

Center for Health Care Strategies' Response to HHS SDOH RFI (11/15/18)

HHS has issued a [request for information \(RFI\)](#) to *better understand how healthcare providers and plans identify and manage Medicare patients who have social risk factors*. HHS will be using the information it gathers from the RFI to produce a report requested by Congress. The report will examine factors such as income, education, race, employment, housing, etc.

With the recognition that social determinants of health (SDOH) can account for up to 40 percent of individual health outcomes¹, particularly among dual eligible populations, their providers are increasingly focused on strategies to address patients' unmet social needs (e.g., food insecurity, housing, transportation, etc.). With support from the Robert Wood Johnson Foundation, the *Partnership for Healthy Outcomes* brought together Nonprofit Finance Fund, the Center for Health Care Strategies, and the Alliance for Strong Families and Communities to capture insights on partnerships between community-based organizations and health care organizations, particularly those serving low-income and vulnerable populations. Insights from one of the partnerships profiled, Eastern Virginia Care Transitions Partnership, can help to inform future efforts to address social needs among dual eligible populations, as noted in the responses below.

Background on EVCTP: In 2012, in response to a funding opportunity from the Centers for Medicare & Medicaid Services (CMS) Innovation Center's Community-Based Care Transitions Program (CCTP), Bay Aging — an Area Agency on Aging (AAA) serving the southeastern region of Virginia — teamed up with five health systems to form the Eastern Virginia Care Transitions Partnership (EVCTP). The partnership is designed to reduce hospital readmissions and improve quality of care among older adults and those with complex illness through an evidence-based care transition model and in-home assessments. This unique collaborative effort is a largescale partnership including Bay Aging and four other AAAs, four health systems, three managed care organizations (MCOs), and other health care and human service providers. Since then, EVCTP's success in helping consumers transition from hospital (or another care setting) to home and reducing hospital and nursing home readmissions has led to the formation of a statewide coalition of 25 AAAs, known as VAAACares. The program serves as a one-contract, one-stop entity for comprehensive care coordination, care transitions, and other community-based services for Virginia's dually eligible Medicare and Medicaid beneficiaries².

The specific questions HHS are interested in include:

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

In the EVCTP example, in preparation for the CCTP funding opportunity, which charged awardees with reducing avoidable 30-day all-cause hospital readmissions by 20 percent, EVCTP conducted a root cause analysis to identify clinical diagnoses linked to the highest volume of readmissions within the aging

¹ B.C. Booske, J.K. Athens, D.A. Kindig, H. Park, and P.L. Remington. "Different Perspectives for Assigning Weights to Determinants of Health." University of Wisconsin Population Health Institute, 2010.

² D. Kozick. "Collaborating to Reduce Hospital Readmissions for Older Adults with Complex Needs: Eastern Virginia Care Transitions Partnership ." Partnership for Healthy Outcomes, 2017.

population. Based on this data, EVCTP defined its target group for CCTP as Medicare and dual eligible beneficiaries with at least one of the following diagnoses: (1) congestive heart failure, (2) chronic obstructive pulmonary disease, (3) acute myocardial infarction, (4) pneumonia, and (5) septicemia. Additionally, upon discharge, EVCTP coordinates in-home and community-based supports for Medicare and dual-eligible individuals across the state. Following a hospital discharge, a coach from the local Area Agency on Aging (AAAs) conducts in-home assessments and virtual check-ins to further assess social risks. Eligible patients, based on screening results, are linked to a dedicated coach who then connects them to services based on their specific social service needs, including: transportation to medical appointments, home-delivered meals, and home repair to facilitate independent living.

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

Promising strategies for improving care for patients with social risk (from the EVCTP partnership example) include meeting the patients where they are – meaning, connecting them with a dedicated coach in the hospital, prior to discharge, to ensure that timely linkages are made with the social service providers who can address needs that prevent future avoidable admissions. Dedicated and experienced coaches also conduct in-home and virtual check-ins to further assess and monitor patients’ social risk needs, recognizing the evolving nature of the target population’s needs over time. The EVCTP partnership also models the potential benefits of a collaborative approach to improving care for patients with social risk by bringing together the expertise of health care professionals with established community-based social service providers (in this case, Area Agencies on Aging), well-versed, culturally sensitive, and experienced in identifying and addressing the social risk issues that present in dually eligible populations. Tapping into the network of AAAs also helped the partnership successfully scale its operations across the state of Virginia.

- **How are costs for targeting and providing those services evaluated?**

There are inherent challenges to evaluating the costs of related services provided to patients with social risk, some of which are particularly difficult to quantify. In addition to the direct costs of providing the services in question, there are also administrative costs related to the staffing/training for assigned coaches to outreach to and coordinate care for targeted patients. There are also costs associated with maintaining the infrastructure that supports ongoing administrative activities including data collection and reporting processes and maintaining electronic data sharing platforms to support the exchange and compilation of relevant measures to manage ongoing provider activities.

- **What are the additional costs to target services, such as case management, and to provide additional services (e.g., transportation)?**

N/A

- **What is the return on investment in improved outcomes or reduced healthcare costs?**

While ROI is often difficult to measure given the challenges in assessing costs (and related savings) of social services provided, as noted above, some providers have been able to measure some returns in recent years, particularly in terms of reductions in avoidable ED/inpatient admissions. As an example, the EVCTP partnership, which was originally formed as part of the CCTP program through CMS, with a

specific goal of reducing avoidable admissions by 20 percent (within 2 years), reduced 30 day readmission rates from 18.2 to 8.9 (from Feb. 2013 - Jan. 2015), resulting in an estimated savings of \$17M through on 1,804 avoided readmissions.

