

November 15, 2018

BY ELECTRONIC SUBMISSION

ASPEImpactStudy@hhs.gov

Assistant Secretary for Planning and Evaluation
Department of Health and Human Services

RE: IMPACT ACT Research Study: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors

Dear Sir or Madam:

Thank you for the opportunity to comment on the recently released Request for Information (RFI) on provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors.

Michigan Medicine is known nationally and around the world for excellence in patient care, education, and research. Located in Southeast Michigan, it is composed of the University of Michigan Health System and the University of Michigan Medical School. As one of the largest health systems in our state and one of the nation's leading academic medical centers, Michigan Medicine fulfills its vision to create the future of health care through discovery and become a national leader in health care, biomedical innovation, health care reform, and education through the efforts of its clinicians and staff.

Through the University of Michigan Medical Group, Michigan Medicine employs over 2,700 physicians across 19 clinical specialties, including primary care. It provides both inpatient and outpatient care through its general acute care hospital with over 1,000 inpatient beds; more than 40 ambulatory locations with 140 clinics; specialty centers for cancer, depression and cardiovascular care; and home care services. Annually, the organization provides approximately 50,000 admissions, 100,000 emergency room visits, and 2.3 million ambulatory visits.

Michigan Medicine has historically led the nation in payment and delivery reform through its participation in Medicare's Physician Group Practice Demonstration Project (2005-2010), the Multi-Payer Advanced Primary Care Practice Project (2011-2016), and as a Pioneer Accountable Care Organization (ACO) (2012). Michigan Medicine currently participates in the Medicare Shared Savings Program ACO Track 1, the Michigan State Innovation Model Initiative, and CMS' Comprehensive Primary Care Plus medical home model.

Michigan Medicine is committed to identifying and addressing patients' social determinants of health (SDoH) as part of our overarching population health strategy. As a result of participation in several of the above value-based models, Michigan Medicine has expanded its efforts to identify and address SDoH

and appreciates the opportunity to comment on lessons learned and the importance of considering these factors as we attempt to fully understand the drivers associated with population complexity.

We are responding to some but not all the questions in the RFI. For ease of reference, we have prefaced each of our responses with the question in the RFI that it addresses.

Questions Related to Delivery of Services

- 1. Are social risk data being used to target services or provide outreach? If so, how? How are beneficiaries with social risk factors identified?*

Michigan Medicine participates in the Michigan State Innovation Model (SIM) Patient-Centered Medical Home Initiative, which requires participating Provider Organizations to screen all primary care-attributed patients for SDoH. Michigan Medicine began screening primary care patients in August 2017 and has screened almost 100,000 patients to date. If a patient screens positive for one or more needs on the initiative's screening tool, called the "Partners in Care Questionnaire," the primary care doctor is informed of the positive screen. The doctor discusses the need with the patient and asks if he or she would like a referral to resources to address the need. If the patient wants a referral, the primary care doctor sends a referral to Michigan Medicine's Guest Assistance Program (GAP), a central office comprised of Bachelors-level Social Workers trained in clinical-community linkages. The GAP office calls the patient and completes an additional assessment to understand the need further, then connects the patient to community resources to address the need.

Michigan Medicine is incorporating social needs data into primary care chronic disease management models, including the Diabetes Care Management Model. Compared to the general primary care population, diabetics utilize more services. A patient and family advisory council supported the development of a model that leverages a multidisciplinary care team to proactively manage diabetics. During weekly care team meetings, patients' disease and social history are discussed to identify a lead care manager and supports the patient may need to achieve HbA1c control. Care managers include a Pharmacist, Nurse Care Navigator, Registered Dietitian, and a Social Worker. Patients work with care managers to adjust medications, set goals, and connect with community resources. During this care management process, care managers are able to screen patients for social needs, re-screen patients, and/or follow-up on previously identified needs. Incorporating this data into the care team's decision-making has highlighted the impact of social needs on our patients' abilities to meet their health goals.

While routine screening is only done in the primary care setting, Michigan Medicine employs Social Workers throughout the organization to assist patients with behavioral health and social needs. Physicians throughout the health system can refer patients to Social Workers if social needs are identified. Additionally, if a patient is identified as particularly socially and medically complex (certain criteria must be met) by a physician, the GAP office, or an in-clinic/emergency department (ED) Social Worker, he or she can be referred to Michigan Medicine's Complex Care Management Program (CCMP). The CCMP is comprised of allied health professionals (the majority are Masters-level Social Workers) who provide intensive case management for complex patients. CCMP coordinates with community resources, including Community Mental Health and other social service agencies, to identify and address patients' barriers to managing complex medical conditions.

