

November 16, 2018

Assistant Secretary for Planning and Evaluation, Room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

RE: RFI: IMPACT Act Research Study: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors

Submitted electronically via ASPEImpactStudy@hhs.gov

UnityPoint Health (“UPH”) appreciates this opportunity to provide feedback on the request for information. UPH is one of the nation’s most integrated healthcare systems. Through more than 30,000 employees and our relationships with more than 290 physician clinics, 38 hospitals in metropolitan and rural communities and 15 home health agencies throughout our 9 regions, UPH provides care throughout Iowa, central Illinois and southern Wisconsin. On an annual basis, UPH hospitals, clinics and home health provide a full range of coordinated care to patients and families through more than 6.2 million patient visits. In addition, UPH is committed to payment reform and is actively engaged in numerous initiatives which support population health and value-based care. UnityPoint Health Accountable Care (UAC) is the ACO affiliated with UPH and has value-based contracts with multiple payers, including Medicare. UAC is a current Next Generation ACO, and it contains providers that have participated in the Medicare Shared Savings Program as well as providers from the Pioneer ACO Model.

UPH respectfully offers the following comments.

OVERALL QUESTION

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

It is widely accepted that social determinants of health greatly impact an individual’s health and quality of life. As an integrated healthcare system, our goal is to collaborate with community partner organizations to provide the right care, at the right time, without defect or duplication for our patients and their families, and improving reliability in care coordination across the care continuum. Our care delivery footprint lies in nine regions across three states and our efforts at standardizing holistic patient assessment and care coordination is ongoing. Our workplan targets:

- Connection to primary care physicians
- Cross-continuum care plans to share information

- Standard approach to patient and caregiver education
- No wrong door policy
- Mechanism for targeted case management
- Risk stratification for disease process, social determinants and social programming
- Organizational sustainability
- Ability to contribute in measurable applicable standardized quality benchmarks

The implementation of our approach relies heavily on the skills of our social workers (embedded throughout our healthcare system in a variety of roles) and preferred providers, is supported by data and various decision support tools and is dependent upon the robustness of available community resources.

Given our largely rural geography, we would like to emphasize that rural communities have additional challenges when addressing social risk factors – both in healthcare and community supports. In Iowa, UPH is participating in the Iowa SIM Healthcare Innovation and Visioning Roundtable, which was established in recognition that “socio-economic challenges in providing access to high quality healthcare in Iowa’s communities threaten the sustainability of the healthcare system and the health of Iowans.”¹ The variability of resources across geographies is a real concern that does not lend itself to uniform, prescriptive requirements for social risk interventions. Not every community has public transportation or available and affordable housing stock and food deserts (even in our agricultural state) are prevalent. In addition, the rural population itself generally is older, more medically complex, and less affluent. **We would encourage that any recommendations be evaluated for impact on rural beneficiaries and consider gaps in the distribution of publicly available resources.** We were encouraged by the release of the first CMS strategy related rural health this spring and would urge that CMS tap into that Rural Health Council and relevant stakeholders to assure appropriate fit within rural communities.

DELIVERY OF SERVICES

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

A traditional medical view of a patient using Evaluation and Management (E/M) coding, ACO metric capture and other commonalities are available for capture. These include presence of falls, depression, substance abuse, tobacco use, enrollment in Medicaid, and dual eligibility status to list a few. Various indicators are then automatically transferred to our EPIC common care plan updated by navigators and coordinators.

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

In Iowa, the Medicaid Integrated Health Home (IHH) program has been particularly successful for adults who meet the criteria for a Serious Mental Illness or children who meet the criteria for a Serious Emotional Disturbance.² This program is authorized through a State Plan Amendment. The IHH provides care coordination through a team of professionals, including access to Family and Peer Support services, and

¹ Healthcare Innovation and Visioning Roundtable, Recommendations to Governor Reynolds on Improving the Health of Iowans, September 2018, p 2 accessed at https://dhs.iowa.gov/sites/default/files/SIM_RoundTable_Recommendations_Sept2018.pdf

² State Plan Amendment - <https://dhs.iowa.gov/sites/default/files/Attachment%203%201-H%20-%20SPMI%20Page%201-50%20as%20of%20030416.pdf>; and Iowa Medicaid Enterprise informational webpage - <https://dhs.iowa.gov/ime/providers/integrated-home-health>

across all aspects of an individual's life, including coordination of physical health care and successful transitions from inpatient and other residential treatment. Community Mental Health Centers (CMHC) are among the organizations that provide this intensive care coordination service. Due to the investment of resources within our CMHCs and the trust that they have built within their communities, we are investigating **an expanded IHH model for the entire population in which CMHCs would retain a lead agency role**. Features of such a model include outreach within the community and staffing levels would equal about 1 community support specialist FTE per 150 patients.

