across the lifespan, including by providing developmentally appropriate care for children and youth. CCBHCs also must meet standards for the range of services they provide and are required to get people into care quickly. CCBHCs are required to provide nine services: crisis services; outpatient mental health and substance use services; person- and

family-centered treatment planning; community-based mental health care for Veterans; peer family support and counselor services; targeted care management; outpatient primary care screening and monitoring; psychiatric rehabilitation services; and screening, diagnosis, and risk assessment. CCBHCs can be supported through the Section 223 CCBHC Medicaid Demonstration, the SAMHSA-administered CCBHC Expansion (CCBHC-E) Grants, or independent state programs separate from the Section 223 CCBHC Medicaid Demonstration. In 2017, the first CCBHCs were funded under Medicaid, with 67 operating in eight states. Today, there are more than 500 CCBHCs in 46 states, the District of Columbia, and Puerto Rico. The CCBHC initiative is operated through an HHS partnership across SAMHSA, CMS, and the Office of the Assistant Secretary for Planning and Evaluation (ASPE).

Through the CCBHC grantee network of clinics and technical assistance (TA) centers, SAMHSA has improved the quality and accessibility of care by strengthening treatment and recovery services and expanded community efforts to provide a continuum of treatment and recovery supports for individuals living with serious mental illness or serious emotional disorders, their families, and their caregivers.

Accomplishments to Date

In March 2023, SAMHSA released the updated 2023 Community Behavioral Health Clinics Certification Criteria, which established several mechanisms to address SDOH. For example, CCBHCs are required to establish care coordination partnerships with community and social service providers to ensure linkage with needed services, seamless transition, and follow-up supports based on the needs of individuals receiving services. Additionally, the required comprehensive evaluation following an initial assessment must include an overview of relevant social supports, SDOH, and HRSNs, such as housing, educational, vocational, and family/caregiver supports, and identify any relevant social service needs of the person receiving services, with necessary referrals made to social services.

In FY 2023, the SAMHSA's CCBHC-E grants network of clinics served more than 781,000 individuals. Among the individuals served through the CCBHC-E grants, there was an overall improvement in several areas, including housing, education and employment, and criminal justice system involvement. For example, there was a 31.2 percent reduction in CCBHC clients who reported being homeless at any night in the last month after six months of receiving services (from 5.1 percent at baseline interview rate to 3.5 percent at six month follow up). Additionally, there was a 9.9 percent improvement in CCBHC clients who reported being employed or enrolled in school (from a baseline rate of 37.9 percent to 41 percent at six month follow up). The CCBHC-E grantees also reported substantial improvement in individuals served who had some involvement in the criminal justice system. Of the unique individuals served through the CCBHCs in FY 2023 with criminal justice involvement, there was a substantial reduction in any arrest in the last 30-days from a baseline rate of 1.8 percent to 0.9 percent at the six month follow up interview, an overall reduction of nearly 50 percent.

Goal Three: Whole-of-Government Collaborations

Whole-of-government approaches, public-private partnerships, and community engagement are necessary in addressing social needs and enhancing population health for communities that have been historically marginalized and are often underserved. Similar to addressing the needs of individuals, tackling policy challenges related to addressing SDOH requires a comprehensive approach across levels of government ("whole of government") and the private sector, with an emphasis on working with local community-based efforts to assess local needs, plan development, and service delivery through networks of community-based organizations. HHS is working to improve integration between government agencies that fund the delivery of health care services and social services across the federal government, and with state, local, and tribal governments. The Department is also working to support actions on the community level that support and sustain systemic interventions through multi-sector partnerships.[8]

Administration for Children and Families (ACF)

Disseminating Best Practices to Address Housing Stability for Human Trafficking Victims

Access to secure housing can provide opportunities for gainful employment, education, healthy food, and health care. It can reduce exposure to community violence and the risk for exploitation, including human trafficking. In recent years, federal agencies have coordinated to enhance access to a range of housing interventions for individuals and families who have experienced human trafficking. The National Action Plan to Combat Human Trafficking directed regional offices with HHS, the Department of Housing and Urban Development (HUD), the Department of Justice (DOJ), and the Department of Labor (DOL) to explore the development of a pilot collaboration with federally funded service providers to connect survivors of human trafficking with sustainable housing and meaningful employment. In Fiscal Year (FY) 2021, ACF launched the Regional Anti-Trafficking Initiative Support and Engagement (RAISE) Program to fund and support regional anti-trafficking efforts through awards ranging from $25,000 to $50,000 that support a broad range of activities, such as by launching and evaluating a pilot collaboration to increase the number of emergency housing vouchers leveraged, and access to affordable, safe housing options.

Accomplishments to Date

In December 2020, ACF launched a Housing and Economic Mobility Toolkit, which includes guiding principles for working with survivors of human trafficking, strategies for developing community partnerships, and clarification about survivors' eligibility for existing housing resources. Since the time of publication through mid-November 2023, the Toolkit has been viewed 1,985 times. In September 2022, ACF published an updated information memorandum on Federal Housing and Economic Mobility Resources to increase awareness of federally funded programs, trainings, and resources to improve access to safe housing and meaningful employment. This resource was created in collaboration with DOL's Employment and Training Administration and members of the Federal Interagency Human Trafficking Housing Workgroup. ACF funds organizations to provide comprehensive case management

[8] For example, see the Federal Plan for Equitable Long-Term Recovery and Resilience, available at: https://health.gov/our-work/national-health-initiatives/equitable-long-term-recovery-and-resilience

and referrals, including for housing assistance, to individuals who have experienced a severe form of trafficking in persons. In FY 2022, ACF's Domestic Victims of Human Trafficking Program and Trafficking Victim Assistance Program together provided housing services to 1,407 clients. Recognizing that adverse credit information can limit access to safe housing and other services and resources, ACF issued a Program Instruction (PI) based on the Consumer Financial Protection Bureau's Final Rule entitled Prohibition on Inclusion of Adverse Information in Consumer Reporting in Cases of Human Trafficking. The rule prohibits consumer reporting agencies from reporting adverse credit information resulting from an individual's human trafficking experience. The PI authorizes recipients of grants from the Office on Trafficking in Persons (OTIP) to issue required documentation to seek removal of adverse information from their credit report on behalf of affected individuals.