Currently, Michigan Medicine is implementing an Epic functionality called the Longitudinal Plan of Care (LPOC). The LPOC is designed for clinicians throughout the system to understand a patient's care across the continuum. In addition to recent visits, problem lists, health goals and other clinical indicators, the LPOC displays a patient's social needs.

As part of the Michigan SIM, two counties in Southeast Michigan—Washtenaw, which is Michigan Medicine's home county, and Livingston, which is just to the north—were selected as a Community Health Innovation Region (CHIR). Michigan Medicine participates in the SIM CHIR ED Intervention. The goal of the intervention is to reduce unnecessary hospital ED use by connecting frequent users with social services. Patients become eligible for the intervention in two ways: through provider referral or predictive model. The predictive model incorporates dozens of variables—including previous ED use, diagnosis, health insurance, zip code, age, and gender—to predict individuals' future ED utilization in the next 6 months. The top 12 patients from the predictive model output are referred into the ED Intervention weekly. For participants in the intervention, care coordination involves a team-based approach among community-based organizations that is facilitated by an Information Technology (IT) platform called *MI Care Connect*, developed and hosted by PCE Systems. The Center for Health and Research Transformation (CHRT) serves as the administrative "hub" for the intervention. Each participant in the intervention is assigned to one of 11 community "hublets" (a health care provider or social service organization) based on a needs assessment and any pre-existing relationships between the participant and a hublet. The assigned hublet serves as the lead entity for care coordination, while working with other hublets on a shared care plan for the participant. Depending on the circumstances of a particular case, hublets work with participants to connect them to the services they need—such as establishing a relationship with a primary care provider, identifying food resources, applying for affordable housing, or accessing transportation assistance. Community Health Workers housed at the Washtenaw Health Plan serve as a shared resource for engaging participants and working to meet participant goals. Hublets meet together twice monthly, once a month to present and problem-solve cases, and once a month to make adjustments and improvements to the intervention work-flow and processes.

2. *Are there especially promising strategies for improving care for patients with social risk?*

Michigan Medicine's efforts to identify and target patients with SDoH are in their infancy. Evaluations for the Michigan SIM are currently analyzing the impacts of SDoH on health care utilization in the Medicaid population, as well as the impact of the SIM CHIR ED Intervention on health care utilization and outcomes. However, early evidence from the Intervention suggests that a shared IT platform and allowing clinical and community partners to coordinate services for a patient with social risk factors reduces duplication and waste among the providers and enhances patient satisfaction. Additionally, Community Health Workers have been particularly successful at contacting and engaging individuals who have social needs but are not medically complex. These individuals have proven the most difficult

to engage in the intervention because they do not have regular contact with the health care system beyond their use of the hospital ED.

- 3. How are costs for targeting and providing those services evaluated? What are the additional costs to target services, such as case management, and to provide additional services (e.g. transportation)? What is the return on investment in improved outcomes or reduced healthcare costs)?*

The impact of targeting patients with social risk factors is currently being evaluated by Michigan Medicine and the State of Michigan. The costs of providing targeted services, including case management, to patients with SDoH include labor costs related to employing both Bachelors-level and Masters-level Social Workers (BSWs and MSWs) throughout Michigan Medicine, software license fees and training for shared IT platforms, and administrative management to implement and monitor SDoH initiatives. For example, to support primary care-embedded care management, Michigan Medicine spent approximately \$6.5 million in Fiscal Year 2018 to support 75 Full Time Equivalents, including Pharmacists, Dietitians, Nurse Care Navigators, Panel Managers, and Social Workers. These care managers provide a broad variety of services—including medication reconciliation, psychotherapy, chronic disease management, clinical-community linkages, and gap closures—to 225,000 attributed primary care patients, approximately 8% of whom were identified with one or more social need through screening. In order for health care providers to realize a return on investment for reduced health care utilization that results from addressing SDoH, Michigan Medicine encourages the Department of Health and Human Services (HHS) to increase the proportion of Medicare payments linked to health care outcomes and quality. The current Fee-For-Service payment system does not encourage providers to reduce health care utilization and therefore reduces the incentive to address SDoH and improve outcomes.

