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Social Determinants of Health and Value-Based Pay

April 20, 2023

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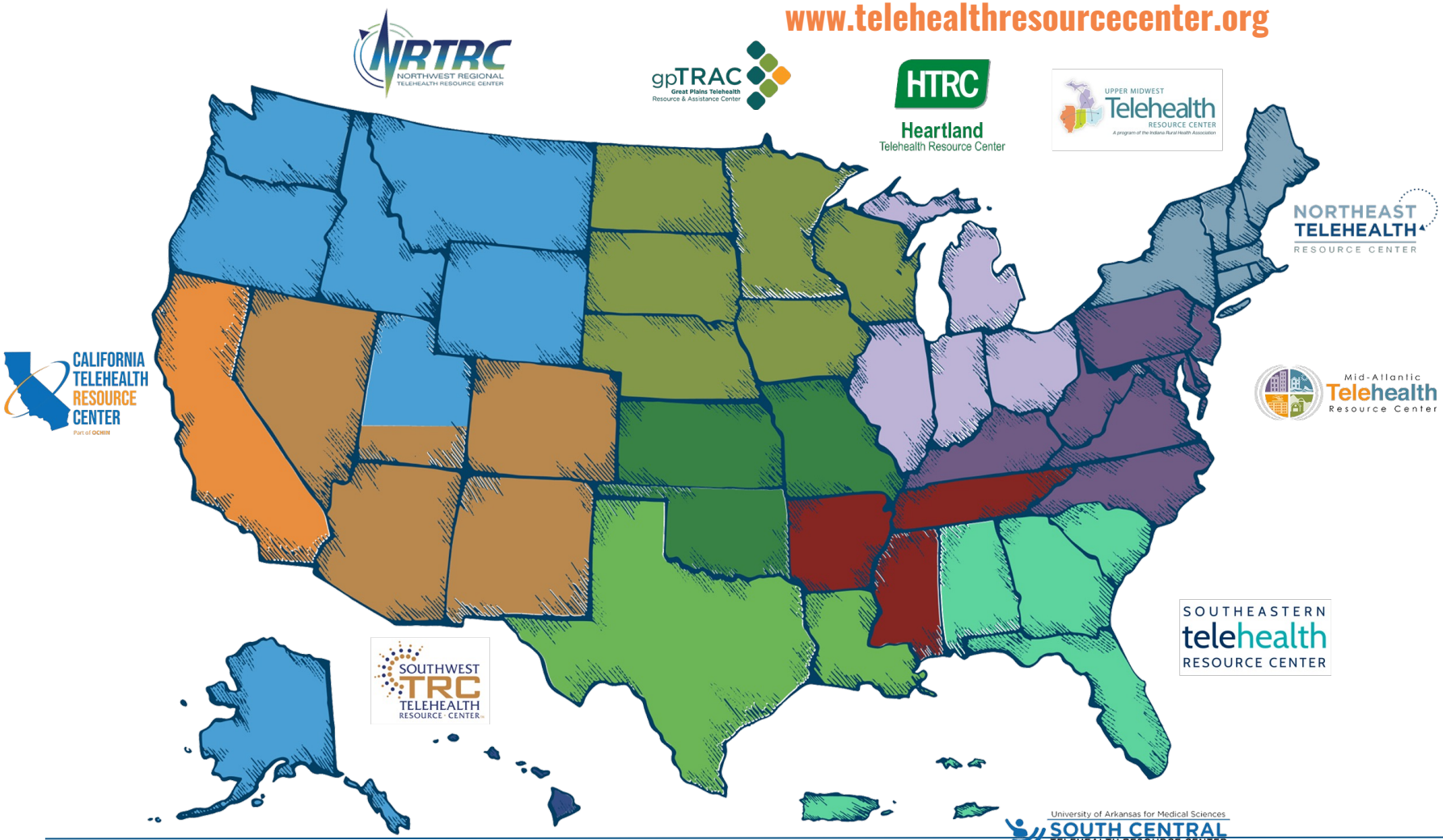

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Social Determinants of Health and Value-Based Pay

California Telehealth Resource Center

April 20,2023

The Presentation will Begin Momentarily

Ned Mossman, MPH

OCHIN

A driving force for health equity

Why Focus on SDOH Data? *Equity and Sustainability*

Provide users with point of care **context about patients' lives** and situations and the opportunity to work upstream to affect health

