Society of Hospital Medicine
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1500 Spring Garden Street
Suite 501 • Philadelphia, PA 19130
P: 800.843.3360 • F: 267.702.2690
hospitalmedicine.org

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Dear Yale-CORE Addressing Social Needs eCQM Development Team,

The Society of Hospital Medicine (SHM), representing the nation's more than 46,000 hospitalists, appreciates the opportunity to provide feedback on the Addressing Social Needs electronic clinical quality measure (eCQM) you are developing for the Centers for Medicare and Medicaid Services (CMS). SHM's Performance Measurement and Reporting Committee reviewed the draft measure specifications and wanted to share the following perspectives.

Hospitalists are front-line physicians in hospitals whose professional focus is the general medical care of hospitalized patients. They have experience with both hospital- and clinician-level performance measurement and are central in hospitals' efforts to improve quality and efficiency of care for their patients.

Broadly, SHM believes it is laudable to move towards recognizing the impact of social needs on outcomes for patients and, where appropriate, directing resources to address those needs. Social needs are the result of inequities and broader social failures and can significantly impact health outcomes for patients. We are strongly supportive of the effort to measure the social needs of patients to better understand our patient populations, add potential new data for risk adjustment or stratification, and encourage appropriate follow-up. While we agree that the hospital may be an important touch point for intervention, we caution that it should not be and cannot be solely on the hospital to address patients' social needs. In many cases, outpatient non-acute settings may be a more appropriate level of care for the sort of outreach, relationship-building, and long-term interventions needed to address the social needs of patients.

We offer the following specific comments on the measure:

Measure More Appropriate at the System, Not Clinician Level

The Specifications Document for Public Comment notes that while "the measure is initially being developed for the Inpatient Hospital Reporting (IQR) program, though CMS anticipates including the measure in additional programs such as the Merit-based Incentive Payment System (MIPS), Medicare, and Hospital Outpatient Quality Reporting (HOQR)." We strongly caution against using this measure for clinician-level assessment. In most cases, providing an assessment and coordinating follow-up for social needs would not be conducted by a clinician who is billing Medicare. Inpatient care involves multidisciplinary team-

based care, and much of this work will be conducted by other team members, such as case managers, social workers, nurses or other health professionals. It would not be appropriate to use this measure to assess the performance of clinicians who bill Medicare but are not directly involved in conducting the assessment or providing the follow-up. This measure, as designed, should not be used for the MIPS.

Evidence for Impact of Universal Assessment and Follow-up

One effect of this measure will be to direct (or re-direct) more hospital resources toward identifying and addressing social needs of inpatients. Using the inpatient admission as an opportunity to understand and address social determinants of health is a worthy goal. However, we are unaware of evidence demonstrating that the implementation of a universal screening approach will result in meaningful change for patients or avoid unintended downstream consequences. For example, the implementation of universal assessment may reprioritize scarce staff and other hospital resources away from other important functions related to the safe and equitable provision of healthcare. At a time when nurses, case managers and other members of the healthcare workforce are already short-staffed in many hospitals, this could have the unintended consequence of exacerbating care disparities, when compared to the impact of a more targeted screening and treatment approach. The follow-up required in the measure is broad-based and encompasses a wide variety of activities. The lack of specificity or requirements for quality of the follow-up leaves this aspect of measure at risk of being completed pro forma. We ask for more information and evidence of the effectiveness of this universal screening and non-specific follow-up approach and consideration of potential downstream impacts.

Issues with Scoring System

By trying both to identify patients who have social needs and assess whether the patient receives follow-up for those needs, the scoring system becomes too complicated for a hospital to assess its performance. Both aims are important. In fact, we believe that identifying the number of patients who have social needs (and what those needs are) could help with future risk adjustment/assessment strategies across the Medicare program. This is important data on its own that could not be gleaned from the proposed scoring methodology. We also believe incentivizing healthcare systems to provide follow-up for patients who have social needs identified is valuable. We strongly recommend a different approach for scoring, such as separating the two aims into separate measures, to make it easier for hospitals and Medicare to understand their performance and to open future uses from this data.

We have concerns with the scoring system as proposed and strongly suggest Yale-CORE refine the specifications. As we understand it, using a scale of 0 to 5 suggests that a higher score is “better” for performance on this measure. In combining the two goals of the measure, we believe the scoring rubric does not appropriately account for patients who opt-out of either or both screening and follow-up. The scoring may also need adjustment for patients who screen negative.

Patients may decline to respond to screening questions and decline follow-up for a variety of reasons. The scoring rubric suggests that a patient who declines screening would be granted a score of 1 or 2 (if the provider identifies a social need without using the screening tools). Patients who are screened, but

decline follow-up, which is within a patient's rights to do so, would be granted a score of 4. By limiting the score of 5 only for patients who are screened positive and receive follow-up, the measure seems to prioritize intervening with patients, regardless of their wishes. We do not believe this is appropriate. For patients who screen negative for social needs, which will be a significant portion of patients, it seems like the highest achievable score on the measure is 3. We do not agree there should be a "penalty" associated with patients who do not have social needs identified in the measure.

Concern about EHR Support for this Measure

As this measure is an eCQM, we carefully considered the role of EHRs and coding workflows in documenting performance for this measure. Z-codes, which form the backbone of this measure, are not selected at the point of care, rather they are mapped to using information collected in the medical record either by creating pathways in the EHR or by selected manually by coders. This leads to a high potential for variability in how information in the medical record is translated into Z-codes. Connecting follow-up and determining what is appropriate follow-up also requires coding support or resources. A significant amount of work and education needs to be done to ensure accurate and consistent capturing of this data across hospital systems. There is also a significant amount of backend work to develop and maintain new workflows in EHR systems.

Healthcare-related Social Needs: Addressing Affordability of Medications

Medication affordability is an integral dimension of social need, and highly impactful on health outcomes, that is not captured by this measure. While we understand how the social needs in the measure (transportation, housing, food, and utilities) can impact patient's health, we see medication affordability as directly connected to outcomes associated with the hospitalization. Not addressing medication affordability is a missed opportunity to confront this common barrier to care. We encourage Yale-CORE to consider incorporating or addressing this element of social needs in the measure.

Conclusion

SHM greatly appreciates the opportunity to provide feedback on this measure under development. If you have any questions or require more information, please contact Joshua Lapps, Director of Policy and Practice Management at jlapps@hospitalmedicine.org.

Sincerely,

Kris Rehm, MD, SFHM
President, Society of Hospital Medicine