Examples of On-the-Ground Impact

ACF Region 3's Regional Interdisciplinary Collaborative Working Group to Disrupt Human Trafficking facilitates collaboration across federal, state, and local agencies to raise awareness and build capacity to address human trafficking across the region. In June 2021, ACF's Region 3 received RAISE funding through the OTIP. ACF Region 3 used RAISE funds to provide training for residential foster care providers to improve service programs for children who have experienced trafficking and children in foster care at risk of trafficking. ACF Region 3 also used RAISE funds to support the inaugural 2021 Regional Anti-Trafficking Summit, which convened professionals in child welfare, social services, medical communities, and other systems and focused on the importance of trauma-informed services. The summit featured 178 participants and 58 speakers. ACF Region 3 has since continued to hold Regional Anti-Trafficking Summits in 2022 and 2023, and most recently held the 4th Annual Regional Human Trafficking Summit in February 2024. These Summits are aimed at sharing best practices, learning from survivor experts, and exploring multidisciplinary approaches to regional partnerships. RAISE funds were also used to support consultant fees for lived experience experts to help plan and facilitate the 2021 summit. Through this project, RAISE funds increased the number of residential staff providers who are trauma and trafficking informed; the number of residential care providers in ACF Region 3 who have the knowledge to create Commercial Sexual Exploitation of Children (CSEC) policies and protocols that align with best practices; the number of residential care providers in ACF Region 3 who can create a diverse, non-judgmental, and engaging culture for youth who are exploited and at high-risk for human trafficking within their facility; and the ability of providers in ACF Region 3 to create and maintain a coordinated system of care.

ACF's Region 4 is working in close partnership with OTIP, OASH, SAMHSA, and HRSA to coordinate communication channels and anti-trafficking support for states. The Region 4 Anti-Trafficking workgroup is working with states on a shared 2024 agenda to better integrate human trafficking, substance use, and behavioral health sectors alongside other priority work identified by the states.

ACF's Region 5 used RAISE funds to develop a study on the impacts of the Chicago Housing Authority's Human Trafficking Housing Pilot (2017-2020). The long-term goal of the RAISE-funded study was to understand the pilot's impact on addressing housing needs for survivors coming out of both labor and sex trafficking, international and domestic. Prior to the pilot, over half of the 16 respondents either lived in a shelter or were homeless. Following their participation in the pilot, 100 percent of survey respondents agreed or strongly agreed that they found safe and stable housing and reported feeling

safer overall. Additionally, 100 percent of survey respondents agreed or strongly agreed that they were satisfied with the housing they were able to find with the help of their caseworker. Connections to caseworkers or other support staff played a critical part in ensuring not only being housed but being supported through the experience of navigating systems and traditional processes that exist in the voucher process. Seventy-five percent of survey respondents reported feeling supported by caseworkers while finding housing. Outside of finding housing, respondents reported many benefits of engaging in the pilot including staying drug free and sober; engaging in and completing a GED program; decreased anxiety by engaging with behavioral health services; reuniting with family; and feeling safer (being defined as beginning to trust people that they originally did not know). Understanding survivors' experiences from participating in the pilot demonstrated the necessity of concurrently securing stable housing while providing ongoing services tailored to address the needs and bolster the self-identified goals of survivors. The pilot established an innovative and successful supportive housing model for survivors of human trafficking and has since transitioned into an ongoing program initiative of Chicago Housing Authority.

Administration for Community Living (ACL)

Facilitating State Adoption of Medicaid Flexibilities to Address Housing Stabilization

Many people with disabilities, older adults, and people experiencing homelessness need assistance obtaining housing that is both affordable and accessible. Many also need access to community-based supportive services, such as behavioral health care services, personal care assistance, tenancy supports, accessible transportation, and home-delivered meals, in order to live successfully and stably in the community. Without housing and services that meet their needs, they often have no choice but to live in facilities, like nursing homes and homeless shelters, or on the streets. In 2021, HHS and the Department of Housing and Urban Development (HUD) launched the Housing and Services Resource Center (HRSC) to improve access to affordable, accessible housing and the critical services that make community living possible. Within HHS, this partnership is led by the ACL and includes ACF, CDC, CMS, SAMHSA, and ASPE. The HRSC provides a federally coordinated approach to providing resources, program guidance, training, and technical assistance to public housing authorities and housing providers; state Medicaid, disability, aging, and behavioral health agencies; the aging and disability networks; homeless services organizations and networks; health care systems and providers; and tribal organizations.

Accomplishments to Date

In November 2023, HHS and HUD announced the Housing and Services Partnership Accelerator (Accelerator), which will support states with Medicaid programs working to expand innovative housing-related supports and services through an approved section 1115 demonstration or an approved section 1915(i) state plan benefit covering people with disabilities and older adults who are experiencing or at risk of homelessness. Implementation of these new Medicaid-covered housing-related services and supports remain in the early stages, and many states have expressed interest in receiving greater support with implementation including through knowledge exchange with other states. The Accelerator responds to states' requests for assistance to tackle a common set of issues, including payment models and rates; alignment with federal and local housing assistance programs; provider capacity; partnerships

with health organizations, community-based organizations, and housing agencies; and data integration/sharing. States have a unique opportunity to take a whole-of-government approach to address housing stability by emphasizing greater collaboration and coordination across state and local health and housing agencies and community-based organizations to optimize resources, cover resource gaps, align state and local policies, and deliver more integrated and seamless services. The Accelerator is a 12-month technical assistance program and learning collaborative that will leverage federal collaboration to support selected states by providing them with individualized technical assistance and the opportunity to learn from peer states. HHS and HUD received an overwhelming response with applications from fifteen eligible states and DC. A rigorous review and scoring process, including interviews with state teams, led to the final selection of eight states (Arizona, California, Hawaii, Maryland, Massachusetts, Minnesota, North Carolina, and Washington) and DC.