Population health management - high leverage activities for **targeted subpopulations**

Understanding areas of **need in the clinic and the community** for policy, advocacy, and resource allocation

Risk stratification and payment adjustment – more **complex patients** require more resources

See NASEM (2019): Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health

Learning from the Collaborative: SDOH Research

Key Learnings from OCHIN research studies

- At the clinic level, **adaptability** is key to implementing SDOH screening and action
- Other Success Factors:
  - External motivators, such as *grant or reimbursement requirements*, or encouragement from professional associations
  - Presence of a strong SDH screening *champion or advocate*
  - Clinics that *start small with a target population then scale up*

Learning from the Collaborative: Member Experience

OCHIN is not prescriptive

- We encourage member organizations to screen for the SDOH domains that make the most sense for their patients, practice and community
- Seeking to build library of emerging best practices

Diverse clinic membership = diverse workflows

- Proliferation of screening tools
- Team roles and timing in visit for screening and entering data varies widely
- Variation in outreach staffing – some clinics have CHWs/Promotores, Care Managers, Outreach Specialists

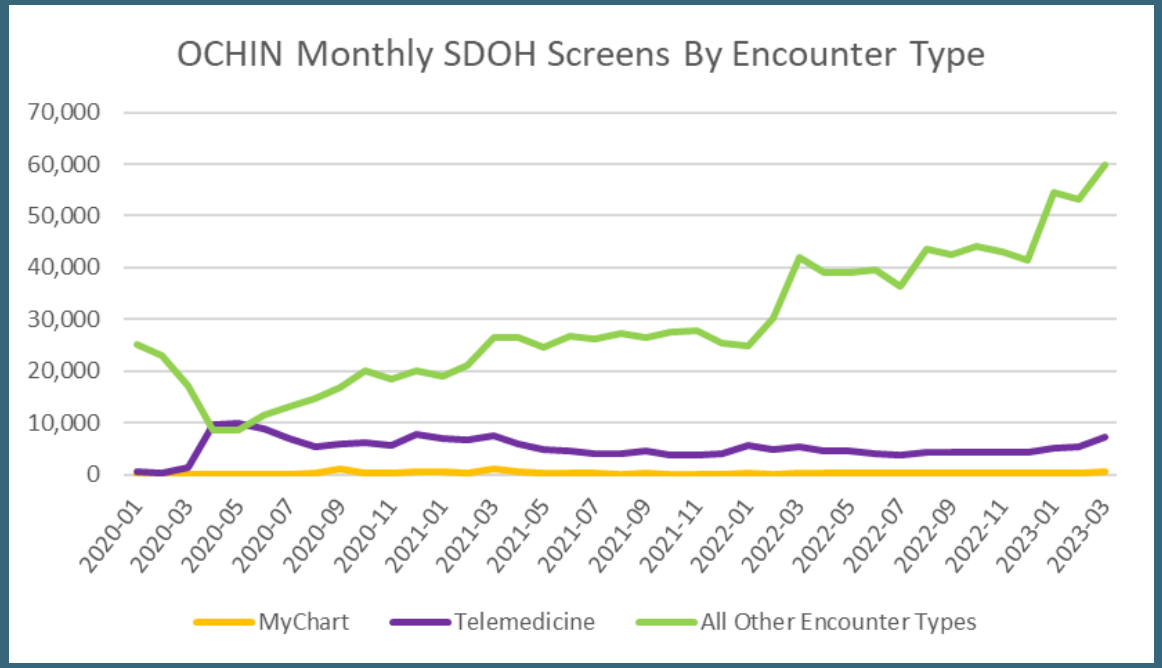
Telehealth can play an important role in maintaining/improving access

- *COVID exacerbated disparities in access to all types of care*
- *Digital access in and of itself can be a social driver of health*

See: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8019343/

SDOH Screening via Telehealth – Accelerated by COVID

- Telehealth SDOH screening grew exponentially during the pandemic
- Has since leveled off - *opportunity for further screening growth*
- Benefit from specialized screening approaches (empathetic inquiry, motivational interviewing, etc.)
- Surveys have shown patients are overwhelmingly satisfied with having SDOH needs addressed via telehealth[1]



- Screening for digital access *as an SDOH* can help understand barriers and facilitate appropriate solutions

1) See: https://www.cureus.com/articles/116138-patient-satisfaction-with-medical-and-social-concerns-addressed-during-telemedicine-visits

OCHIN

To enable digital access, assessment, and assistance with social needs, SDOH data must be actionable and interoperable with other EHR information. Three “S” factors:

Structured

- Is the data stored in consistent, organized, easily-queried (i.e., not free-text) fields?

