Subject: Expanding Access to Screening Tools for Social Determinants of Health/Social Determinants of Health in Payment Models (Resolution 711-A-17, Resolution 816-I-17)

Presented by: Gerald E. Harmon, MD, Chair

Referred to: Reference Committee G
(Theodore A. Calianos, II, MD, Chair)

INTRODUCTION

At the 2017 Annual Meeting of the House of Delegates, Resolution 711-A-17, “Expanding Access to Screening Tools for Social Determinants of Health,” was referred for report back. Resolution 711-A-17, which was introduced by the Medical Student Section, asks that the “AMA provide access to evidence-based screening tools for evaluating and addressing social determinants of health in their physician resources; support the continued integration of evidence-based screening tools evaluating social determinants of health into the electronic medical record and electronic health record; and support fair compensation for the use of evidence-based social determinants of health screening tools and interventions in clinical settings.” At the 2017 Interim Meeting of the House of Delegates, Resolution 816, “Social Determinants in Health in Payment Models,” was referred. Resolution 816-I-17, which was introduced by the American College of Preventive Medicine, asks that the “AMA support payment reform policy proposals that incentivize screening for social determinants of health, as defined by Healthy People 2020, and referral to community support systems.”

Resolution 711-A-17 was referred for report back at the 2018 Annual Meeting and Resolution 816-I-17 was referred for report back at the 2018 Interim Meeting. As the referred resolves in each resolution deal with components of a common issue, this report will address the topic as a whole, and present recommendations accordingly.

BACKGROUND

Defining Social Determinants of Health

The World Health Organization defines social determinants of health (SDH) as “the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.” There is a national emphasis in the United States on addressing the SDH by creating “social and physical environments that promote good health for all.” There are five key areas of SDH: economic stability; education; social and community context; health and health care; and neighborhood and built environment. Within each of these areas, there are key issues that contribute to the underlying factors of SDH. For example, economic stability examines the impact of employment, food insecurity, housing instability and poverty on a patient’s ability to access health care and adhere to treatment.
Recognition of the role SDH play in influencing health outcomes is growing in the health care field, and many physicians are developing strategies to effectively address these conditions which impact every patient. Care models are currently being refined to include selection and implementation of SDH assessment tools; collection of patient-level information related to SDH; creation of workflows to track and address patient needs; and identification of community-based social service resources and tracking referrals.2

Evidence-based Screening Tools for Evaluating and Assessing Social Determinants of Health

There presently are several tools available for screening of risks or issues related to SDH. Most tools, including those described here, are free to use. The Protocol for Responding to and Assessing Patients’ Assets, Risks and Experiences (PRAPARE) Implementation and Action Toolkit, sponsored by the National Association of Community Health Centers, was designed to create and implement a national standardized patient risk assessment protocol to assess and address patients’ SDH as well as tools to respond to SDH data.3 The PRAPARE assessment tool consists of a set of national core measures as well as a set of optional measures for community priorities. The full question set can be administered in nine minutes or less. A recent study in the *Journal of the American Board of Family Medicine* found that standardizing SDH data collection and presentation in electronic health records (EHRs) could lead to improved patient and population health outcomes in community health centers and other care settings.4 As of July 26, 2016, the National Association for Community Health Centers reported that only 4 EHR vendors (EPIC, NEXT GEN, eClinical Works, and GE Centricity) currently support the PRAPARE electronic templates.

Another tool, the Patient Centered Assessment Method (PCAM), assesses a patient’s lifestyle behaviors, mental well-being, social environment, health literacy, and communication and care coordination needs.5 This resource contains a section focused on actions that can be taken to address the needs and issues identified in the assessment as well as the level of service coordination needed to ensure referrals can be practically accessed by the patient. A 2015 study found that while PCAM did not impact patient satisfaction or perception of practitioners’ empathy, it did increase both the number of onward referrals per referred patient and the proportion of referrals to non-medical services addressing psychological, social, and lifestyle needs.

The American Academy of Family Physicians (AAFP) released an initial screening toolkit for SDH in 2018 to help physicians recognize and respond to various social factors that affect their patients’ health.6 The toolkit includes both a short and long screening tool that includes questions that have been tested, validated, and purposefully assembled to reveal the health hurdles that patients are facing and a sample patient action plan for staff to indicate what types of referrals are needed for patients. As of the time of this report, there are no studies available on the effectiveness of this toolkit. The aforementioned resources indicate there are evidence-based tools to screen for SDH which are accessible and free for physicians to use.