Centers for Disease Control and Prevention (CDC)

Supporting Community-Driven Solutions to Improve SDOH

Six in 10 Americans live with at least one chronic disease, like heart disease and stroke, cancer, or diabetes. Such chronic diseases are the leading causes of death and disability in America and are a leading driver of health care costs. SDOH influence chronic disease risk factors and contribute to persistent chronic disease disparities across the country.

CDC invests directly in communities to reduce chronic diseases among populations who are at increased risk for health disparities. Through CDC's Closing the Gap with Social Determinants of Health Accelerator Plans funding, recipients develop multi-sector actions plan and implementation strategies to address SDOH. Leadership teams from public health agencies and multi-sector representatives, such as governments, private businesses, non-profit and community organizations, and health care, are working together to address SDOH in areas such as housing, transportation, and food systems through community health assessment and long-range planning and implementation of policy, system, environmental, and programmatic changes. Through this increased collaboration and engagement across multisectoral partners, this initiative seeks to improve SDOH and health outcomes in communities with the poorest health outcomes.

Under Addressing Conditions to Improve Population Health (ACTion), a three year cooperative agreement, CDC provided funding in 2023 to five recipients who were ready to take ACTion in communities to implement policy, systems, and environmental change interventions that address SDOH. The SDOH domains prioritized for these projects include:

- Built Environment
- Community-Clinical Linkages
- Food and Nutrition Security
- Social Connectedness

Specific outcomes to be achieved through ACTion include changes in group and organizational behavior and norms, adoption of new policies and practices, and changes in availability and accessibility of health

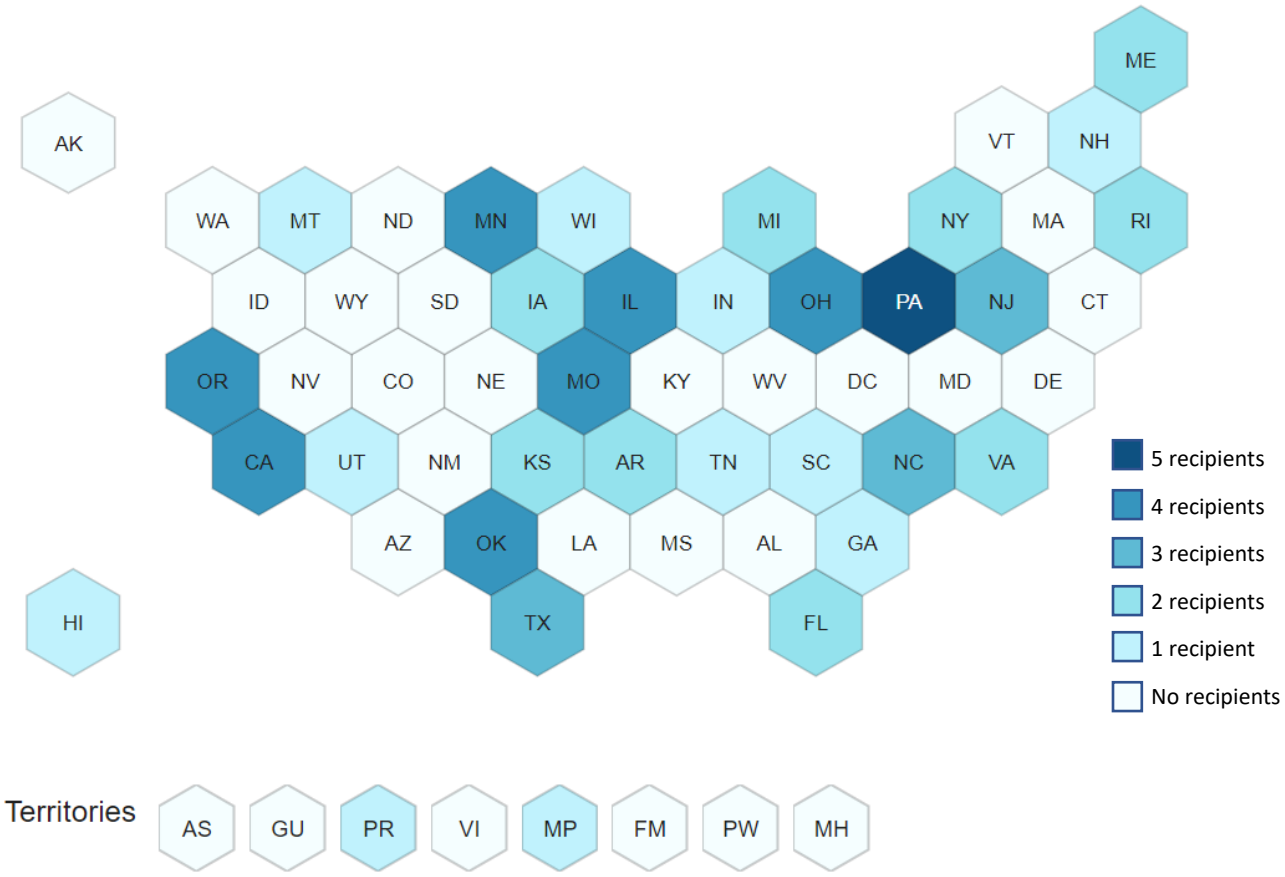
care and community services. CDC also funded a modeling project to examine health and financial impact of SDOH policy, systems and environmental strategies.

Finally, CDC supported an environmental scan to summarize the evidence in five SDOH (built environment, community–clinical linkages, food and nutrition security, social connectedness, and tobacco-free policies) that are strongly tied to chronic disease conditions and communities that are most affected to help inform future research, program, and technical assistance investments.