Standardized

- Are the questions, answers, screeners and tools used to collect data consistent across systems?
- Are codesets or mappings used to represent the data documented and available?

Systematically Collected

- Are only a particular subset of patients consistently screened?
- Are there distinct clinic or organizational factors like specialties (e.g., pediatrics, behavioral health), grants (e.g., HRSA 330c vs. 330h), payor mix, staffing, etc.?

See: http://hiteqcenter.org/DesktopModules/EasyDNNNews/DocumentDownload.ashx?portalid=0&moduleid=952&articleid=330&documentid=214

Examples of Structuring Social Needs and Referral Data

- Ensuring responses that *indicate an identified need* (i.e., "positive" answers) are flagged
- Ensuring *declined* answers not included in denominators
- Linking SDOH referrals to an identified need/problem/concern
- Including SDOH domains from pre-set list in question/tool definitions
  - Consider granularity (e.g., housing instability, housing quality, homeless status)
- Avoiding free text responses unless required or as supplemental context
- *Facilitates scripting for telehealth/remote administration, portal, etc.*

	LINE_COUNT	FLT_KEY	FLO_MEAS_ID	COMPARE	VALUES	MAPPED_VAL	DECLINED_VALS	FLO_MEAS_NAME	DISP_NAME
13	13	FOOD-12	11405	=	Yes	2	DECLINED	R OCHIN HP FOOD INSECURITY	In the past year, did you ever eat less than you
14	14	FOOD-2	3495	>	0	2	DECLINED	R SDH FOOD WORRY MONEY TO GET MORE	Within the past 12 months, the food you bough
15	15	FOOD-3	6567	>	0	2	DECLINED	R BHN SDH FOOD WORRY MONEY TO GET MORE	Within the past 12 months, the food you bough
16	16	FOOD-4	6569	>	0	2	DECLINED	R BHN SDH FOOD WORRY RUNNING OUT	Within the past 12 months, you worried whethe
17	17	FOOD-5	1993	=	Often|Sometimes	2	Don't Know	R FOOD INSECURITY Q1	Did you worry that your household would run o
18	18	FOOD-6	1995	=	Often|Sometimes	2	Don't Know	R FOOD INSECURITY Q2	Did your household run out of food before you
19	19	FOOD-7	2255	=	Yes	2	DECLINED	R SDOH QD1: HARD TO PAY FOR: FOOD	Hard to pay for: Food

Standardization Successes

HL7 Gravity Project

- Successful updates to ICD-10-CM Diagnosis “Z-codes”
- SNOMED/LOINC mapping updates and cataloging
- Recognized SDOH Steward for NIH Value Set Authority Center (VSAC)
- Completed (STU2) FHIR IG for interoperability of SDOH data

SDOH Concept Recommendations incorporated in USCDI v2-3 by ONC

- Includes Assessment, Goals, Problems/Concerns

Standardization – Ongoing Challenges

- Proliferation of screening tools/questionnaires*
- Lack of Progress on CPT/HCPCS Procedure Coding
- Outcomes left out of USCDI SDOH concepts
- Inclusion/exclusion/priority of domains
- Capacity, capability, and infrastructure of CBOs is widely varied
- *Lack of research/evaluation on alternative administration settings*

*In February 2023, CMS posted a list of approved screening tools for housing, food, and transportation in Medicare Advantage SNP health risk assessments.
See: https://www.cms.gov/regulations-and-guidance/legislation/paperworkreductionactof1995/pra-listing/cms-10825

