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VIA EMAIL: ASPEImpactStudy@hhs.gov

Brenda Destro
Deputy Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Re: Request for Information on Provider and Health Plan Approaches to Improve Care for Medicare Beneficiaries with Social Risk Factors

Dear Ms. Destro:

Greater New York Hospital Association (GNYHA) is pleased to respond to the U. S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Planning and Evaluation's (ASPE's) request for information on provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors.

GNYHA is a trade organization representing more than 160 hospitals and health systems across New York, New Jersey, Connecticut and Rhode Island. Through work across the membership, and particularly our New York members, GNYHA has had the opportunity to learn how social determinants of health are being assessed and addressed. We have done this as part of our ongoing support of our hospital-sponsored primary care practices and, more recently and more broadly, hospital-led organizations implementing New York's Delivery System Reform Incentive Payment (DSRIP) program. A key DSRIP component has been to assess what social risk factors contribute to poor health outcomes and how they may be addressed to reduce avoidable hospitalizations and emergency department use. A parallel component of New York's DSRIP program has been for the State to move Medicaid managed care contracts to higher levels of value-based arrangements. While DSRIP is targeted to Medicaid beneficiaries (a subset of whom are dual-eligibles), we believe that the lessons learned from this experience would also benefit the development of a general approach for Medicare beneficiaries and Medicare Advantage plans entering into value-based payment arrangements.

GNYHA's response will summarize ongoing efforts, best practices, and challenges to (1) screening patients for social risk factors; (2) addressing social determinants of health; (3) data collection; (4) and evaluating interventions. [1]

[1] Within this response, we use the terms "social risk factors" and "social determinants of health" interchangeably.

Screening Patients for Social Risk Factors

In a recent survey conducted by the New York State Department of Health's Bureau of Social Determinants of Health, fewer than half of the 260 responding providers—which included hospitals, community-based practitioners, and federally qualified health centers—routinely screen patients for social needs. The survey results are consistent with GNYHA's experience with member hospitals, which are in various stages of implementing screening tools and workflows to assess patients for social determinants of health.

New York hospitals are also in the early stages in considering how they might use patient demographic information to address social risk factors and health disparities. GNYHA has begun to work on this issue in the context of CMS's Partnership for Patients (PfP) initiative. GNYHA is co-leading a Hospital Innovation Improvement Network for approximately 175 New York hospitals, and as part of that effort, we surveyed PfP participating hospitals regarding collection of demographic, race, and ethnicity information. Forty-six hospitals responded indicating that they regularly collect this information as part of admissions and outpatient registration. While this data collection is a promising start, there is work to be done to use it for effective interventions and to integrate it with separately gathered data based on screening patients.

Selecting a Screening Tool

In assessing social risk factors, an initial challenge that GNYHA members have encountered is selecting a screening tool. There are numerous screening tools available, some validated and others developed more informally based on provider and social worker experiences in treating their patients. Some tools include questions on several social determinants, while others focus on one or two key social needs. The Center for Medicare and Medicaid Innovation's Accountable Health Communities (AHC) project requires a specific screening tool and GNYHA members participating in the AHC project are working with that tool. GNYHA hospitals not participating in the AHC project have spent a considerable amount of time reviewing and assessing existing tools. In some cases, hospitals determined that none were right for them and created their own tool by pulling questions from existing tools, rewording questions to better meet their needs, and adding questions that they did not find in any tool.

To assist member hospitals that have not yet selected a screening tool, GNYHA is creating a repository that will be available on its website shortly. We believe that having screening tools and questions available in one place will help GNYHA members accelerate the selection process. As more hospitals and practitioners begin using and validating screening tools, we expect that there will be more clarity on which work best within different settings and under different circumstances. A similar effort to create a national repository of screening tools may be something that HHS or another agency may want to undertake.

Implementing Screening Workflows

Another challenge that GNYHA members have encountered is developing a workflow that supports effective screening without being overly burdensome. Most GNYHA members with whom we have discussed screening tools are conducting screenings annually. GNYHA members, for the most part, have not yet developed best practices in screening; instead, they are continuing to test different screening workflows and administration modalities (e.g., paper-based, using tablets). Related to this, hospitals must determine who should perform the screening. Some tools are designed to be self-administered by the patient or a family member and others are

administered by staff, particularly if the screening tool is not available in the patient's preferred language. From our discussions with GNYHA members, the typical staff members who administer social determinants of health screenings are patient navigators, community health workers, health coaches, social workers, and volunteers. A positive screen (i.e., a finding that a patient has a significant social need) is typically forwarded to a social worker who can conduct a more thorough assessment and begin interventions. Hospitals must then consider how screening results can be communicated to the health care practitioner and what – if anything – the practitioner is expected to do with the information.

