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ARIA JAVIDAN:
Hello my name is Aria Javidan and I'm the product manager for the national consortium of telehealth resource centers. Welcome to the latest presentation of the NC TRC, today's session is on Social Determinants of Health and Value-Based Pay. Today's webinar is being hosted by the California Telehealth Resource Center. These webinars are designed to provide timely information and demonstrations to support and guide the elements of your telehealth programs.

Just brought a little bit of background, the consortium located throughout the country there are 12 regional telehealth centers one focus on telehealth policy and the other focused on telehealth policy. Each one focusing on the effective use of telehealth and supporting access of the telehealth services in rural and unsupported communities.

Just a few tips before we get started. Your audio has been muted for today's webinar. Please use the Q&A function of the zoom platform to ask questions. Questions will be answered at the end of the presentation. Please also note the closed captioning is available for today's webinar that is located at the bottom of your screen.

Today's women are also being recorded and will be able to access today's antipasto nurse at the NCTRC YouTube channel. With that I will pass it over to Aislynn Taylor program specialist at the resort center.

AISLYNN TAYLOR:
Hi thank you Aria, I'm Aislynn Taylor a I am the program solo show list at the California telehealth resource owner. We are glad to be hosting today's presentation. Today I am thrilled to introduce our guest speaker for today Ned Mossman, he is the director of committee health at a parent company. Net has spent over 20 years at the intersection of healthcare, research and IT. In 2014 he joined OCHIN Inc., he oversees OCA ends initiatives around increasing understanding of social needs assessment, prospector cooperation health equity and value-based care.

He also plays an active role in a number of national stakeholder groups focused on bridging healthcare and social needs where he cochairs the strategic advisory committee since 2018 he served on the board of directors of 211 until a nonprofit that helps people identify navigate social service programs and activities to address needs such as housing, housing, childcare and tradition.

Mr Mossman received a master of public health and epidemiology and biostatistics from Oregon health and science-- Oregon 8002. Now we will pass it over the net thank you so much for presented today.

NED MOSSMAN:

Thank you so much for having me, I will go ahead and share my screen. Hopefully the right one comes up. Alright, so I'm going to talk a little bit about our expense at OCH I a with social determinants of health and trying to make determines of health Inc. integrated into clinical care. And I'm going to do this through a telehealth lens because there is an important impact that both telehealth has enabled this work and that it is really part and parcel of it. Both on the data side, on the social needs side.

I will be speaking to those factors as I go through this there we go. So just as a reminder, why do we focus on the social determinants or some people call them the social drivers of help nowadays. Which kind of like because determinants sounds like it is something you can't change or that is permanent. A social drivers has a little bit of a better ring to it. Primarily it is that equity and sustainably. Particularly for health center members verbally across primary care and across all care. So understanding context about patients lives, providing the opportunity to work upstream to affect factors and improve factors that affect their health. To be able to do publishing health management. So taking high leverage activities.

Instead of having patients use lower leverage care, being able to do high leverage outreach so people working in the top doing outreach. Often by telehealth modalities and reaching targeted subpopulations for whom they can make the biggest difference. H and then understanding that there is a need understanding the community for your own resource allocation but also for advocacy and partnerships potentially to be able to understand should we partner with a food bank, should we partner with a housing agency. Also to advocate for those things in the community.

Lastly there is that sustainability component. So understanding and being able to do basic retread of vacation around payment and potentially adjustment acknowledges that more complex patients. Not just medically and clinically but socially complex patients require more resources to care for.

So as Aislynn mentioned we are a collaborative at OCHIN made up of over 150 member committee centers, critical access hospitals and health departments and all sorts of organizations that underserved patients by and large.

We also have a research department that has done a number of NIH funded studies look at implementing social determinants of health screening and action and thinking about factors including telehealth that both enable that enter affected by that.

So some of the findings, the one I really want to point out here is at the clinical level adaptability is key to be able to permit screening an action for social needs. So being successful in dealing with that. I want you to keep that in mind for a couple of slides, we will come back to that. And then other factors obvious the external factors like grants or reimbursements. Or even just encouragement from

associations that clinics are part of was a motivator to engage in a success factor. The Mac presence of a strong championship, emphasizing that work with social screening needs to be driven from the top down as supposed to something that is done more informally or just at the point-of-care level without real commitment from leadership.