Systematic Collection – Measurement and Payment

Current Nationwide Measurement Examples

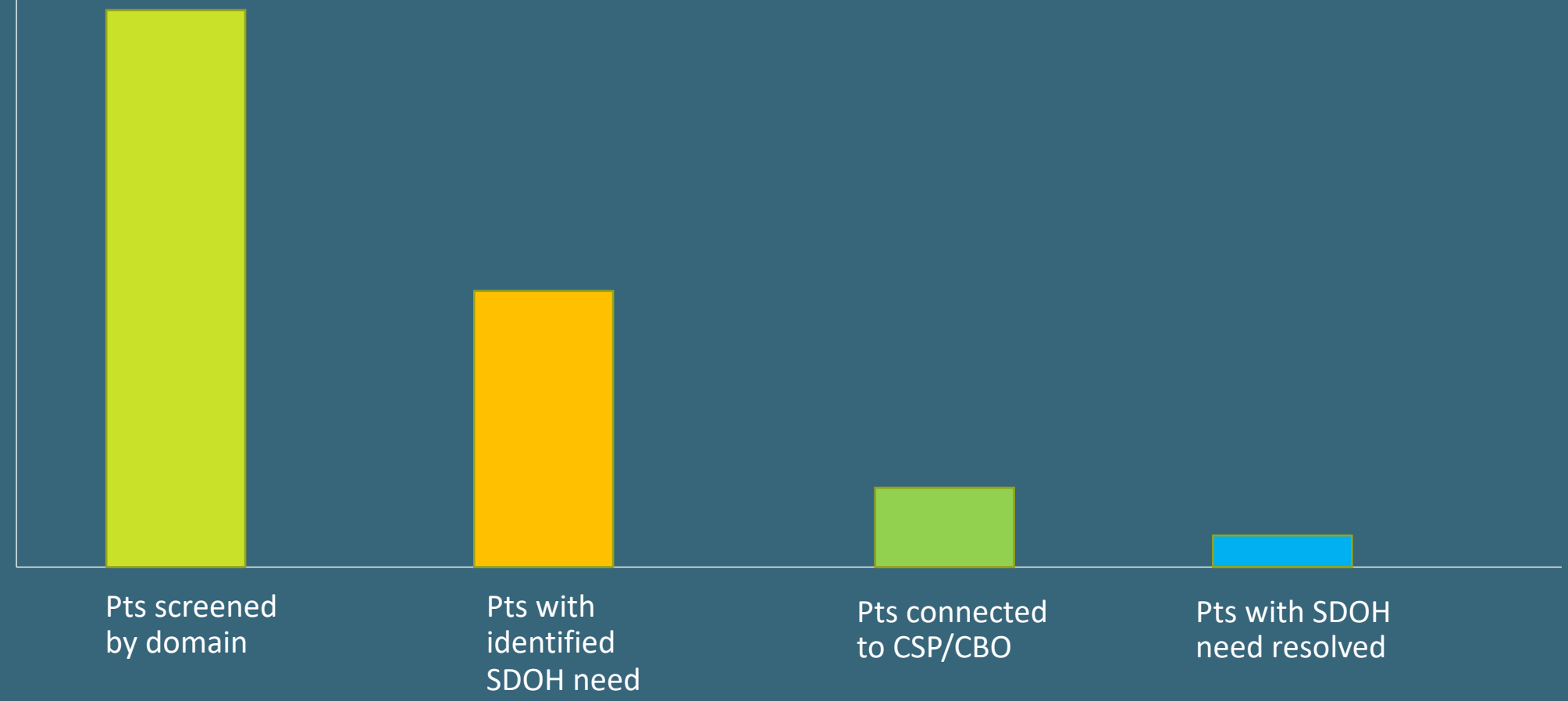
Measurement Program	HEDIS (NCQA)	Inpatient Quality Reporting (CMS)	Outpatient MIPS (CMS)
Domains	Food Housing Transportation	Food Housing Transportation Utilities Interpersonal safety	Food Housing Transportation Utilities Interpersonal safety
Population	All health plan members	Patients 18 years or older admitted to hospital	Patients 18 years or older in a MIPS eligible provider practice
Measure 1	% of members screened at least once for the 3 domains	% of admitted patients screened for all 5 domains	% of patients screened for all 5 domains
Measure 2	% of members with an identified need for one of the 3 domains who received an intervention within 30 days (per domain)	% of admitted patients screened for all 5 domains who had an identified need (per domain)	% of patients screened for all 5 domains who had an identified need (per domain)

2024 Proposed MIPS Measures*	
Connection to Community Service Provider (CSP)	% of beneficiaries ≥18 years reporting they had contact with a CSP for at least 1 of their HRSNs (food insecurity, housing instability, transportation problems, utility help needs, or interpersonal safety) **within 30 days after screening** (annually)
Resolution of At Least 1 Health-Related Social Need (HRSN)	% of beneficiaries ≥18 years reporting that at least 1 of their HRSNs (food insecurity, housing instability, transportation problems, utility help needs, or interpersonal safety) was **resolved within 6 months** after screening (annually)

