

## Response to Request for Information Regarding Social Risk Factors for Health

I am responding from a PACE program (Program of All Inclusive Care for the Elderly) in Rhode Island. The model of PACE, in its name even, is directed to provide all-inclusive care. Our mission is to preserve and sustain the independence of older adults who have significant health needs and wish to remain in the community.

PACE programs are uniquely organized to address social and economic risk factors in the population we serve and have a high percentage of persons with these risk factors. Greater than 90% of our participants are dually eligible and therefore compromised by poverty, including a high percentage of ethnically diverse persons and immigrants, living in lower socio-economic neighborhoods, have high utilization of public assistance programs and often face housing struggles. A majority have low health literacy, a history of poverty, poor nutrition, inconsistent health care, higher than average trauma history, significant behavioral health and substance abuse history and have multiple medical co-morbidities.

As we are a capitated insurer, it is imperative that we address these social/economic issues to reduce risk and improve our participant's health. Here is how we assess and manage these issues.

### **How does PACE of RI identify beneficiaries with social risk factors:**

1. From the first call and through the intake process we are collecting information about income, housing, education, social support systems, occupational history, language, and transportation issues in addition to medical history. Also collected is information about gender, race, ethnicity, and nativity. This information is collected via in person home visits to the person's home where further observations about the living situation and other risk factors are made and documented.
2. Upon enrollment in the PACE program a social work assessment, including a full social history, by an MSW is conducted by an MSW, again in the participant's home and a full social history is completed. This again reviews the social history, family relationships, current social support systems, financial concerns, housing, language, legal history, trauma history, psychological risk factors, as well as screening for depression and cognitive health. cognition.

3. Upon enrollment there is also an assessment by nutrition and the community RN in a home visit which encompasses a nutrition history and current nutritional issues, which may uncover food insecurity issues.
4. Each participant is assigned a SW/RN case management team that remains stable throughout their tenure in the PACE program. This ability to form a relationship with the participant and for the participant to be able to identify persons whom they can trust and share concerns with forms the core of our ability to identify the SES and intervene rapidly when risk factors arise.
5. The unique ability of the PACE program to individualize care for each participant and the depth of the relationship leads the participant to naturally bring their concerns to the 'team' when social and economic problems or crises occur. Unlike in the traditional medical system, there is not duality in the system that would split medical care from assistance with SES issues.

**Approaches used to address the needs of beneficiaries with social risk factors:**

1. PACE is based on the Interdisciplinary Team approach to provision of care. Therefore, each participant not only has a PCP but also 10 other members of the team who serve to assess, monitor and respond to social risk factors. Team members include CNAs at the day center or in the home, transportation personnel, rehab staff, day center staff, RNs in both the day center and home, social worker and activities staff, all of whom are in frequent communication with and are observing the participant in a 'high touch' pattern. Team meetings occur several times per week when those at most risk are reviewed and plans to intervene can be made.
2. Some of the service provided that address these issues routinely include:
  - a. Transportation: to and from medical appts as well as to and from the day center and at times to attend appts to maintain, renew or start public assistance programs
  - b. Interpreter services: professionally trained interpreters are provided for all assessments, medical appts, and when needed for other services
  - c. Technology: Use of medication machines and personal emergency response systems (e.g. Lifeline)

- d. Medication delivered to the home, including OTC medications that are felt necessary by the medical team
- e. No co-pays for any service, including medications
- f. Coordination of all care
- g. Life enrichment activities provided in our day center
- h. Rep payee services
- i. Social work case managers assist with a large variety of issues including:
  - i. Housing
    1. Assist with completing housing applications
    2. Coordination with housing residential service coordinators to address special needs to maintain access (e.g. home care services)/ prevent eviction
    3. Rep payee services to maintain access to housing
    4. Assist with accessing or maintaining SNAP, social security benefits
    5. Assist with pest removal (e.g. HC to deal with bed bugs)
    6. Coordinate with legal services
    7. Assist obtaining bedding and furniture
    8. Write letters for accommodating medical needs (e.g. two-bedroom apts.)
  - ii. Food Insecurity
    1. Assist with accessing or maintaining SNAP, social security benefits
    2. Provide MOW
    3. Going to food pantries
  - iii. Transport
    1. Assist with accessing RIDE program
    2. Assist with completing bus pass applications
  - iv. Utility Needs
    1. Help complete LIHEAP applications
    2. Assist with utility protections letters