- 4. What are the best practices to refer beneficiaries to social service organizations that can address social risk factors?*

Michigan Medicine's GAP is a central office that exists to connect patients to resources if their social needs are barriers to receiving needed health care. The GAP office has created an internal database of social services in Washtenaw County and surrounding areas and updates this database monthly.

When a patient is referred to the GAP office, social workers complete an in-depth assessment with the patient that often uncovers information beyond the reason for the original referral. The GAP office has found that this assessment is essential to fully understand the patient's needs in order to provide the right resources to successfully address those needs. The assessment also seeks to understand if the patient is independent enough for the GAP office to provide contact information for the resource and let the patient make direct contact with the resource. If not, the GAP office staff will call the resource and do a three-way telephone call while the patient is still on the line to ensure a connection is made.

As a result of needs identified in the community, Michigan Medicine recently added a question to the SDoH screening tool related to social isolation. GAP office BSWs did not feel equipped to address social isolation, so referrals for social isolation and intimate partner violence will instead be sent to the in-clinic MSWs who have additional training related to these needs.

Michigan Medicine has learned the importance of having care management resources embedded within the health care setting, compared to outsourcing this work to a third party. The ability for care managers and physicians to document findings and services in a patient's electronic medical record strengthens the ability to coordinate across care settings and prevents patients from being asked to repeat information each time they are connected to a new member of the care team.

5. *What lessons have been learned about providing care for patients with social risk factors?*

Michigan Medicine has made several changes to the Partners in Care Questionnaire as a result of lessons learned throughout the first year of screening patients. For example, Michigan Medicine's employment question was originally worded, "In the last 4 weeks, have you been looking for work?" Several patients screened positive who had a job and were looking for another but did not need assistance. Related to health literacy, the original question was worded, "Do you ever have trouble understanding your doctor's written instructions?" Several patients in the older age groups (65+) responded positively because they interpreted this question as a vision question. In the original workflow, if a patient screened positive for one or more domains (needs), the Medical Assistant would put the responses into the electronic medical record and pend a referral to the GAP office. The physician was then expected to discuss the positive screening with the patient and ask if the patient wanted a referral for assistance with accessing resources. If the patient answered "yes," a referral was sent to the GAP office. If the patient answered "no," this was not discretely documented, except in the note at the physician's discretion. This process caused Michigan Medicine to not fully understand how many patients did not desire assistance and why.

To date, Michigan Medicine has relied on anecdotal evidence from the physician, when available. Capturing this data in a discrete field will allow Michigan Medicine to do additional analysis to understand the root causes of patients who screen positive but do not desire assistance. A gap in resources for a particular domain or patient population cannot be addressed unless the reasons patients are not getting or seeking adequate help are fully understood. For example, a high positive rate for food insecurity may lead local funding agencies to conclude that more funding is needed for food banks. However, evidence to date suggests that food resources are available in the community, but patients have a difficult time getting to the resources and that transportation is an underlying reason that they experience other needs. They may therefore respond that they do not want assistance with food insecurity, even though they cannot access the resources. One solution that has resulted from this

finding is to fund in-clinic resources so patients can access food, pharmacies, and other services while they are already at a medical appointment.

While Michigan Medicine provided scripting for Medical Assistants and physicians to discuss positive screenings with patients, some physicians have communicated that they did not feel equipped to discuss SDoH with their patients or they did not think it fit within the scope of a medical visit. As a result of these findings, Michigan Medicine would like to enhance training for residents and faculty around screening for and addressing social needs. Similarly, prior to the launch of the screening initiative, several physicians thought it was unnecessary to screen patients for SDoH because they were certain they knew if their patients had these needs. However, many were surprised that several patients screened positive.

Another lesson learned is that community social service providers were generally excited that the Provider Organizations were screening for SDoH and were not concerned about introducing new capacity issues. They were also very interested in using the data collected by the Provider Organizations to apply for additional funding, tailor existing services to meet identified needs, and partner to address gaps in services.

6. What are barriers to tailoring services to patients with social risk factors? How can barriers be overcome?

One major barrier to providing services for patients with social risk factors is the ability for community social service agencies to bill third party payers, including Medicare and Medicaid, for services. Additionally, Community Health Workers, which have been found to be particularly effective at engaging patients to address their social needs, often cannot bill for their services. Michigan Medicine strongly encourages HHS to consider allowing social service agencies to establish billing processes and for certain types of providers, including Community Health Workers, to be allowed to bill Medicare for services.