Accomplishments to Date

CDC has funded 71 organizations to develop an implementation-ready SDOH Accelerator Plan. Each of these communities has established or is establishing a multi-sector partnership to improve the health and well-being of communities by addressing challenges related to the environment, food and nutrition availability and accessibility, clinical and community services, social connectedness opportunities, and tobacco-free policies. The total funding for three years was approximately $8.725 million.

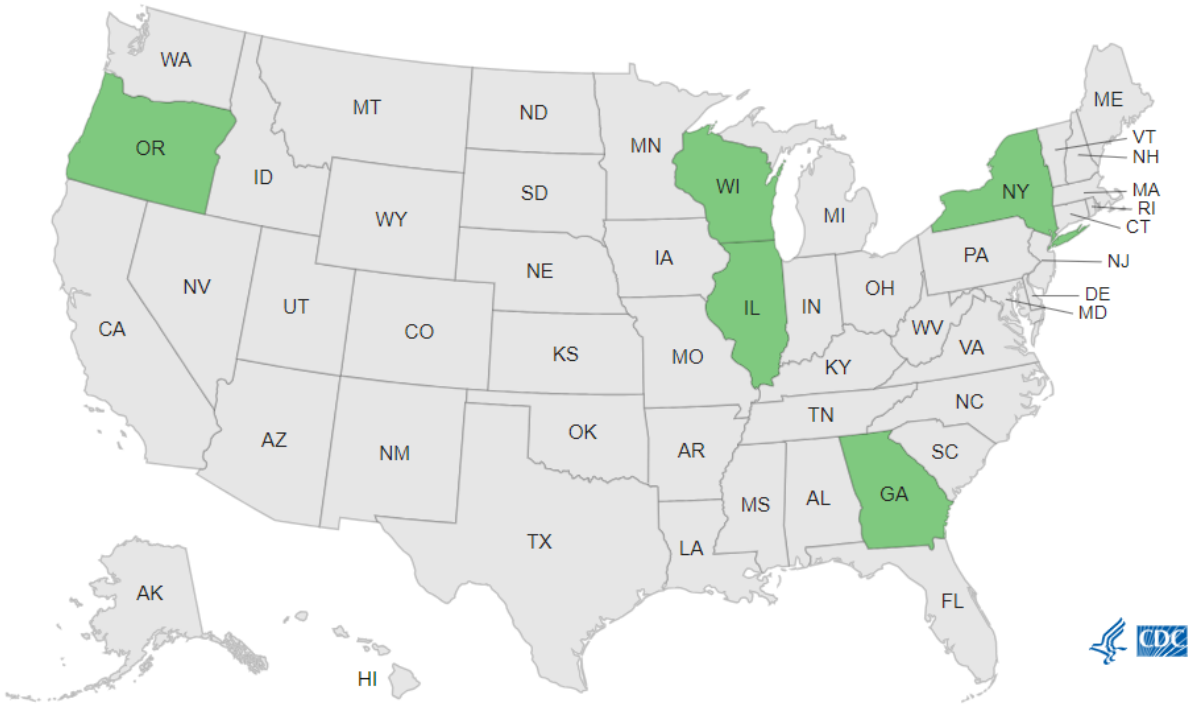
Number of Closing the Gap with Social Determinants of Health Accelerator Plans recipients, by state or territory, 2021-2023



The five ACTion communities funded to implement their plans aim to improve local conditions by enhancing and increasing the availability and accessibility of health care and community services. CDC will evaluate the implementation and policy, systems, and environmental (PSE) changes achieved

between 2023 to 2026. Beginning Fall of 2024, CDC will gather data on barriers to and facilitators of effective implementation and collect quarterly data on progress made utilizing PSE strategies. CDC is also providing technical assistance to build the capacity of recipient communities to evaluate local PSE changes and measure what was accomplished.

Addressing Conditions to Improve Population Health (ACTion) Recipients, 2023-2026



Examples of On-the-Ground Impact

The Arkansas Department of Health has prioritized Crittenden County for its SDOH Accelerator Plan, acknowledging its classification as a high vulnerability area within the top seven percent of counties nationwide, as determined by the CDC/Agency for Toxic Substances and Disease Registry (ATSDR) Social Vulnerability Index. Almost 60 percent of children and 43 percent of adults in Crittenden County live below 200 percent of the federal poverty line. Limited access to healthcare, affordable nutritious foods, and public transportation are driving factors of health disparities, particularly impacting people with lower incomes, Black or African American persons, and older adults living in Crittenden County. Crittenden County has a high prevalence of hypertension (66 percent), obesity (43 percent), and diabetes (25 percent). Over 75 percent of the population is overweight or obese, and 40 percent of residents in Crittenden County have had no physical activity in the past 30 days compared to 30.9 percent across Arkansas. Furthermore, 30.6 percent of the population are current smokers.

The Arkansas Department of Health's SDOH Accelerator Plan Leadership Team was developed out of a smaller contingent of Crittenden County community leaders working on conditions such as food insecurity, health, and transportation. The plan brought together representation from city and county government, state legislators, healthcare, transportation, housing, public health, education, emergency

management, Chambers of Commerce, home visiting, faith-based, corrections, community outreach, and behavioral health. The Leadership Team established partnerships across multiple sectors to leverage these formed relationships to strengthen community clinical linkages and address food insecurities and transportation barriers to improve health outcomes in Crittenden County.

With support from CDC, Crittenden County convened multisector partners to develop an SDOH Accelerator Plan highlighting the community's most pressing needs. Leveraging the SDOH plan, Crittenden County was able to obtain funding and launched Connect Crittenden, a central resource hub and referral network, was launched to overcome identified issues, such as limited staff resources; support collaborations to address the identified community needs for ambulatory and wheelchair-accessible transportation and prescription medication delivery services; and develop support joint ventures to provide nutritious food boxes, a mobile food pantry, and a fruit and vegetable prescription program. Since the Connect Crittenden resource site launch over 1,600 new organizations have been added to the site with direct referral capabilities to connect with other programs to provide services to residents and to create a thriving social care network.