3. Connect to free cell phones and reduced-cost landline service

v. Interpersonal safety

1. Report abuse, fraud, self-neglect
2. Department of Elderly Affairs
3. Alliance for Long-term Care (LTC Ombudsperson program)

vi. Misc.

1. Working with community victim advocates
2. Answering questions about social security benefits and certifications for medical insurance
3. Take ppts. to local offices to obtain social security cards, birth certificates and State ID
4. Assist with connecting to immigration services
5. Assist with financial issues (debt or managing banking problems)
6. Refer family members to social services
7. Refer clients to services for the blind

3. Community based collaborations we utilize are many and include:

- a. State Department of Health
- b. State Department of Health and Human Services
- c. State Ombudsperson for Long Term Care
- d. The Alzheimer's Association
- e. Local police and fire departments
- f. RI Emergency Management Agency
- g. RI Special Needs Registry
- h. RI Bar Association and RI Legal Services
- i. Housing departments and resident service coordinators in senior housing
- j. Department of Elderly Affairs
- k. YMCA
- l. Local Food Bank and pantries
- m. URI Outreach Programs

- n. Senior Victim Advocates
- o. Assisted Living Facilities
- p. RI Geriatric Education Consortium
- q. Hospital Ethics Committees
- r. SE Asian Community Center

**What evidence do you have of these approaches on quality outcomes and the total cost of care?**

1. Even though PACE cares for the highest risk dual eligible population in the Medicare pool our hospitalization and re-hospitalization rates match or are lower than the rates for the total Medicare population.
2. Rate of falls and sentinel events are low
3. Rate of pressure ulcers is low and success with difficult wound management is high
4. ER utilization is reduced after enrollment in PACE
5. Though we care for participants who qualify for nursing home care, our long-term care utilization is low.
6. Caregiver stress levels are reduced after the participant enrolls in PACE

**How does our plan disentangle beneficiaries' social and medical risks and address each?**

1. This is accomplished using the Interdisciplinary Team (IDT) Care Plan meetings where the participant's goals and problems are integrated into a plan of care after assessment by the 11 disciplines.
2. Each discipline is responsible for a thorough assessment at least every six months that informs the team about risks and problems.
3. This is also accomplished through routine team meetings where the IDT can problem solve issues of any type that arise between care plans.
4. This means, for example, that the PCP is not responsible to solve housing or finance issues, and the social worker is free from resolving medical concerns. Yet they remain aware of the total person and can tailor the discipline specific interventions in context of the total social, economic, cognitive, medical picture.

Unique, also, to the PACE program is the ability to be flexible about how the benefit is utilized. We can utilize our resources to assist in many of these socio-economic issues because we have latitude to perform tasks that might be excluded from the standard Medicare benefit. Quite a few times we ask ourselves, 'Could they (the participant) get this service in a regular health plan'? And though the answer is 'no' we often need to provide that service to make the participant successful in their current situation.

In conclusion, the PACE model allows for a holistic approach to health care that is structured to address both medical and socio-economic concerns in development of a plan of care. It is clear from our experience in RI that without this integration, health care would be compromised. The participant seems to benefit in an added way when their fears and anxieties about social and economic concerns are addressed and this allows for a sense of safety and security. When the more basic needs for life such as food, housing, heat, and safety are addressed the participant and family can focus on measures to ensure health. The relationships fostered by this model of care make this partnership possible. The integration afforded by the IDT approach allow each discipline to utilize their skills, training and strengths to address the varied needs of the participant at risk.