You know the last 10 years or so we have seen the increase in connecting social care and healthcare really be something that takes it out of the informal activities that we know our health centers have been working in this space just informally for decades. But really in the last 10 years or so are all around doing this as something that is an acknowledged duty with the supportive leadership.

And then lastly this is sort of common sense and it goes for a lot of different types of implementation success but starting small. Matching initial activities to whatever that baseline capacity is, and then once you are dialed in then the workflows and scaling up can occur. Certainly for increment in telehealth programs as well.

And then in addition to our research group we have been able to learn just from the member experience in our collaborative. So we encourage our members to screen using whatever technology or modality or in person or whatever works best for them, for the patient's for them and their communities. We are really trying to build a library of emerging best practices.

We see huge diversity in the workflow because our members are highly diverse, we know there is kind of frustratingly a proliferation of different screen tools out there and I will talk about some ways that we sort of work around that and made that work across a number of different ways to screen and ways to use that information.

In the understanding that team roles, who is doing the screening and how it is being done both the screening and the outreach again varies widely between clinics.

I will point out here that both in terms of maintaining access and in terms of being something that is also a social determent in it of its self. Telehealth and access to digital care and digital literacy are all things that are wrapped up in the types of social needs, especially the poverty driven social needs that we see and that our members work with.

We know especially from the pandemic that access was highly affected and in fact across our members, telehealth screening for social determinants grew exponentially. It went from zero essentially in a month to over 10,000 screenings that were conducted via telehealth for social risk screening.

In a single month which is astounding. And that harkens back to that adaptability that I mentioned,

where clinics were still acknowledging the need to continue doing social risk screening and were able to pivot doing it as they were with much of their work via telehealth. As supposed to those in person visits it just were not possible in the pandemic hit.

You'll see that that sort of leveled off and became normal but the growth has not been there in the last couple of months. So we can really see this as an opportunity to help expand screening. We consider the number of overall screening has been going up throughout our membership but we really see telehealth as an opportunity for our members to increase their screening activity in a sustainable way.

I will say that both in person and via telehealth, specialized screening approaches for some of the sensitive nature of some of the needs that are talked about is beneficial. So there are numerous trainings around there around empathetic inquiry, we have seen that used to great success in many cases. If you're wondering about how to train your staff to do these questions, especially via telehealth where you are not in the same room with the person to do those screenings. And the sensitive matter, those are important approaches to doing that, I would encourage you to seek those out.

I will say having said that that the research and the surveys that a been conducted on patients who have had telehealth administration social determinants screenings so that patients are overwhelmingly satisfied with having their needs screamed for via telehealth.-- Is screened for via telehealth. I imagine that that is consistent with other types of telehealth satisfaction as well.

And then again I will just reiterate that screening for digital access has a social determinant, as a social driver can help understand what those bears are and facilitate things like telehealth and being able to use it on a broader spectrum of patients.

So I'm going to go a little bit into the data and the use of data. Because as I mentioned, this is work that our community health centers have been doing for decades. And the thing that is really news integrating and clinical workflow. What is becoming possible is being able to treat this data as other clinical and health-related data. Enabling digital access and digital use of this information.

So assessment, assistance with social needs you have to be able to use it in the EHR to successfully do that that goes for telehealth and the operability across systems as well. So they put out a while about these 3S factors, and I really like this way of framing it describes the different fronts and approaches we have to think about social needs data to be able to exchange it, to be able to use it in the EHR and digitally enable use like cross sector care coordination. Those 3S's are structure, is the data stored not just in free text. Is it stored win a way that the answers have meaning that can be understood in the EHR.

Is it standardized? Are the questions, answers, screening tools consistent across systems or are there

code sets or mappings and are these documents consistently. In the last one that I think is overlooked is systematically collected, so understanding is only particular subset of patients was screened has a really big impact when you try to roll up her aggregate that data and make conclusions about it.

Part of that goes back to understanding the nature of the specialties, the nature of the organization, the nature of the clinics. Either receiving only certain kinds of grants provide care? That's an example, and our members what are they doing with telehealth, are they serving a particular region or specialty. Again as you try and aggregate this data those are factors that you need to understand.