**Currently in CMS rulemaking process*

Objective: Create a Cascade of SDOH Metrics

The SDOH action measures OCHIN submitted leverage the prior screening measures to create a meaningful measurement cascade, enabling stakeholders to track progress in SDOH screening, referral, and resolution



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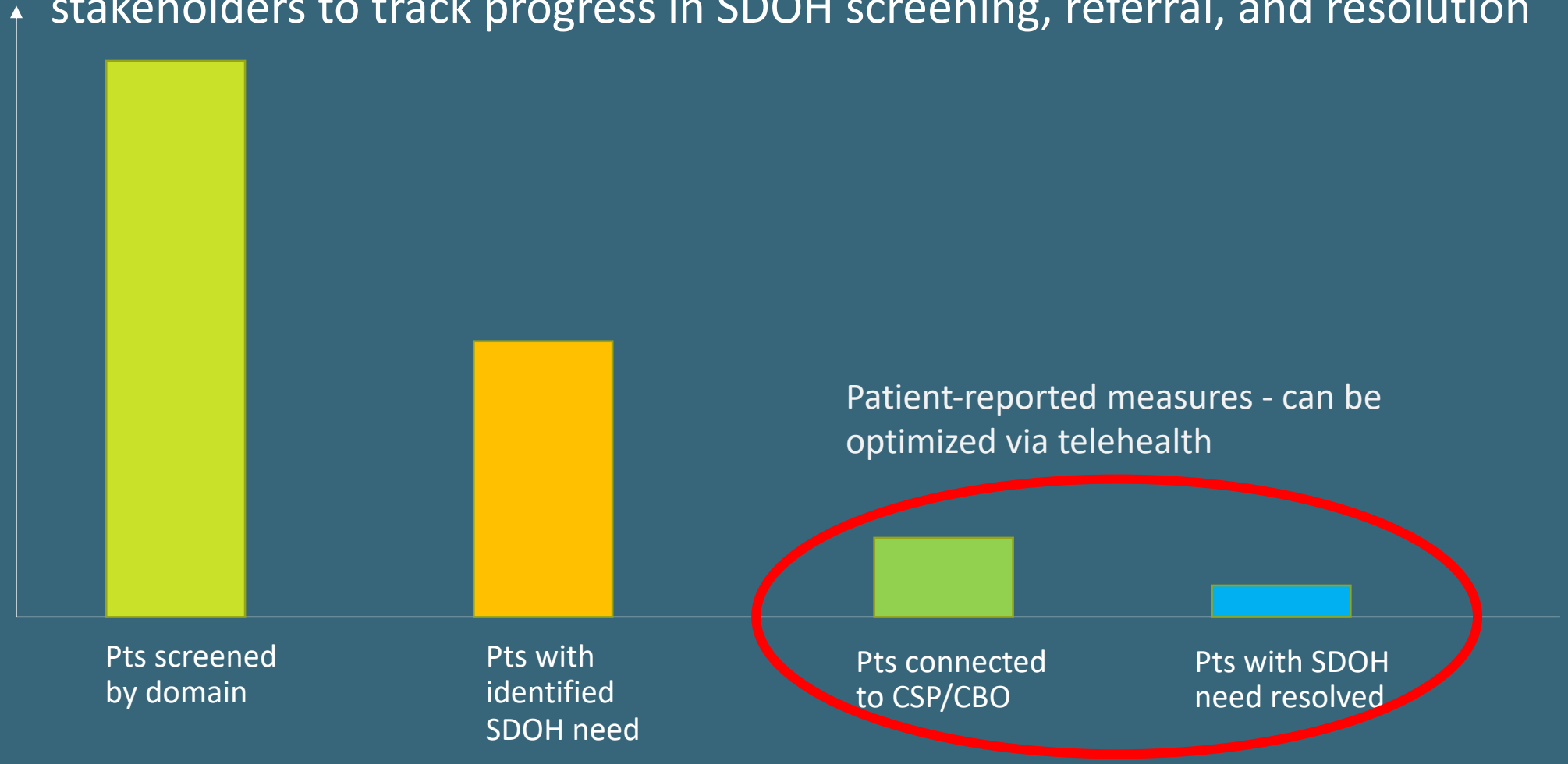
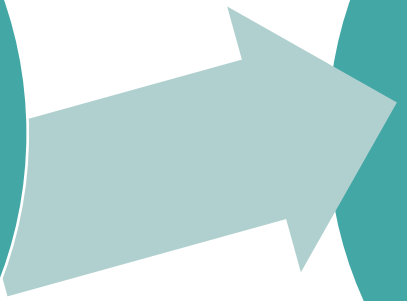


