Modern Healthcare

HHS test will try addressing social needs to improve health

By **Steven Ross Johnson** | January 5, 2016

Chicago's North Lawndale neighborhood was seeing extremely high rates of infant mortality when Debra Wesley joined Mount Sinai Hospital in 1986 to run its family planning department.

“It was beyond just a medical issue,” Wesley said. “You just couldn't take the approach of just focusing on the medical conditions. You had to take the approach of, what was going on in the community?”

What was going on in North Lawndale, a low-income community on the city's West Side, was pervasive teenage pregnancy. So Wesley formed partnerships with community organizations focusing on sexual health education and lifestyle choices for middle-school girls.

That work, Wesley said, helped bring down the rates of teen pregnancy and infant mortality and formed the basis for a social services organization run by Sinai Health System that works to address social and economic factors affecting health outcomes.

A growing number of healthcare providers are trying similar strategies. But even as emerging payment models reward keeping people healthy, the initiatives are complicated by the dominant fee-for service payment structure and a lack of direct financial support from Medicare, Medicaid and private payers.

The CMS Innovation Center announced Tuesday that it would explicitly test whether addressing the social conditions that affect health can lower healthcare costs and improve the quality of care. The effort reflects the government's ambition to shift the industry toward value-based payment models as well as an acknowledgement that social factors, not just the quality of healthcare services, determine the health of a community.

“If we want to see better health results and lower costs down the road, then addressing social factors has to be part of the package,” said Elaine Waxman, a senior fellow at the Urban Institute.

The CMS will award up to $157 million in grant funding to 44 “bridge organizations” to screen Medicaid and Medicare beneficiaries for health-related social needs and

connect them with local social services.

The new initiative, called the **Accountable Health Communities Model**[1], is the first federal effort to focus specifically on social needs and learning how community partnerships among healthcare providers and nonmedical social support entities might improve overall healthcare delivery.

The funding may be expanded to more sites based on the results of the pilot. Waxman said the pilot will give the CMS an opportunity to tackle barriers to partnerships between clinicians and social services groups.

“Traditional healthcare providers and community providers speak completely different languages,” Waxman said. “Just getting a common language, a common set of goals and understanding each other's priorities is a bit of a challenge.”

A number of studies have shown that communities with high levels of crime, poverty, homelessness, hunger and unemployment tend to have higher rates of chronic conditions such as diabetes, hypertension, obesity, stroke and heart disease.

Income has been the single largest social factor correlated with overall health. A 2014 report from the Robert Wood Johnson Foundation's Commission to Build a Healthier America found that 23% of African-Americans who earned less than 100% of the federal poverty level had a health status that was “poor to fair” compared with 6.8% of blacks with incomes that were more than 400% of the poverty level.

“We know that so much that goes into health happens outside of the doctor's office,” said Andrea Ducas, a program officer at the Robert Wood Johnson Foundation. “More and more I think we're seeing clinicians and providers paying attention to this, so this definitely feels like an evolution that's consistent with where the field is going.”

Waxman said the government's attention to health-related social needs is a logical progression from the Affordable Care Act's focus on expanding insurance coverage and reforming the way Medicare pays providers.

“We spent a lot of time in the healthcare sector wrestling with issues around coverage and payment models,” Waxman said. “Costs are not going to abate solely because more people have coverage, so now I think it's probably a natural juncture to turn attention to these sorts of strategies.”

Details of the pilot program appeared in an article **published Tuesday in the New England Journal of Medicine**[2]. Participating entities can choose to enter one of three program tracks.

One will provide up to $1 million to each of 12 clinical delivery sites to provide screening and referral services to Medicare and Medicaid beneficiaries.

Another 12 participants in a second track will receive up to $2.57 million to add community navigation services that ensure patients' needs are met after the

screening and referrals.

And 20 sites in a third track will receive up to $4.51 million to provide screening, referrals and navigation while also building partnerships and organizing efforts with local entities that will meet community needs on an ongoing basis.

The program is open to community-based organizations, hospitals and health systems, academic institutions, local government entities, tribal organizations, and for-profit and not-for-profit local and national entities with the capacity to develop and maintain a referral network between clinical delivery sites and community service providers.

To judge whether their efforts are working, the CMS will look at the reduction in total healthcare costs, emergency department visits and hospital readmissions, said Dr. Darshak Sanghavi, director of Preventive and Population Health Care Models Group for the Innovation Center.

Applications will be accepted[3] until Feb. 8 and the grant recipients will be announced this fall for initiatives to begin in early 2017.

The CMS has scheduled webinars for potential applicants on Jan. 21 and Jan. 27.

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