One of the screening workflow issues being explored is whether screenings should be for all patients or targeted to a subset of patients. We understand that some vendors are marketing a product whereby publicly and commercially available data sets can be analyzed with the goal of targeting screening efforts towards particular individuals, communities, and populations. In discussions with GNYHA members, the concept and overall approach may be of interest as they think about how to best utilize resources.

Ambulatory Care Experience with Social Risk Factors

Over the last 10 years, New York's primary care practices (e.g., hospital-affiliated, community health centers, physician practices) have been engaged in a significant effort to incorporate behavioral health screenings for depression, anxiety, and substance use disorder into their workflows. Much of this work has been done as part of efforts to achieve patient-centered medical home (PCMH) recognition by the National Committee for Quality Assurance. In our experience working with GNYHA members, there is sometimes a disconnect between the ambulatory experience and new efforts being considered for inpatient settings. The significant communication and tracking workflow experience developed for these screening tools in the ambulatory settings could potentially be leveraged to assess social risk factors for Medicare beneficiaries in hospital inpatient settings and other parts of the health care continuum (e.g., skilled nursing facilities).

Addressing Social Determinants of Health

Screening for social determinants of health has been coupled with promising strategies to implement interventions to address identified needs. GNYHA members have undertaken some of this intervention work themselves, but what is emerging more commonly are efforts to partner with community-based organizations (CBOs) that provide social services.

Hospitals Addressing Social Determinants of Health

GNYHA member hospitals, and particularly their ambulatory care departments, have added new roles to help ensure that patients with complex needs attend appointments and adhere to medication and self-care regiments. These care manager, care coordinators, health coaches, and community health workers employed by the hospital are often called upon to help address social needs which contribute to exacerbation of chronic diseases. Medicaid beneficiaries with two or more chronic health conditions are also referred to one of New York's Medicaid Health Homes. The Health Home program provides reimbursement for care management services for enrolled patients, and care managers often help patients navigate both their medical and social needs. These staff roles have been critical to addressing these needs and in reducing potentially avoidable hospitalizations.

As part of their efforts to address social determinants of health, hospitals have also begun to educate practitioners and other clinical staff on social risk factors to help them understand the impact of these issues on patients and how it may impact their treatment adherence and health outcomes. In response to graduate medical education accreditation requirements and more public awareness of social risk factors, New York's teaching hospitals have started to focus on ensuring that medical residents are aware of these issues as part of their education. GNYHA recently completed a project working with 15 member teaching hospitals in New York where the residency programs were partnered with local CBOs (e.g., food banks, senior centers) and primary care residents were educated regarding how the CBOs assisted their clients. The residents reported appreciating the opportunity to learn about some of the services available in the community to help their patients with their social needs, and the CBOs expressed appreciation at being able to work more closely with their local hospitals for the benefit of their mutual clients.

CBOs Addressing Social Determinants of Health

GNYHA members recognize that New York's CBOs provide critical services to address social determinants of health and many of these organizations have a long history of providing critical support to their communities. In particular, GNYHA member hospitals have reported that they are impressed at how CBOs are trusted entities whose staff understand the local landscape and cultural concerns. While hospitals and health systems seek to collaborate with CBOs whenever possible to address patients' social needs, there are some challenges that have emerged to navigating successful hospital-CBO partnerships. These challenges are detailed in a publicly available research report sponsored by GNYHA and the New York Academy of Medicine, entitled ***Partnerships Between New York City Health Care Institutions and Community Based Organizations: A Qualitative Study on Process, Outcomes, Facilitators and Barriers to Effective Collaboration*****.**

Based on the research, keys to successful partnerships include invested leadership from both partners; appropriate consideration of the financial needs of the CBO; systematized workflows for the two organizations; routine communication between the two entities; and a clear set of metrics to define successful outcomes. Partnerships with these elements have resulted in improved care for high-risk patients, and this has been documented in data collected by GNYHA members that have implemented these interventions. The major challenge associated with CBO partners is related to sustaining the projects, programs, and related staffing that comprise partnership activities. As part of their DSRIP participation, New York CBOs have provided services to address social needs, including patient outreach, cultural competency trainings, community health worker services, and chronic disease management education. With DSRIP funding slated to end in March 2020, hospitals and CBOs are discussing how to financially support partnerships that are becoming well-established and more integrated into patient care.

As social risk factors are identified and CBO partnerships are developed, a need has emerged to improve connectivity between hospitals and CBOs to facilitate referrals and ongoing communication about shared patients. Many GNYHA members have adopted technology to assist in this effort and GNYHA has been a forerunner in supporting this effort through its Health Improvement Tool for Empowerment (HITE), which was developed 20 years ago. HITE, which is publicly available at www.hitesite.org, allows users to search thousands of free and low-cost social service resources in their community. HITE, along with other technology, allows staff

from hospitals and social service organizations to search for services related to needs identified in a social determinant of health screening. Other technology solutions that can send referral notices to CBOs that can provide those services are also being tested.