Another promising strategy is to **strengthen our ability to leverage social service organizations** to best utilize expertise and scarce resources. We cannot overstate the importance of public health departments and area agencies on aging in this respect. When we make a community handoff, we need to be confident that the individual referred will have a central point of contact and that the point of contact accepts responsibility for that individual and perhaps the family. We have moved the needle in Fort Dodge, Iowa, where the Webster County Health Department is responsible for follow-up assessments and care coordination for individuals with social determinants of health needs. In other regions, we are involved in "basic needs" groups, which are collectives of health and social services agencies, which monitor the use of wrap-around services, strive for efficiencies and identify service gaps.

- **How are costs for targeting and providing those services evaluated? What are the additional costs to target services, such as case management, and to provide additional services (e.g., transportation)? What is the return on investment in improved outcomes or reduced healthcare costs?**

Although this question focuses on costs, the Iowa Healthcare Innovation and Visioning Roundtable has suggested that **Healthy Communities should demonstrate value more broadly through valid and reliable metrics that measure desired outcomes**.³ These metrics are:

- Unnecessary or potentially preventable ED use
- Potentially preventable hospitalizations
- Cost (e.g. total cost of care)
- Linkage with appropriate primary behavioral health care
- Other institutional care
- Appropriate care and patient outcomes
- Health improvement
- Community care

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

We believe that referral best practices should involve referrals to reputable agencies with capacity to provide appropriate supports in a timely manner. In Iowa and Wisconsin, the United Way organizations sponsor the 2-1-1 service. This service is available by phone, text and internet – it is free, available 24-7, and identifies local human services and health resources and services. The Area Agencies on Aging have also been updating the functionality of the Aging and Disability Resource Center (ADRC) database. We believe that there is much potential to more specifically customize the ADRC database to provide more

³ https://dhs.iowa.gov/sites/default/files/SIM_Roundtable-HealthyCommunitiesWorkgroupBreakout_06142018.pdf

robust decision support when services are needed. As part of this effort, we are working with the Iowa Department on Aging to explore community management options.

Given the shortcomings of current solutions, many health systems and health plans, including Medicaid managed care organizations, have invested in creating their own community support profiles/databases. These usually attempt to identify those agencies with capacity and particularly look to leverage community organizations with public funding (federal, state and local) as well as private grants and sustainable funding sources. It appears that there are numerous well-intended, but duplicative, efforts in this area, which may benefit from federal leadership.

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

Our workplan, referenced in response to the initial overall question, incorporates action steps from our lessons learned and evidence-based practices. In terms of population health, we need to serve this population where they are, as our ability to steer care or services is limited by social risk factors. In terms of resources, we need to partner with community liaisons who are trusted within the community. While a couple of our urban regions are employing a community health worker model, this model has not been widely tested in our rural areas.

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

Lack of community resources: For rural areas, resources may not exist. It is disingenuous to make referrals to agencies without capacity or ability to timely respond. To mitigate this barrier, we would suggest that CMS be clear regarding expectations for providers to directly address social needs and further that gap analyses could be undertaken to identify service / resource deficiencies and assure that resources are allocated accordingly. We believe this gap analysis could be incorporated with some standardized elements within Community Health Needs assessments.

Impact of multiple social risk factors: Similar to a patient with complex, compounding conditions, it has been our experience that individuals often have several social risk factors. Multiple risk factors make community hand-offs more difficult. The presence of multiple factors often manifests itself by individuals moving from one crisis to another - paying rent, getting food, finding work, locating transportation, paying for medication, etc. Fragmented service delivery makes it difficult for organizations to stay connected with individuals over time and results in a relatively short window of time in which to influence this population. This short timeframe is hampered by this population's more transient nature, not only in physical location but also with frequently changing phone contacts. These concerns would be mitigated by a centralized agency or point of contact that can address and coordinate multiple social service needs. We would suggest that a more global support payment rather than individual subsidies in housing, subsidies in food, and other compounding needs would be a much better use of the actual resources versus the administrative structures duplicated from agency to agency

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

It would be our contention that within the greater burden of poverty there lies the need to assess individual or family unit needs. Depending on that individual’s support structure, the ability to give right care, right services, right place and right time is often highly individualized.