Just an example of structuring this data, is ensuring that anything that indicates identified needs or social needs that a patient has, which is a quote unquote positive response to screening is flagged in the EHR and the declined answers are not added into a denominator so if your patient does not want to answer you are not assuming either way that there is or is not a need.

Then linking referrals to an identified need, problem or concern that can be documented. This is something that as we have moved from just trunks documents reading to document action-- document screening to document action is something that we are really wrestling with now I would say.

Then also just considering our granularity about how we categorize the domains. So food, housing, transportation and whether there are potentially subdomains for example housing stability versus homelessness. So with housing things like mold, pass etc. Really thinking about-- pests leaving about the granularity but if this is all done well it allows you to successfully standardize because you can roll things up to a level of a diagnosis.

In the gravity project the HL7 Gravity Project that was started in the University of California San Francisco has all the major code sets to include social drivers and social determinants codes and allowed for mapping of those and has really worked on interoperability across systems. Enke pleaded an entire information guide about being inoperable with those code sets.

I will also note that as this work has progressed concept recommendations around social needs have been included and incorporated into the US CDI which is what is used to identify health record technology. They've identified social needs, assessments, goals and problems/concerns.

The outcomes is sortable we would like to know but hopefully in later versions they will include social needs outcomes as well. So there are some challenges ongoing to standardize vision and I will know that off the top. Again I mentioned that list of screening tools that feels larger every day.

CMS has created a list of approved screeners for a couple different programs that may be a big to come. They may use that code set pardon me, they may use that list of screeners to be the approved

list in the future. You may want to keep an eye on that link and the screeners that are included there.

There also has been a lack of progress on CPT which is the procedure part. So we're getting much better with the code and to identify need quote unquote see codes but to be able to-- C codes, but – Z codes. That's what makes it hard to have a denominator that makes sense if you know the number of patients that had an identified need, you would want to know if you are thinking about a rate of an identified need, who is a screen?

So being able to code that effectively is still a little bit of a gap. The other thing is that working with again through telehealth, through technology, through technology enabled resisted platforms across sectors. So in healthcare and the social services is a challenge because this is relatively new again and the infrastructure of the community organizations we've often just refer to them as CBO's, but that includes social service agencies, nonprofits, any organization that provides services to address social needs that are identified in screening.

In the capacity of his organizations as you would except as widely varied. Natalie the capacity to provide services but their capacity to engage in Electronic Verification-- not only their capacity to provide services but the number of platforms and popping up to help facilitate that. I also want to point out that there has been in standardization a lack of evaluation and research around different administration settings.

Again I think this is some place telehealth can really shine, we do need more research to help us understand the benefits and the barriers to doing these screenings via telehealth. But the current evaluation worries more about what the wording of the question was and what needs identifies. As opposed to saying it is being administered on a paper questionnaire in the waiting room or is it being done via telehealth. Or is it being done in the exam room of the MA or rooming stop. Really understanding what the difference in benefits of different alternative administration settings are could help us point out some more benefits of telehealth enabled care.

So then when it comes to systematic collection I talked a little bit about how understanding the different ways this is being done for different types of clinics, for different types of facilities in different regions. Even within a clinic, within an organization, which patients already focusing on. Are they trying to do highly targeted and high leverage in outreach so there screening patients or are they screening everybody every visit?

Something that tries to tie this together a little bit in terms of encouraging systematic collection is measurement. You can see that there are nationwide examples through health plans, through reporting for hospitals and then through outpatient through voluntary system unlike the other 2. There are-- now measures for social screening. It is important because if there are clinics that have been

engaged in this work without a formal path to reimbursement outside let's say a plan that negotiates this into part of the reimbursement, this is not something that has had a good avenue to being either measured or compared across care settings and how this work is being done.

Again I mentioned that survey showed that patients are pleased with the way that being asked these questions over telehealth has worked for them as opposed to having to do it in person at the doctor's office. I think there's a real potential to succeed in these measures via telehealth that again having these measures will enable us to show.