Implementing Community-Based Interventions to Address Factors that Influence Health

A core strategy or goal of public health is that every person has a fair and just opportunity to reach their full health potential. CDC seeks to remove systemic and structural inequities, as well as barriers to health linked to race or ethnicity, education, income, location, or other social factors. Racial and Ethnic Approaches to Community Health (REACH) is a national program administered by CDC to reduce racial and ethnic health disparities. Through REACH, recipients plan and carry out local, culturally appropriate programs to address a wide range of health issues among disproportionately affected populations including Black and African American, Hispanic and Latino, Asian American, American Indian and Alaska Native, and Native Hawaiian and other Pacific Islander persons by addressing preventable risk behaviors, including tobacco use, poor nutrition, and physical inactivity. In rural, urban, and tribal communities across the United States, REACH recipients use the following evidence-based strategies as part of culturally tailored interventions designed to improve social and environmental conditions:

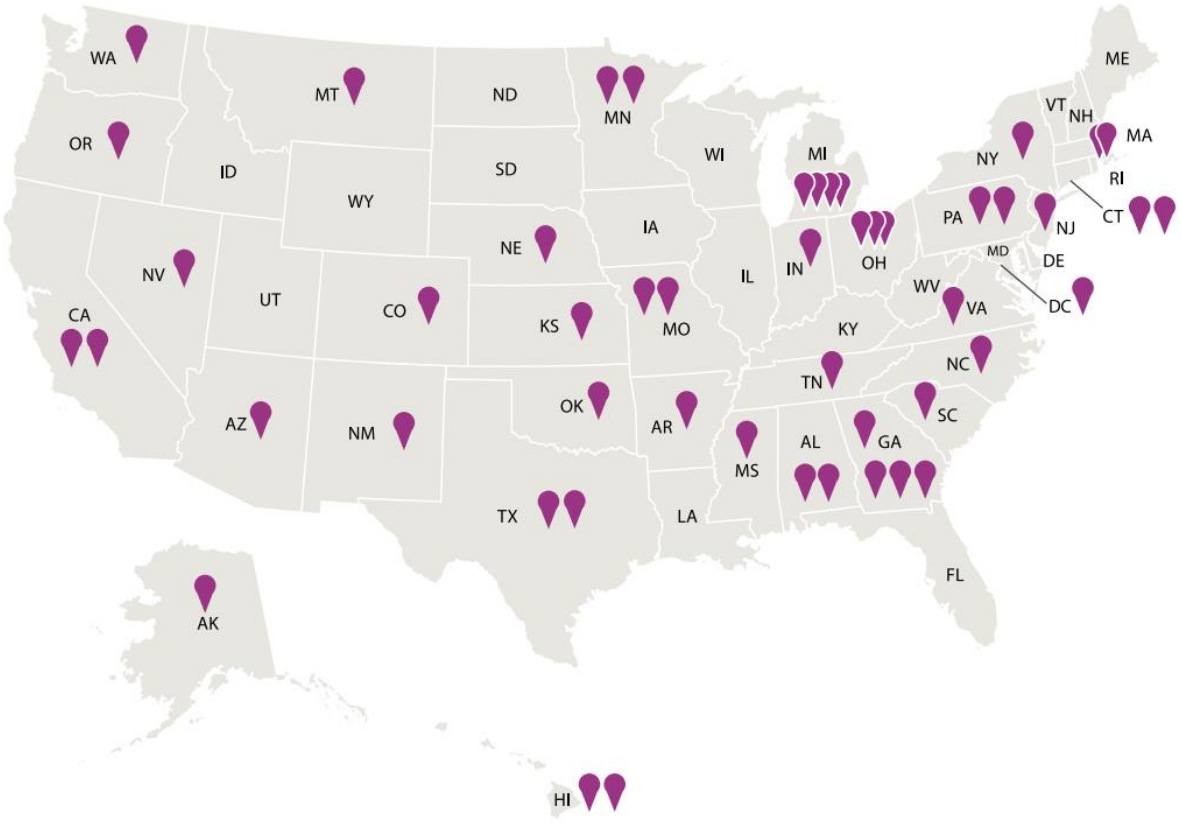
- Increase options for good nutrition across the lifespan by improving access to healthy foods. For example, communities can promote healthy food service and nutrition standards in worksites, community settings, and charitable food systems and/or expand fruit and vegetable voucher and prescription programs.
- Increase physical activity by promoting designs that create places for safe and accessible physical activity, including implementing local level policies and activities to connect pedestrian, bicycle, or transit transportation networks (i.e., activity-friendly routes) to everyday destinations.
- Implement policies and activities that achieve continuity of care for breastfeeding families. For example, communities can increase the community's ability to provide consistent, tailored, evidence-based lactation education and support by regularly training anyone who provides services to families.
- Implement policies and activities that support healthy growth and development in Early Care and Education (ECE) settings including creasing access to healthy foods, breastfeeding support, opportunities for physical activity, and Farm to ECE.

- Establish policies and activities that increase supports for Family Healthy Weight Programs (FHWPs). These family-centered, intensive health behavior and lifestyle treatment programs focus on nutrition, physical activity, and behavior change strategies and can be delivered in a clinical or community setting by trained program staff. Communities can build or strengthen and formalize local partnerships to lay the groundwork to implement FHWPs and identify a partner organization that will implement the FHWP.
- Prevent and reduce tobacco use by adopting or strengthening tobacco prevention and control policies.
- Implement practices to increase awareness, confidence, demand, and access for flu, COVID-19, and other routinely recommended adult vaccines. For example, communities can build partnerships between vaccination providers and the community to make more opportunities for priority groups to get vaccinated.