Another barrier is Michigan Medicine's capacity to connect to and follow up with all patients who screen positive. The GAP office has limited capacity, and Michigan Medicine has 225,000 primary care patients who are now being screened. Currently, there is a four-week lag time between when a patient screens positive and when the GAP office staff reach out to them. Michigan Medicine encourages HHS to provide additional financial support to address SDoH if universal screening is implemented in the future.

Additionally, coordinating care for patients with complex social needs is challenging without a shared IT platform. Without the ability to understand who else has a relationship with the patient and coordinate with those agencies, work is often duplicated, and time is wasted at agencies whose capacities are already limited. It is essential to provide flexible funding, like per-member-per-month payments, to support the development of infrastructure that can be accessed whether the patient is within the health system or out in the community.

Questions Related to Data

7. Which social risk factors are most important to capture?

Michigan Medicine captures the following domains, which were agreed upon by local health system and social service agency leadership. All of the domains below are required by the Michigan SIM, except health literacy and social isolation.

- Food
- Transportation
- Utilities
- Healthcare affordability
- Family care (child/elder care)
- Employment
- Social isolation
- Health literacy
- Personal safety (intimate partner violence)
- Housing

8. Do you routinely and systematically collect data about social risk? Who collects this data? When is it collected? Is it collected only once or multiple times for a beneficiary? Is it collected consistently across populations (i.e. Medicare beneficiaries, Medicaid beneficiaries, patients receiving specific services, etc.)? What are the burdens of this data collection on plans, providers, and beneficiaries?

As a result of Michigan Medicine's participation in the SIM, all primary care practices screen patients for SDoH. All patients, regardless of health insurance, complete the screening at new patient visits and annually (or every three years, depending on the patient) during Health Maintenance Exams (HMEs). The current screening questions appear below:

1. In the last 12 months, did you worry you would run out of food before you got money to buy more?

Yes No

2. In the next 2 months, are you worried that you may not have stable housing?

Yes No

3. In the last 12 months, has the utility company shut off your service for not paying your bills?

Yes No

4. In the last 12 months, did you not see a doctor when you needed to or skip medications to save money?

Yes No

5. In the last 12 months, did you have to go without health care because you did not have a way to get there?

Yes No

6. Do you need help finding a local career center and/or job training?

Yes No

7. In the last 4 weeks, did getting elder care or child care, make it difficult to work or study?

Yes No

8. How often do you have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

Never Rarely Sometimes Often Always

9. How often do you feel isolated from others?

Never Rarely Sometimes Often Always

Michigan Medicine is currently planning to implement Epic's SDoH module to collect the data and populate the Longitudinal Plan of Care. Additionally, Michigan Medicine is researching Interactive Voice Response technology in order to follow up with patients who have been connected to resources by the GAP office. Once these quality improvement efforts are completed, Michigan Medicine would like to expand screening to other visit types, including visits at the primary care clinics other than HMEs, specialty visits, and ED visits. It took significant resources to create a validated, standard list of questions and to implement the questionnaire at all participating primary care clinics. Currently, the primary burden limiting the expansion of the screening is the GAP office's ability to reach all patients who screen positive within a reasonable time.

9. Would standardized data elements for EHRs help you to collect social risk data? If so, how could these data elements be standardized?

Yes, standardized data elements would help collect social risk data and would allow HHS to accurately use these data to compare social needs across providers. Prior to Epic's module, Michigan Medicine and other Provider Organizations in our region spent a significant amount of time researching and agreeing upon a standard list of questions in order to aggregate data in our region. Michigan Medicine encourages HHS to recommend a specific list of questions or domains for more accurate data aggregation and comparison. Additionally, Z codes are a special group of ICD-10 codes for the reporting of factors influencing health status and contact with health services. Michigan Medicine encourages HHS to consider incorporating Z codes into risk adjustment methodologies, including Hierarchical Condition Categories (HCC). The HCC risk adjustment methodology currently only reflects a patient's medical

complexity, as there are limited data elements to indicate a patient's social risk. The ability to automatically bill a Z code when a patient screens positive for a social need can easily be built into an electronic health record. Z codes could be leveraged across the country as a standard way to document and bill for social needs.

Thank you again for the opportunity to provide a response to the Request for Information on provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors. Please let us know if you have any questions. I can be reached by telephone at 734-647-7483 and by email at leahhv@med.umich.edu.

Sincerely,

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