COLLECTION AND USE OF DATA

• Which social risk factors are most important to capture?

We recommend a two-tiered approach, under which an initial capture of a small set of information could be extracted from the EHR as the result of the annual wellness visit or social history within the E/M documentation (and outside a separate assessment tool). Per guidance of the American Academy of Family Physicians, the Past, Family, Social History component of the CPT code for E/M visits creates an opportunity to record these data points.⁴ Social History is described as age appropriate review of patient activities (substance use, living arrangements, sexual history, employment, education, etc.) and it is specifically noted that Medical Decision Making refers to the complexity of establishing a diagnosis and/or *determining a management option* (italics added). While notations of specific social determinants of health is not mandated, they can push a patient into the high complexity category due to the factors surrounding the patient’s situation. Below is a list of social risk factors that may be contained within the EHR and should serve as a starting point.

Data Points	When Collected	Notes
Employment	At registration if insurance is on employer plan	
Insurance status	At registration	
Transportation	E/M	“who brought you today?”; “do you have a way to get back home and to pick up the medications I’ve prescribed?”
Nutrition	Required as part of the BMI discussion	Noted on After Visit Summary
Personal safety / falls prevention	In falls protocol	
Ability to afford medications		Quality indicator in the CG-CAHPS “stewardship of patient resources”
Housing	Triggered if home safety concerns	Addressed as home safety falls
Physical activity	E/M	
Substance use	E/M	Includes tobacco
Mental health	Separate depression screening at visits	
Disabilities	HCC and updated problem list	

⁴ <https://www.aafp.org/practice-management/payment/coding/evaluation-management.html>

Family and community support	Updated if care navigator or coordinator	
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Given that the above are already documented, we are not convinced that CMS needs to require the capture of additional screening data points and would not support the addition of a separate initial social risk questionnaire to an already arduous rooming process. Of course, if these EHR screening data trigger a more robust evaluation, we would support follow up via further assessment and/or referrals.

- **Do you routinely and systematically collect data about social risk? Who collects this data? When is it collected? Is it collected only once or multiple times for a beneficiary? Is it collected consistently across populations (i.e. Medicare beneficiaries, Medicaid beneficiaries, patients receiving specific services, etc.)? What are the burdens of this data collection on plans, providers, and beneficiaries?**

It is our opinion that **registration into an EHR (requirement in interoperability, meaningful use and E/M visits) already provide a platform to collect basic social risk screening data.** We do not dispute that social determinants of health impact health outcomes and quality of life. The challenge with requiring healthcare providers to collect additional data internally is that we don't know the most useful social risk data to collect and collecting a very comprehensive record has come with almost infeasible administrative burden. We would remind CMS that should these documentation requirements change to become more specific, this will result in EHR vendor report builds and associated costs and training efforts.

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

There is quite a lot in the Meaningful Use standards. We would request that CMS distinguish the requirements in the medical record itself versus the EHR platform.

- **What are barriers to collecting data about social risk? How can these barriers be overcome?**

Social risk factors are maintained by multiple service organization and data platforms. Interoperability and privacy concerns are issues inherent with sharing information to coordinate care and resources. In some instances, community organizations may not have online platforms. Further challenges to collecting data is that existing platforms are not standardized and the data contained lack consistency, accuracy and completeness. To minimize these challenges, states or the federal government could institute data standards as a condition of receiving public funds.

- **What do you see as promising future opportunities for improving data collection? For using existing or future data to tailor services?**

In one of our regions, we are piloting an artificial intelligence solution to reduce readmissions or avoidable ambulatory conditions. This tool utilizes social and public data (in public domain and purchased databases), creates geographic clusters based on zip+4, makes assumptions based on the data and then offers a list of interventions. The region in the pilot experienced a reduction in readmissions and the tool supported our social workers to perform targeted triage/interventions. That said, it is unclear that the addition of social risk data at the Census block or higher level of aggregation results in performance gains in identification when considered alongside clinical EHR data.

Instead of requiring providers or health plans to track data from multiple sources for screening, we would suggest that HHS explore the potential for using public databases (federal and state) to establish a social risk screening score. Data could include heating assistance, food assistance, unemployment, and rental assistance. Similar to an HCC score, CMS could create a social risk score that triggers interventions or further assessments.

We are pleased to provide input on this request for information. To discuss our comments or for additional information on any of the addressed topics, please contact Sabra Rosener, Vice President, Government and External Affairs at sabra.rosener@unitypoint.org or 515-205-1206.

Sincerely,



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