Another CHCS project, [Promoting Integrated Care for Dual Eligibles](#) (PRIDE), is a national initiative made possible by The Commonwealth Fund that is focused on advancing high-quality integrated care for dually eligible beneficiaries. This learning collaborative of nine leading integrated Medicare-Medicaid health plans that are locally based and have special expertise in serving this population, have developed various approaches to delivering targeted, value-added services to meet their members' social service needs. The plans are not paid to provide value-added services described in this brief (i.e., value-added services are not included in rate-setting calculations), but the plans often offer them because they anticipate that doing so will improve health and cost outcomes. PRIDE plans described several challenges with assessing the return-on-investment of value-added services, including:

- Lack of specific methodologies and consistent data to understand the impact of offering services to different members in an ad hoc manner;
 - Assessment of “intangible” factors to measuring overall member well-being, such as improved quality of life by living at home;
 - The impact of cost avoidance, rather than actual spending, as appropriate. For example, it is difficult to measure how many people could be admitted to a nursing facility without these value-added services;
 - General internal capacity to conduct the resource-intensive analyses needed to determine a return-on-investment; and
 - Difficulty in projecting additional demand for value-added services.
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- **What are the best practices to refer beneficiaries to social service organizations that can address social risk factors?**

One promising approach to referring beneficiaries to relevant social service organizations is to link them to a dedicated coach (with community ties) who can help navigate the patient through the various resources available and prioritize the various services offered to improve patients' health. Also, maintaining a shared database for the care team to share relevant data in real-time seems to further support addressing social risk factors effectively.

- **What lessons have been learned about providing care for patients with social risk factors?**

Some lessons from our EVCTP case include:

1. **Involving active champions in the design and implementation of care models that address patient issues.** For EVCTP, the president of the Bay Aging, the leading AAA, and the vice president of clinical integration for Riverside Medical System, not only encouraged other AAAs and hospitals to participate, but were able to address early concerns from AAAs and health systems. These champions were able to activate meaningful participation from provider partners/community stakeholders. Both acknowledged that the partnership would not have been successful without strong representation from each.

2. **Building in flexibility into Service Models** – Designing and implementing a nimble service model that can evolve with the needs of its target populations is vital to ensure that care continues to be responsive to changing patient needs. Partnerships should adapt their service models based on community feedback, outcomes data, and changes in the local/federal political and regulatory environment. The patient community has and should continue to play a particularly active role in identifying unmet needs and making suggestions for program design.
 3. **Making time for upfront relationship-building.** CBO and health care partners build trust with one another through shared governance, contributions of in-kind services, and sharing patient data — with each contributing distinct and complementary areas of expertise. This relationship-building process also extends to patients becoming more engaged in their own care as the partnerships support a more person-centered approach.
- **What are barriers to tailoring services to patients with social risk factors? How can barriers be overcome?**

We noted significant barriers to providing care to patients with social risk factors, particularly in terms of ongoing capacity-building needs of providers who care for them. As such, some ways these barriers can be addressed include making available:

1. Advice on **financing and potential funding models** to support activities – challenges remain around securing sustainable funding to support infrastructure and services for patients with social risk factors.
 2. Support for providers with planning for and building appropriate capacity, including **estimating the costs** related to providing specific partnership services.
 3. Guidance on **measurement approaches for collecting and communicating data across partners** and making informed decisions based on this data.
 4. Assistance with more **formal evaluations of outcomes and cost savings** to supplement the largely anecdotal findings that have been tracked to date.
- **For patients with social risk factors, how does patients’ disability, functional status, or frailty affect the provision of services?**

Patients’ disability further substantiates the need for support to prioritize the various resources available to patients, as well as individual priorities to ensure a person-centered approach to their care. Furthermore, the ability to screen patients in their homes and provide services at home or virtually helps to promote effective care for patients for whom travel is challenging.

- **Which social risk factors are most important to capture?**

N/A

- **Do you routinely and systematically collect data about social risk? Who collects this data? When is it collected? Is it collected only once or multiple times for a beneficiary? Is it collected**

consistently across populations (i.e. Medicare beneficiaries, Medicaid beneficiaries, patients receiving specific services, etc.)?

Identifying program metrics that resonate across all provider partners and reaching consensus on an effective outcomes-reporting process are time-intensive and complex for partnerships, yet vital to their ongoing success. The CBOs and health care partners interviewed are working toward more formal evaluations of cost savings realized through partnership, which to date have generally been tracked anecdotally.

Most partnerships we have explored have data-sharing systems in place, though these vary in complexity and sophistication. For some partnerships, data shared between partners has evolved from basic utilization measures, which were simplest to vet with the group at first, to more sophisticated trend analyses and quality improvement indicators, through a “learn-as-you-go” approach. Many share patient-level data as part of service delivery, while some share data to communicate progress toward partnership goals internally and/or externally.

- **What are the burdens of this data collection on plans, providers, and beneficiaries? · Would standardized data elements for EHRs help you to collect social risk data? If so, how could these data elements be standardized?**

Data collection is burdensome for providers and MCOs as illustrated by the EVCTP case study, where the hub AAA received pushback initially in terms of time and resources to support data collection and has since dedicated significant staff time to refine reporting to support the partnership’s activities. Standardized data elements for EHRs could help stakeholders with data collection and also facilitate the analysis and review of data by other stakeholders, including state representatives interested in scaling the model. It is also important to note that many, if not most, of community-based, local organizations and home-and community-based provider agencies that provide personal care and other Medicaid LTSS have limited data management infrastructure and capital to invest in expanding this capacity. As traditional Medicare providers and plans consider how to partner with these organizations, they might think about how to support investments and educate these organizations about how to use new systems to collect, analyze and report data.