Address Equity Today, Build into Payment Systems Tomorrow

Need to ensure that as payment models are re-engineered so that SDOH are factored in

- Cover services to address social drivers of health
- Adjust to account for cost in clinical context associated with social drivers of health

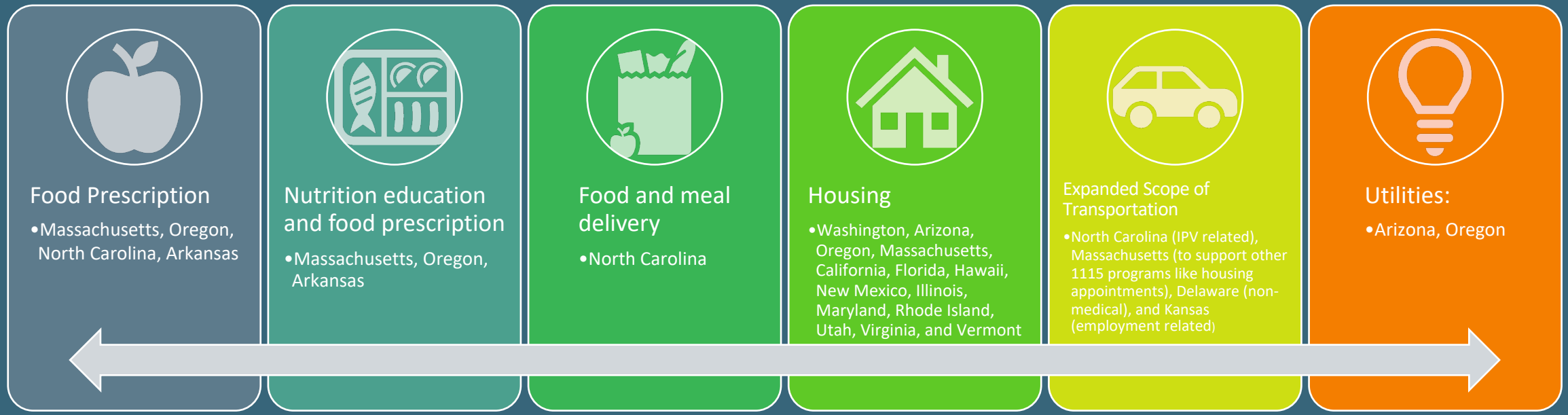


Quality measures in existing programs provide glide path

See NASEM (2019): Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health https://nap.nationalacademies.org/read/25467/chapter/4

State SDOH Payment Initiatives

- 1115 Waivers



- Other initiatives:
  - CA Enhanced Care Management payment (CalAIM ECM and ILOS) https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx
  - Proposed CA SDOH Bill AB85 – would require health plans to reimburse for screening and referrals based on social needs as of 1/1/2024 https://legiscan.com/gaits/citation/560427

CMS Focus on Measurement and Screening > Action

CMS accelerating momentum . . . .

Perspective

Aligning Quality Measures across CMS — The Universal Foundation

Douglas B. Jacobs, M.D., M.P.H., Michelle Schreiber, M.D., Meena Seshamani, M.D., Ph.D., Daniel Tsai, B.A., Elizabeth Fowler, Ph.D., J.D., and Lee A. Fleisher, M.D.