Accomplishments to Date

Since 1999, REACH recipients have used community-based, participatory approaches to identify, develop, and implement effective strategies for addressing health disparities. In FY 2023, REACH funded 50 organizations across 33 states.

Racial and Ethnic Approaches to Community Health Recipients, FY 2023



Through the REACH Program, between 2018 and 2022:

- More than 8.6 million people have more opportunities to be physically active through activity friendly routes to everyday destinations;
- More than 2.3 million people have better access to healthier food systems;
- More than 1 million people have access to food service guidelines or health nutrition standards in community sites;
- More than 1.2 million people were reached through community support to start and continue breastfeeding;
- Over 1 million people benefited from local smoke free or tobacco free policies that were implemented or strengthened; and
- More than 41 thousand patients have been referred through formal partnerships with locally available health and preventative programs.

Additionally, COVID-19 and influenza vaccine promotional efforts of REACH recipients has resulted in translating materials into over 20 languages, training over 1,000 community influencers, and vaccinating over 50,000 community members.

Examples of On-the-Ground Impact

The COVID-19 pandemic increased and exacerbated food insecurity among communities of color, specifically African American/Black people and Asian American people, the two largest racial/ethnic populations living in SeaTac and Tukwila, cities in South King County, Washington. As inflation increased and supply constraints reduced the availability of food, the overall cost of food increased. Access to healthy foods is an important part of good overall health. Both adults and children who experience food insecurity are more likely to also experience poor physical, oral, and mental health.

Public Health Seattle King County Racial and Ethnic Approaches to Community Health (KCREACH), a CDC funding recipient, provided technical assistance to one of their partners, Food Innovation Network (FIN) to enhance the local food system, increase access to healthy food, and to support local food businesses in South Seattle and South King County. FIN‘s Tukwila Farmers Market provides fresh, local produce to the community at affordable prices while also supporting farmers, such as, local Black, Indigenous and People of Color (BIPOC), refugee, and immigrant farmers. In partnership with KCREACH, FIN:

- Expanded its Tukwila Famers Market and implemented an American Heart Association funded Heart Bucks voucher program to increase access to healthy, locally grown produce for community members who are experiencing food insecurity;
- Applied for the Tukwila Farmers Market to become an approved distribution site for the Summer Food Program (funded by the City of Seattle), which distributes meals to school-aged children for 10 weeks during the summer break; and
- Provided entrepreneurs with marketing, training, and other services through FIN’s Food Business Incubator program, which helps women, including women of color and immigrants who are entrepreneurs launch and scale to successful local businesses and created a community hub where people can learn about and celebrate the community’s rich and diverse food traditions.

Between 2018 and 2023, FIN hosted 89 market days, helped 10 local farmers and 14 local businesses through the farmers market, helped more than 300 families connect to food access programs, and

provided over $50,000 in the Heart Bucks program for over 400 families to purchase healthy, local, produce.

Centers for Medicare & Medicaid Services (CMS)

Increasing Access to Healthy Foods and Health Care Coverage through Cross-Enrollment

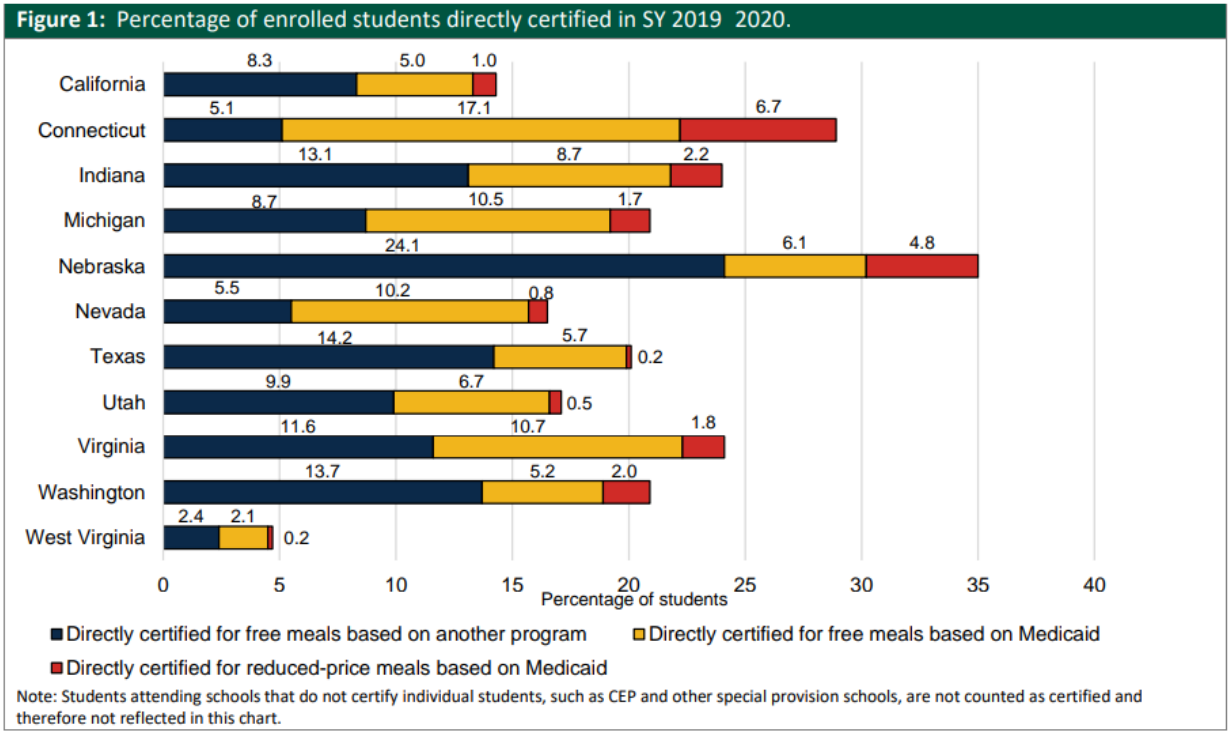
Improving access to healthy foods is important to improving health outcomes and may also help reduce health care costs. Many families that receive benefits through U.S. Department of Agriculture's (USDA) Food and Nutrition Service (FNS) programs, such as the Supplemental Nutrition Assistance Program (SNAP), also receive health coverage through Medicaid or CHIP.[9] This provides an opportunity to coordinate policies across these programs to improve program participation and reduce administrative burden. To facilitate this, CMS is collaborating with FNS to increase enrollment in Medicaid and FNS programs for eligible families. This initiative is working to identify strategies to facilitate enrollment in Medicaid, explore the use of the Medicaid Data Hub for SNAP income verification, and share data that will allow for the agencies to analyze reenrollment in Medicaid and WIC to assess strategies for states to better leverage Medicaid enrollment to increase WIC enrollment.