Right now the 2 existing measures are around the percentage of patients screened and then the percentage of patients who have not identified need. At the proposed metrics in 2024 they're currently undergoing the rulemaking process and in other sectors as well also talk about addressing social needs. Not just screening and who had it but were they connected to committee service providers? Another thing for CBO and CSP what we're seeing is supposed to be able to have an actual measurement cascade. To be able to see who is screening, which of those patients were identified only to those patients are connected to communis service appropriately.

Then which of those patients have a need actually resolved. You can see especially the patient reported measures that go outside of healthcare they absolutely will be optimized for telehealth. This is care coordination we do not need to have somebody come into your office to tell you that they connected with the community service provider. These are elements I expect telehealth to have a huge impact on.

I mentioned that it is really about equity and sustainability but it is in that order too. So, we really need to ensure that the way the payment models are being engineered or reengineered these days that they are covering services that enable both understanding and addressing social determinants of health but also to account for the cost of doing that.

And then building up of quality measures in existing programs to both provide a glide path for that but to also provide an understanding on how does working. Part of that as I said was there are those measures of the federal level, but the states in their Medicaid waivers, the states have had what is called the 1115 waivers passed to allow them to experiment with the way that they are delivering Medicaid at the state level.

Almost all of the waivers that have gone through have had an aspect of understanding, addressing and trying to enable connection to services for various social needs and social drivers of health. So in addition to the waivers here you can also see in California, there is a care management payment and services for enhanced care measurement activities. Include addressing social drivers. Also there are some proposal require health plans, not just Medicaid but health plans for screening and social need.

And then I will say that, I've already mentioned the federal measurements landscape but this is, they are increasing their focus is supposed to, they are not done I guess that is the way I will say it. So momentum is accelerating at CMS for these quality metrics, in fact in a New England Journal a position paper was put up by CMS by their leadership across different Medicare and Medicaid payment systems.

They really echoed that universal foundational measures for screening and social drivers for positivity in screening but also for those addressing and resolution of social needs are on their list. So these are again, these are things that are being put into, factored into their course set for Medicaid. That is the state level. But also that Medicare and CMS have restated their commitment to being able to measure these.

In other words there continue to be more ways to measure all of this. So then touching a little bit more on that evolution into care coordination across health and social services so that addressing these needs becomes easier. We know again that primary care and social services have been natural collaborators but it is been in a more informal way through much of the past decades although there are plenty of formal partnerships. Odetta has always been a barrier. Again-- but data has always been a barrier. Again this is a place where telehealth can help exchange information anymore formal, organized and consistent way. But to name the specific challenges with that, getting patient consent both obtaining it and sharing it and maintaining and documenting it to demonstrate that the patient has agreed to have their data shared outside of healthcare runs into some of the regulatory and legal frameworks between healthcare and social services and outside organizations are subject to HEPA. Different approaches, standards, technologies all of this also points to the gaps in resources many committee organizations do not have the same resources and level of funding and power that healthcare has.

So again these new approaches are seeking to use technology to bridge the data divide and to enable this collaboration. There are extremists in several states that have looked at extending telehealth to use across sectors and help build out those partnerships. Really the nature of those electronic partnerships, they are often referred to as community information exchange as opposed to health information exchange.

There also called social service resource locators or other acronyms. They have 3 really important component services. So the 3 pieces that they need to have art a directory of community resources that is accessible from the healthcare setting. Closed-loop referrals, that is sort of the whole idea is to be able to do this electronically and have the information flow both to the committee organization and the back into healthcare and vice versa when the referrals are coming from social services and healthcare. And then again I mentioned a really important factor is to document and share patient

consent.

As I said the social service resource locators are a platform and a category of platform. Tina is in providing a platform to that does not require the organization on the receiving side to install any special platform necessarily. They are just a web-based platform that can be used to help manage that coordination across sectors and to inform others in the community and others who are involved in the patient's care about the services provided in the patient status.

Then there are also other initiatives like 211s in other states and regions. Often they provide the data used by other platforms. These type of arrangements, part of the strength is that obviously able to connect patients to resources directly. Another part of that goes back to the data, being a provider important data on needs in the community for capacity building and resource allocation and advocacy. Again, I will reiterate that these all can incorporate telehealth enables care coordination efforts. That is a strength, being able to do this via telehealth as opposed to doing it in office visits. And then of course there are other challenges. Engagement by community organizations, their infrastructures and capabilities are widely varied. More so even than in healthcare. Many of them don't do coordination care, I will also point out that trust in healthcare sector is low and understandable because many of them have been burned in the past were they have created a partnership or took on clients from healthcare settings that were sent to them from healthcare settings and they were not provided with any resources or capacity building activities to help support that.