OCHIN, a nonprofit health information and innovation network, integrated SDH screening tools into leading electronic health records (and released an evidence-based set of SDH domain areas for inclusion in EHRs, which was piloted among EPIC users).7 The integration of the SDH screening tools into the EHR among EPIC user has the potential to reach 25.8 percent of the U.S. physician practice market share. The SDH flowsheet developed by OCHIN provides several means for easily entering patient-reported SDH information that is not already collected in other places in the EHR, such as demographics or social history. Additionally, the data collection tools were designed to be flexible so that anyone on the care team could enter data.
In addition, in 2017 our AMA in collaboration with Lucro launched a platform that streamlines the ability for physicians and health systems to find a number of tools/solutions available on the market, including screening tools for SDH. The platform allows physicians to request information on the clinical validation for a tool, how the tool fits into a workflow/integrates with an EHR, etc., and compares tools to other options available. The Lucro platform is available at app.lucro.com. Also, AMA is currently developing a STEPS Forward™ module to address SDH which will provide physicians with tools, curriculum, and templates to assist in measuring and addressing SDH. The module will also provide strategies for intervention and resources to assist in the understanding of SDH and implementation of tools in practice. Our AMA expects to release this new module in May 2018.

Incentives for Use of Evidence-Based Social Determinants of Health Screening Tools and Interventions in Clinical Settings

Public payers, such as Medicaid and Medicare, may provide financial incentives to encourage providers to address the social needs of their patients as well as the social conditions in the communities in which they serve. For example, Medicare’s Comprehensive Primary Care Plus (CPC+) model, which is a multi-payer, patient-centered primary care medical home, requires participating clinicians to risk-stratify patients based on health-related social needs and other factors. CPC+ provides extra payments to participating practices to cover non-face-to-face services and allows practices to provide intensive care management and other supportive services to patients with complex needs. According to the 2016 Kaiser Family Foundation 50-state Medicaid budget survey, states are using managed care and alternative payment models to improve quality and to help screen for social factors impacting health outcomes. In Fiscal Year 2016, 26 states reported requiring or encouraging managed care organizations to screen for social needs and provide referrals to services, and four states intended to do so in FY 2017.

AMA POLICY

AMA Policy H-160.909, “Poverty Screening as a Clinical Tool for Improving Health Outcomes,” encourages screening for social and economic risk factors in order to improve care plans and direct patients to appropriate resources.

Policy H-160.919, “Principles of the Patient-Centered Medical Home,” outlines the principles of the patient-centered medical home (PCMH), one which states that care is to be coordinated and/or integrated across all elements of the complex health care system and the patient’s community. This policy further calls for care that is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner. The policy asserts that the payment structure should appropriately recognize the added value of the PCMH and pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources, and recognize case mix differences in the patient population being treated within the practice.

Policy D-478.995, “National Health Information Technology,” directs AMA advocacy in the health IT arena, and specifically calls for continued research and physician education on EHR design and features that can improve health care quality, safety and efficiency.

Policy H-295.874, “Educating Medical Students in the Social Determinants of Health and Cultural Competence,” states that our AMA: (1) Supports efforts designed to integrate training in SDH and cultural competence across the undergraduate medical school curriculum to assure that graduating
medical students are well prepared to provide their patients safe, high quality and patient-centered care; (2) Will conduct ongoing data gathering, including interviews with medical students, to gain their perspective on the integration of SDH and cultural competence in the undergraduate medical school curriculum; and (3) Recommends studying the integration of SDH and cultural competence training in graduate and continuing medical education and publicizing successful models.

DISCUSSION

Screening for SDH does not need to be administered by a physician and it can be performed upon check in, or while rooming the patient, so that it does not disrupt the flow of the visit while promoting more comprehensive care. Screenings are most frequently conducted by the other members of the care team such as the registration staff, medical assistants, and care coordinators. Having knowledge about a patient’s SDH may help physicians understand barriers patients face in adhering to recommended treatments. For example, if a patient screens food insecure, they may not be able to fill prescriptions or take medication as recommended. Knowing such information in advance, may help physicians engage in collaborative discussions with their patients regarding treatment options that make sense for the patient.

Key principles for expanding access to screening tools for SDH are reflected in existing AMA policy. Several tools for screening are publicly available for physician and care team use and have been incorporated into some EHR products. Furthermore, our AMA is developing a related STEPS Forward module to increase physician awareness and understanding of SDH. Also, national initiatives exist to incentivize providers for screening for SDH. Based on these factors, the Board of Trustees believes existing policy and actions regarding access of screening tool are sufficient. However, AMA Policy D-478.995, “National Health Information Technology,” could be amended by addition to urge EHR vendors to adopt SDH templates without adding further cost for physicians.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolutions 711-A-17 and 816-I-17 and the remainder of the report be filed.

1. That the following policies be reaffirmed:
   - H-160.909, “Poverty Screening as a Clinical Tool for Improving Health Outcomes”
   - H-160.919, “Principles of the Patient-Centered Medical Home”
   - H-295.874, “Educating Medical Students in the Social Determinants of Health and Cultural Competence”

2. That Policy D-478.995, “National Health Information Technology,” be amended by addition to read as follows:
   1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.
   2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health
systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care.; and (D) advocates for more research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.

3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.

4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.

5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.

6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.

7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.

8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.

9. Our AMA will urge EHR vendors to adopt SDH templates without adding further cost for physicians.

Fiscal Note: Less than $250
REFERENCES