Efforts are also underway to use technology to "close the loop" on social needs referrals, which mirrors work that has been done for PCMH where providers are encouraged to follow up on referrals to specialty providers. Implementation of these tools is ongoing, and GNYHA views this as a promising strategy to encourage connectivity between organizations that otherwise lack a communication infrastructure. While the focus for much of this effort has been Medicaid beneficiaries with complex needs and limited resources, the approach could be tailored to meet the needs of Medicare beneficiaries also.

Data Collection

A benefit of the screenings being conducted by hospitals and the technology tools being implemented is that more robust data is being collected on individual social needs. The experience with these screenings should be useful for those considering how data on social risk factors might be collected for Medicare beneficiaries. GNYHA hospitals are experimenting with modifications to their electronic health records (EHRs), such as embedding the screening tool, creating structured fields, and interfacing the EHR with the aforementioned search and referral technologies. However, because screening tools vary and EHRs are customizable, it is difficult at this time to standardize screening results and related data, or even aggregate data in a standardized way across providers and communities.

Based on information from GNYHA members that routinely screen for social needs, the issues arising most often are around housing stability (homelessness, risk of homelessness or eviction); housing quality (mold, pests); and food insecurity. GNYHA members believe that these factors are those where providers can most easily track services, provide referrals, and make the greatest impact. While this is a promising list, because most organizations are still in the early stages of reviewing and exploring different screening tools and connecting results to health outcomes, GNYHA believes it may be premature to specify exactly which social risk factors should be captured for Medicare beneficiaries.

Utilizing Z-Codes to Standardize Data Collection

Several GNYHA member hospitals are beginning to utilize "z-codes" to capture information regarding social risk factors. Z-codes are contained within the ICD-10 classification system and categorized as "persons with potential health hazards related to socioeconomic and psychosocial circumstances" (Z55 to Z65). Using these codes effectively, however, is challenging.

One difficulty that has arisen for GNYHA member hospitals with regard to using z-codes is with finding the right code for specific social risk factors. GNYHA members report that not all social conditions are included in the available codes. For example, there are no z-codes that indicate a lack of or difficulty with transportation. On the other hand, in cases where there are codes available for a social condition, providers can become confused about exactly which one to select, and this can lead to data quality concerns. For example, there are 10 codes under Z59, the housing and economic circumstances category. They include "homelessness," "inadequate housing," "other problems related to housing and economic circumstances," and "unspecified problems related to housing and economic circumstances." GNYHA believes that there is an

opportunity to review existing screening tools and make meaningful recommendations for the ICD-10 manual so that information can be collected in a standardized way.

According to GNYHA members, another challenge related to data collection and coding is that the usual workflow for screening and addressing social risk factors does not currently lend itself to successfully integrated documentation. This is particularly the case in the ambulatory care setting where practitioners, not trained professional coders, typically do the coding. For example, during a visit, a patient might be seen by a medical assistant, a nurse, and a doctor. These activities would be documented in the visit note and then finalized and coded by the doctor before the visit is closed. Encounters with social workers or care managers are often separate and are documented in a separate note within the patient's medical record. It is in these social work or care manager encounters where patients will have the most robust discussions about social risk factors. However, in most ambulatory care settings, the social work encounter is not billable and would not generate a z-code or any other ICD-10 code. This means that in order for a z-code to be included on an outpatient claim, the practitioner would need to be apprised of the separate encounter and record it in the "main" note. This complexity makes the consistent capturing of z-codes difficult.

GNYHA members are discussing these issues and working on operational and communication workflows. Regardless of these challenges, GNYHA believes that consistent and correct use of z-codes would be the best way to collect social risk factor data for Medicare beneficiaries.

Evaluating Interventions

It has been extremely challenging for GNYHA member hospitals to demonstrate a clear return on investment from addressing social determinants of health. Hospitals report that what makes this calculation difficult is that it is hard to truly separate out the effects of the social and clinical interventions. As New York hospitals have implemented certain social interventions, they have started to see improvement in certain health care measures, but, again, it is harder to isolate the effect of the social risk factor intervention.

As part of New York's DSRIP program, hospitals have funded "innovation projects" whereby CBOs could partner with a health care provider to address a specific social need and evaluate the effects. This effort is intended to provide hospitals with information on the value and return on investment for specific interventions. These innovation projects are underway, and GNYHA should have more information on these efforts in mid-2019.

Contact Information

Thank you for the opportunity to share this information. We look forward to any future opportunities to participate in your work. Should HHS require additional information, please feel free to contact either me (tjohnson@gnyha.org) or Carla Nelson (cnelson@gnyha.org).

Sincerely,

Tim Johnson
Senior Vice President