Of course part of that fits into the quote unquote medicalization effort, or perceived medicalization towards the CBO's work. All that is of course to say that often times they are not engaged as partners but sort of an outside provider that is not included in planning, resource sharing or those kind of efforts.

So I think I've covered the privacy and consent, and then the last thing I wanted to touch on is that patient trust really is essential in having their care coordinated across these different sectors. So going from place to place, things like a referral to nowhere where they're just handing a list of resources or a phone call is made in the no follow-up happens really can harm that trust and make patients reluctant to engage in this type of coordination in the future.

Telehealth can really help that, it can also harm that if it is not done in a way that focuses on the patient's needs and their wants, their agency. In their ability to make the choices for themselves. So with that I will just leave this list of resources for you here. I know that the slides will be shared and I will turn it back over Aislynn.

AISLYNN TAYLOR:
Thank you Ned, it was very useful for me to understand where they intersect. Thank you so much for this presentation. I want to encourage the participants or attendees if you have questions for Ned now

is the time. Please enter any questions you have using the Q&A feature on the bottom of the screen. I will give it a few minutes while we are waiting for some questions I want to give a quick set up for upcoming events for CT RC we are having an interactive telehealth workshop next week, tips and strategies for telehealth program success. It will be virtual but unlike this webinar we will be asking you to come on camera and be ready to interact with us next week.

We are also having an annual summit in June. So I will share those links in the chat if anybody is interested in continuing their telehealth education. These are geared towards the California region but we are open to all. And I am seeing just some "thank you for the great presentations coming in". Shut up to Ned for a great educational session.-- Shout out to Ned, I will give it a few more seconds for some questions to come through.

So they are in the chat I am dropping registration for our upcoming events. So Ned, to say thank you, excellent ideas and programs. Also great to reference the imperative to follow up on patient needs shared. Thank you to the people that are going to share this presentation to their colleagues. Excellent presentation, great feedback it is always nice to her. We covered a lot of information in this session so I think people are happy to have this education and digest this content.

One question I have for you is "the features of care coordination across health and social services are really more barriers than features, how can you better facilitate such coordination?"

NED MOSSMAN:
You are right they are probably more barriers than features. We know this has been done again in many ways informally in the past. So how do we make this work better than just picking up the phone and making a phone call or handing the patient a list of resources. As it kind of mentioned there is a referral to know where idea that is not great, not a good patient expense, not good patient experience doesn't help anybody. And I would suggest technology, telehealth has a big role to play to be able to enable this. Again there are those platforms that have popped up that are providing a means to do this without a social service organization having to install something on their end and track another system. These are meant to be communitywide so it is not like they would have to implement, like a housing agency would not have to enter something in a bunch of different systems. Like not for every healthcare provider they were good but having one system is important.

AISLYNN TAYLOR:
Next question, "can you speak more to using this data for value-based payments?".

NED MOSSMAN:
Requesting have to be careful with adjustments. Part of our research right now is focused on how to effectively adjust. CMS is very interested in this. They are already looking at adding social

components. There are indices and means to do that the challenges we do not want to create a two-tiered system where if you have social complex patients who have a lot of social needs that you are treating them one way and that if you don't you are treated another way or scored or assessed another way under clinical outcomes. But just understanding if for example you provide care for a large number of homeless individuals. The data would show that they are more expensive and more complex to care for. They have more complex needs and so that has to be accounted for in reimbursement.

AISLYNN TAYLOR:
We've 2 questions asking about the same "how can we get health plans to help with social determinants of health close looped deferrals?".

NED MOSSMAN:
Some health plans already made investments in helping actually to establish networks of those social service resource locators. Some health plans have been very forward in thinking of this. Others is not on their radar and I think if I had a large number of patients I would bring it up in contracting and say look this is a cheap investment you can make. I think if they are looking to play the long game and think about and ultimately reducing cost again this is triple, quadruple Lane stop we are providing better patient care and reducing things like readmission. Your helping address people's most basic needs. The healthcare affects of those social needs. So it is a conversation I would have.