Accomplishments to Date

CMS and FNS worked together to issue an Informational Bulletin to Medicaid officials regarding the FNS demonstration on direct certification with Medicaid for free and reduced-price school meals, which increases access for low-income children, reduces administrative burden for schools and parents/guardians, and improves program integrity. In School Year (SY) 2022-23 and 2023-24, 19 new states were approved to participate in the Direct Certification with Medicaid Demonstration Projects for a total of 38 states participating in the demonstration projects. In SY 2019-20, more than 1.2 million students were directly certified for free meals and 240,000 students were directly certified for reduced-price meals based on Medicaid data in the 13 demonstration states for which these outcomes were measured. State administrative costs decreased over the course of the demonstration, with only three states reporting administrative costs above $5,000 for SY 2019-20.

[9] Center on Budget and Policy Priorities. Opportunities for States to Coordinate Medicaid and SNAP Renewals. February 6, 2016. Available at: https://www.cbpp.org/research/health/opportunities-for-states-to-coordinate-medicaid-and-snap-renewals

Percentage of Enrolled Students Directly Certified, SY 2019-2020



Office of Minority Health (OMH)

Expanding Outreach to Increase Uptake of the Earned Income Tax Credit

CDC has noted that one in six adults reported experiencing four or more types of adverse childhood experience (ACEs) before the age of 18 years.[10] At least five of the top 10 leading causes of morbidity and mortality are associated with ACEs as well as poor socioeconomic outcomes in adulthood.[11] The earned income tax credit (EITC), a benefit for working people with low to moderate income, has been shown to reduce child maltreatment and foster positive health outcomes and reduced health care costs by reducing poverty and enhancing economic stability of low-income, working families.[12] By establishing multi-sectorial partnerships to support EITC outreach and education activities in communities at higher risk for ACEs, OMH's Community-based Approaches to Strengthening Economic Supports for Working Families (CASES) seeks to determine if EITC outreach and education can increase EITC receipt, change risk and/or protective factors for ACEs, and ultimately foster economic stability to prevent ACEs.

[10] Swedo EA, Aslam MV, Dahlberg LL, et al. Prevalence of Adverse Childhood Experiences Among U.S. Adults — Behavioral Risk Factor Surveillance System, 2011–2020. MMWR Morb Mortal Wkly Rep 2023;72:707–715. DOI: http://dx.doi.org/10.15585/mmwr.mm7226a2

[11] Merrick MT, Ford DC, Ports KA, et al. Vital Signs: Estimated Proportion of Adult Health Problems Attributable to Adverse Childhood Experiences and Implications for Prevention - 25 States, 2015-2017. *MMWR Morb Mortal Wkly Rep*. 2019;68(44):999-1005. Published 2019 Nov 8. doi:10.15585/mmwr.mm6844e1

[12] Centers for Disease Control and Prevention (2019). Adverse Childhood Experiences (ACEs) Prevention Resource for Action: A Compilation of the Best Available Evidence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Accessed at: https://www.cdc.gov/violenceprevention/pdf/ACEs-Prevention-Resource_508.pdf

Accomplishments to Date

The Office of Minority Health has funded 23 organizations to establish one or more demonstrations of EITC outreach and education activities. Each of these grant recipients has developed at least one approach for providing EITC outreach and education activities. To date, an estimated 33,111 families have received EITC.

Examples of On-the-Ground Impact

Montefiore Medical Center received a CASES award to implement the "Bronx-PEACH" (Bronx–Promote EITC to support At-risk Children) project in collaboration with partners BronxWorks and Bronx Equity – Integrated Care for Kids (BEInCK NY). One project participant, a single mother of three residing at a BronxWorks-run shelter, had an adjusted gross income of $15,609. Through her participation in the demonstration project, she was able to claim earned income tax credit of $6,935 and child tax credit of $1,966. She ultimately received $6,528 in federal return and $4,154 in NY state return, for a total of $10,682. With the refund, she and her family moved from the shelter into an apartment.

Appendix: Healthy People 2030 SDOH-related Objectives

Healthy People 2030 SDOH Domain	Related Healthy People 2030 Objectives
Health Care Access and Quality	• Reduce the proportion of emergency department visits with a longer wait time than recommended • Increase the proportion of adults who get recommended evidence-based preventive health care • Increase the proportion of adolescents who speak privately with a provider at a preventive medical visit • Increase the proportion of adolescents who had a preventive health care visit in the past year • Increase the proportion of females who get screened for breast cancer • Increase the proportion of females who get screened for cervical cancer • Increase the proportion of adults who get screened for lung cancer • Increase the proportion of adults who get screened for colorectal cancer • Increase the proportion of people who discuss interventions to prevent cancer with their providers • Increase the proportion of people with colorectal cancer who get tested for Lynch syndrome • Increase the proportion of children with developmental delays who get intervention services by age 4 years • Increase the number of community organizations that provide prevention services • Increase the proportion of people with a substance use disorder who got treatment in the past year • Increase the proportion of women who get needed publicly funded birth control services and support • Reduce the proportion of people who can't get prescription medicines when they need them • Increase use of the oral health care system • Reduce the proportion of people who can't get medical care when they need it • Increase the proportion of people with a usual primary care provider • Increase the ability of primary care and behavioral health professionals to provide more high-quality care to patients who need it • Increase the proportion of adults whose health care providers involved them in decisions as much as they wanted • Increase the proportion of adults whose health care provider checked their understanding • Decrease the proportion of adults who report poor communication with their health care provider • Increase the proportion of adults with limited English proficiency who say their providers explain things clearly • Increase the proportion of adults offered online access to their medical record