NEJM (2.1.23)

- **CMS Center Leadership** from across 20 Medicare payment programs, ACO, and Medicare Advantage
- Equity **Universal Foundational Measures**: **Screening for Social Drivers of Health**
- "we also intend for them to eventually cover **follow-up to address identified social needs**"

Preliminary Adult and Pediatric Universal Foundation Measures.*

Domain	Identification Number and Name
Adult	
Wellness and prevention	139: Colorectal cancer screening 93: Breast cancer screening 26: Adult immunization status
Chronic conditions	167: Controlling high blood pressure 204: Hemoglobin A1c poor control (>9%)
Behavioral health	672: Screening for depression and follow-up plan 394: Initiation and engagement of substance use disorder treatment
Seamless care coordination	561 or 44: Plan all-cause readmissions or all-cause hospital readmissions
Person-centered care	158 (varies by program): Consumer Assessment of Healthcare Providers and Systems overall rating measures
Equity	Identification number undetermined: Screening for social drivers of health
Pediatric	
Wellness and prevention	761 and 123: Well-child visits (well-child visits in the first 30 months of life; child and adolescent well-care visits) 124 and 363: Immunization (childhood immunization status; immunizations for adolescents) 760: Weight assessment and counseling for nutrition and physical activity for children and adolescents 897: Oral evaluation, dental services
Chronic conditions	80: Asthma medication ratio (reflects appropriate medication management of asthma)
Behavioral health	672: Screening for depression and follow-up plan 268: Follow-up after hospitalization for mental illness 264: Follow-up after emergency department visit for substance use 743: Use of first-line psychosocial care for children and adolescents on antipsychotics 271: Follow-up care for children prescribed attention deficit–hyperactivity disorder medication
Person-centered care	158 (varies by program): Consumer Assessment of Healthcare Providers and Systems overall rating measures

* Domains are from Meaningful Measures 2.0. Identification numbers are CMS Measures Inventory Tool measure family identification numbers; names reflect the descriptions associated with those numbers.

Care Coordination Across Health and Social Services

- Primary care and social service organizations have been natural collaborators
- Formal and informal partnerships exist
- Data has always been a barrier
  - Patient consent to data sharing
  - Disparate regulatory/legal frameworks
  - Differing approaches, workflows, code sets, and standards
  - Gap in resources/technological capability
- New approaches seek to use technology to bridge data divide and enable cross-sector collaboration – including extension of telehealth across sectors[1]

1) See: https://www.healthrecoverysolutions.com/blog/telehealth-combating-social-determinants-of-health

“Community Information Exchange (CIE)”

- Three principal component services
  - *Community resource directory*
  - *Closed-loop referrals*
  - *Patient consent*
- Social Service Resource Locators (SSRLs) can provide underlying platform
  - Unite Us, FindHelp, etc.
- Community, regional and statewide initiatives across the country
  - 211s often provide the resource directory data
- Can also provide important data on needs for capacity building, resource allocation, and advocacy
- These solutions can incorporate telehealth-enabled care coordination efforts

CIE Challenges for Cross-Sector Data Sharing

- CBO engagement for cross-sector data exchange
  - Capacity, capability, and infrastructure are widely varied
  - Many CBOs do not engage in care coordination
  - Trust in health sector is often low
  - Perceived “medicalization” effort towards CBO work
  - Often not engaged early or as true partners
- Legal and privacy frameworks can be unclear or tenuous
- Competing models for consent requirements
- Patient trust is essential, and telehealth can help *or* harm

Resources:

- Gold et al, 2018. *Guide to Implementing Social Risk Screening and Referral-Making.* OCHIN and Kaiser Permanente Center for Health Research joint publication hosted on SIREN Network Resource Library: https://sirenetwork.ucsf.edu/tools-resources/resources/guide-implementing-social-risk-screening-and-referral-making
- Coughlin et al, 2019. *A logic framework for evaluating social determinants of health interventions in primary care.* J Hosp Manag Health Policy: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6853626/pdf/nihms-1057968.pdf
- Center for Care Innovations, 2017. *ROOTS Logic Model for CHCs.* https://www.careinnovations.org/wp-content/uploads/ROOTS-Logic-Model-v4.doc
- National Academies of Sciences, Engineering, and Medicine, 2019. *Integrating Social Needs Care into the Delivery of Health Care to Improve the Nation's Health.* *https://www.nationalacademies.org/our-work/integrating-social-needs-care-into-the-delivery-of-health-care-to-improve-the-nations-health*
- National Library of Medicine Value Set Authority Center (VSAC): https://vsac.nlm.nih.gov/

Q&A

Facilitated by CTRC Team

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Thank You

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Telehealth Topic: TAP into Telehealth: Innovative Models of Telehealth Access Points (TAPs)
Hosting TRC: Northwest Regional Telehealth Resource Center (NRTRC)
Date: May 11, 2023
Times: 11 AM – 12 PM (PT)

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