AISLYNN TAYLOR:
Definitely keep that conversation going. The long-term return on investment is so key to that conversation. Our next question is from Leona asking "what are some ways that we can let community organizations know about these referral programs?".

NED MOSSMAN:
Like I said a lot of our community based were a single solution comes up in a community so as a united platform that the hospitals and the clinics and the community organizations agree to use. But I would say is that ideally it is not just a matter of letting them know, it's a matter of involving them in the planning. So as these factors, as is platforms and networks are launched at the committee level, ideally you are bringing the community organizations to the table 2. Like true partnerships because that gives trust a lot more than later when you have to go to them and say "can you please use this platform for the quote unquote privilege of taking more of our patients and providing more services". Even if you may not have the capacity, so the more you can involve them in the decision-making. It is hard if you are a clinic that is smaller in a organization and you want part of those decisions.

It is tough, I think I would love to see a manual for being a good healthcare partner for social service. I think one of the things the chapter 1 would say would be "have you help them build capacity according to the patient that you're sending their way?". So every patient that you send for community

organization how are you insured that you are truly partnering with them.

AISLYNN TAYLOR:
Great tips and considerations, we have one more question, so there's anymore please now's your time to please submit. Last question for now is "caring for more extreme high-risk patients, what is the best way to make sure CMS pays for the care of these patients, coding, documentation, contracts or both?".

NED MOSSMAN:
All of the above so in your existing contracts making sure that your availing yourself of what is in that contract. Community health centers I will say have historically under coated the work that they have done. Part of the importance of standardizing the terminology for social needs is being able to document it. So then it goes exactly to your point. I think maximizing what you are actually able to demonstrate to CMS and other payers as well is hugely important. Then that gives you when it comes to that next contract time, it gives you the information you need to say here's how my rates should be set. Here is how we need to be paid to take care of these patients. There are also specific programs like in California I mentioned the enhanced care management. Those sorts of programs are out there.

Again you need to be able to demonstrate the you are following those programs so coding and documentation are still very important.

AISLYNN TAYLOR:
Yes, so valuable. That is all the questions I am seeing. Wait, we have one more. Last one "how can we help get caretaker and case manager buy-in on responding. We are discovering that there is a bottleneck with case managers for clients who may not be able to fill out forms and have communication issues when it comes to getting this information.

NED MOSSMAN:
That is a great question and it is tough. We know from our research that our membership in California, our members lost on average 30% of their staff during the pandemic. As we are rehiring up during the week of that. Is there trying to bring their staffing levels up to where they need to be. The opportunity there is to think about what your staff needs to look like. You need more care coordinators, is that a place you can focus on. I know that is a frequent bottleneck. It is hard, it is hard to in a patient centric manner be able to help patients that have such vastly different needs. So I sympathize, I don't have a perfect answer other than to say thinking about being able to staff in ways that give a little bit more flexibility and a little bit more time for those care grenades to do that work because there's just no substitute for being able to have a conversation with the patient has complex needs.

You know maybe their is the language barriers, or digital failures especially in telehealth maybe there's

a challenge of using the tools that you have. So again being able to staff, folks that can take the time. The take the time to do that work is important.

AISLYNN TAYLOR:

It really is, for us that is something that CT RC does have resources for looking at staff poles for the telehealth program. Always trying to optimize staff time I am not seeing any more questions at this time. So I think we are nearing the end, so I just want to thank you and Ned for presenting on behalf of CTRC we really appreciate it. I will headed to Aria.

ARIA JAVIDAN:

Think you for your presentation, just a reminder that our next webinar will be held on Thursday, May 11, that has been rescheduled from our regular 3rd Thursday schedule. I will be hosted by the Northwest regional telehealth resource center and that will be on tap into telehealth innovative models of telehealth access points. Registration information is available on the NCTRC events page. Lastly we do ask that you take a few short minutes to complete the survey that will pop up with the conclusion of this webinar. Your feedback is very valuable to us. Thank you again to the California resource telehealth center for hosting this webinar and have a great day everyone.

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