	• Increase the proportion of hospitals that exchange and use outside electronic health information • Increase the proportion of hospitals with access to necessary electronic information • Increase the proportion of doctors with electronic access to information they need • Increase the proportion of doctors who exchange and use outside electronic health information • Increase the proportion of people who can view, download, and send their electronic health information • Increase the proportion of people who say their online medical record is easy to understand • Increase the use of telehealth to improve access to health services • Increase the proportion of people with health insurance • Increase the proportion of people with prescription drug insurance • Reduce the proportion of people under 65 years who are underinsured • Reduce the proportion of people who can't get the dental care they need when they need it • Increase the proportion of people with dental insurance • Increase the proportion of low-income youth who have a preventive dental visit • Increase the proportion of pregnant women who receive early and adequate prenatal care • Increase the proportion of newborns who get screened for hearing loss by age 1 month • Increase the proportion of infants with hearing loss who get intervention services by age 6 months • Increase the proportion of infants who didn't pass their hearing screening who get evaluated for hearing loss by age 3 months • Increase access to vision services in community health centers • Reduce the number of new HIV diagnoses • Increase linkage to HIV medical care • Reduce the rate of mother-to-child HIV transmission • Reduce the number of new HIV infections • Increase knowledge of HIV status • Increase viral suppression • Increase the proportion of sexually active female adolescents and young women who get screened for chlamydia
Neighborhood and Built Environment	• Reduce the proportion of families that spend more than 30 percent of income on housing • Reduce the rate of minors and young adults committing violent crimes • Increase the proportion of schools with policies and practices that promote health and safety • Increase the proportion of adults with broadband internet • Increase the proportion of people whose water supply meets Safe Drinking Water Act regulations • Reduce the amount of toxic pollutants released into the environment

	• Reduce health and environmental risks from hazardous sites • Reduce the number of days people are exposed to unhealthy air • Increase the proportion of people whose water systems have the recommended amount of fluoride • Reduce blood lead levels in children aged 1 to 5 years • Reduce deaths from motor vehicle crashes • Increase the proportion of homes that have an entrance without steps • Increase the proportion of adults who walk or bike to get places • Increase the proportion of adolescents who walk or bike to get places • Reduce asthma deaths • Reduce asthma attacks • Reduce emergency department visits for children under 5 years with asthma • Reduce emergency department visits for people aged 5 years and over with asthma • Reduce hospitalizations for asthma in children under 5 years • Reduce hospitalizations for asthma in people aged 5 to 64 years • Reduce hospitalizations for asthma in adults aged 65 years and over • Reduce hospitalizations for COPD • Reduce the proportion of adults who have hearing loss due to noise exposure • Increase the proportion of smoke-free homes • Increase the number of states, territories, and DC that prohibit smoking in worksites, restaurants, and bars • Reduce the proportion of people who don't smoke but are exposed to secondhand smoke • Increase the number of states, territories, and DC that prohibit smoking in multiunit housing • Increase trips to work made by mass transit Increase the proportion of worksites with policies that ban indoor smoking
Social and Community Context	• Reduce the proportion of children with a parent or guardian who has served time in jail or prison • Increase the proportion of the voting-age citizens who vote • Reduce anxiety and depression in family caregivers of people with disabilities • Increase the proportion of adolescents who have an adult they can talk to about serious problems • Increase the proportion of adolescents in foster care who show signs of being ready for adulthood • Increase the proportion of children and adolescents who communicate positively with their parents • Increase the proportion of children whose family read to them at least 4 days per week • Increase the proportion of children and adolescents who show resilience to challenges and stress • Increase the proportion of adults who talk to friends or family about their health • Increase the health literacy of the population

	• Increase the proportion of adults who use IT to track health care data or communicate with providers • Reduce bullying of transgender students • Eliminate very low food security in children • Reduce the proportion of people with intellectual and developmental disabilities who live in institutional settings with 7 or more people
Economic Stability	• Reduce the proportion of adolescents and young adults who aren't in school or working • Reduce the proportion of people living in poverty • Increase employment in working-age people • Increase the proportion of children living with at least 1 parent who works full time • Reduce the proportion of adults with arthritis whose arthritis limits their work • Reduce the proportion of families that spend more than 30 percent of income on housing • Reduce household food insecurity and hunger • Eliminate very low food security in children • Reduce work-related injuries resulting in missed work days
Education Access and Quality	• Increase the proportion of high school graduates in college the October after graduating • Increase the proportion of high school students who graduate in 4 years • Increase the proportion of 8th-graders with reading skills at or above the proficient level • Increase the proportion of 8th-graders with math skills at or above the proficient level • Increase the proportion of children who are developmentally ready for school • Increase the proportion of children who participate in high-quality early childhood education programs • Increase the proportion of children and adolescents who get preventive mental health care in school • Increase the proportion of children with developmental delays who get intervention services by age 4 years • Increase the proportion of students with disabilities who are usually in regular education programs • Increase the proportion of 4th-graders with math skills at or above the proficient level • Increase the proportion of 4th-graders with reading skills at or above the proficient level • Increase interprofessional prevention education in health professions training programs

NOTE: Links and references to information from non-governmental organizations is provided for informational purposes and is not an HHS endorsement, recommendation, or preference for the non-governmental organizations.