THE Value Initiative

Members in Action: Managing Risk & New Payment Models

NewYork-Presbyterian – New York, N.Y.

NewYork-Presbyterian Integrates Social Screening Tool into Clinical Care

The AHA's Members in Action series highlights how hospitals and health systems are implementing new value-based strategies to improve health care affordability. This includes work to redesign the delivery system, manage risk and new payment models, improve quality and outcomes, and implement operational solutions.

Overview

When patients from specific neighborhoods come to NewYork-Presbyterian for medical care, they are now screened for social determinants of health (SDOH) and linked to community resources to support their return to health and wellness.

Patients from the Washington Heights/Inwood neighborhoods and Harlem and the Bronx are invited to participate in self-directed SDOH screenings when they visit one of six NewYork-Presbyterian outpatient clinics or the emergency department (ED) as part of an initiative called ANCHOR (Addressing the Needs of the Community through Holistic, Organizational Relationships). ANCHOR is funded by the Centers for Medicare & Medicaid Services' Accountable Health Communities Model.

The screenings assess patients' adequacy of housing, transportation, food security, safety and

Impact

Integrating SDOH screenings into primary care visits has driven a culture shift among clinical staff at NewYork-Presbyterian. Previously, clinicians were unable to easily identify patients who have both socially and medically complex issues, as well as those with less need for support. The ANCHOR program has allowed them to pinpoint a high percentage of patients for whom prevention and early intervention might mitigate social needs, resulting in fewer ED visits and avoidable readmissions. Additionally, providers in the ED are now more attuned to patients' social needs and are developing their own curriculum on social emergency medicine to educate future emergency providers and medical residents.

Of the approximately 22,000 patients screened from September 2018 to December 2019, more than one quarter screened positive for housing and food insecurity, and approximately 40% of high-risk patients agreed to participate in social service navigation. Through referrals and case conferences with collaborating social service agencies, NewYork-Presbyterian has strengthened its relationship with the community and identified key resource gaps that need to be collectively addressed. Future analysis will involve determining whether there is a decrease in health care utilization and improved health outcomes for those patients.

utilities. Screening results are available to physicians during physical exams and stored in patients' electronic health records.

Patients with two or more ED visits and at least one social need receive follow-up phone calls from Community Resource Coordinators who connect them to social support services via a web-based directory. Patients with fewer than two ED visits receive a printed list of resources tailored to their needs. Residents in these neighborhoods have high rates of poverty, limited English proficiency, unemployment, obesity, diabetes and hypertension.

Lessons Learned

NewYork-Presbyterian staff learned that while patients were initially suspicious of answering social needs questions in a health care setting, over time that has improved.

"I think they're starting to feel that they can trust us with that information and that we're here to help," said Dodi Meyer, M.D., director of community pediatrics at NewYork-Presbyterian/Columbia University Irving Medical Center, noting the paradigm shift among providers and the community takes time, persistence and patience.

Future Goals

In the future, NewYork-Presbyterian aims to calculate ANCHOR's impact on the social determinants of health need and overall health outcomes. NewYork-Presbyterian also will apply learnings from ANCHOR as it rolls out additional population health initiatives in communities throughout New York City related to chronic illness prevention, behavioral health, substance use disorders, women's health, children's health and communicable diseases.

"It's fair to say that new opportunities present themselves quite frequently, and we have gotten better at responding to those needs quicker and more robustly," said Brian Youngblood, project leader for Community and Population Health at NewYork-Presbyterian.

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