

SYSTEMS PRACTICES FOR THE CARE OF SOCIALLY AT-RISK POPULATIONS

April 2016

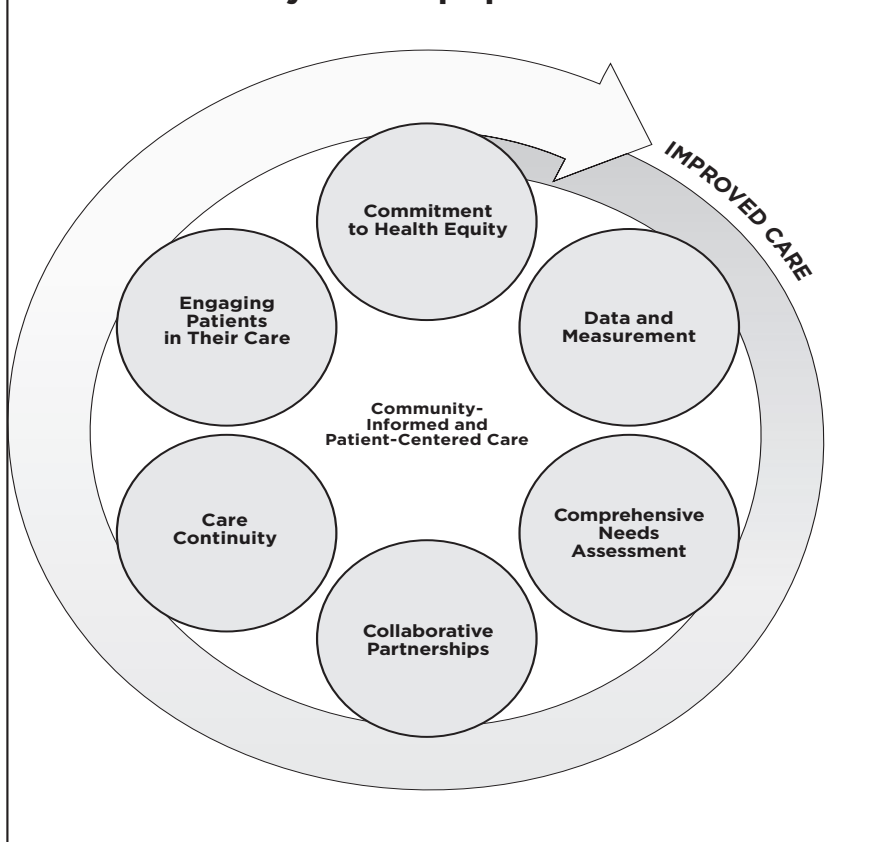
The U.S. Department of Health and Human Services, acting through the Office of the Assistant Secretary for Planning and Evaluation (ASPE), asked the National Academies of Sciences, Engineering, and Medicine to convene an ad hoc committee to identify social risk factors that affect the health outcomes of Medicare beneficiaries and methods to account for these factors in Medicare payment programs. The committee's work will be conducted in phases and will produce five brief consensus reports.

In the first report, *Accounting for Social Risk Factors in Medicare Payment Programs: Identifying Social Risk Factors*, the committee presented a conceptual framework and described the results of a literature search linking social risk factors, including socioeconomic position, to health-related measures of importance to Medicare payment and quality programs. In this second report, *Systems Practices for the Care of Socially At-Risk Populations*, the committee identifies what high-quality health systems do to achieve good health outcomes for socially at-risk populations.

The committee finds that some providers that disproportionately serve socially at-risk populations achieved performance that was higher than their peer organizations—and on par with highest performers among *all* providers. The committee also identifies examples of specific strategies implemented in specific community contexts by providers serving socially at-risk populations with the goal to improve health care quality and health outcomes.

Based on a review of case studies and the literature, members' empirical research, and professional experience delivering care to socially at-risk populations, the committee identifies common themes. These themes describe a set of practices delivered within a system of collaborating partners mainly composed of medical providers as well as partnering social service agencies, public health agencies, community organizations, and the community in which those medical providers are embedded.

Promising systems practices to improve care for socially at-risk populations



As shown in the figure at left, the committee concludes that six community-informed and patient-centered systems practices show promise for improving care for socially at-risk populations:

- *Commitment to health equity*: Value and promote health equity and hold yourself accountable
- *Data and measurement*: Understand your population's health, risk factors, and patterns of care
- *Comprehensive needs assessment*: Identify, anticipate, and respond to clinical and social needs
- *Collaborative partnerships*: Collaborate within and across provider teams and service sectors to deliver care
- *Care continuity*: Plan care and care transitions to prepare for patients' changing clinical and social needs
- *Engaging patients in their care*: Design individualized care to promote the health of individuals in the community setting

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These practices together constitute a general approach to identifying and developing best practices for a specific community context and given specific resources. They pertain to all health systems that serve socially at-risk populations, not only to those providers that disproportionately serve socially at-risk populations.

The adoption and sustainability of the practices require having available resources and aligning financial incentives that make such efforts sustainable. Resources can be used to reduce disparities or to invest in interventions targeted at socially at-risk populations. Additionally, accountability processes that are the basis of financial incentives (like bonuses or penalties) can incorporate equitable care and outcomes. In terms of sustainability, interventions that improve health and quality of care or reduce utilization and cost are only feasible to maintain if the provider is paid in such a way that profits are higher *with* the intervention than *without* (for example, global payment, shared savings, financial incentives).

This report shows that socially at-risk populations do not need to experience low-quality care and bad health care outcomes. With adequate resources, providers can feasibly respond to incentives to deliver high-quality and good value care to socially at-risk populations.

In the next and third report, the committee returns to the question of which social risk factors could be accounted for in Medicare value-based purchasing programs and how.♦♦♦

To download the full report, visit
nas.edu/SystemsPractices