# IPRO QIN-QIO Partnership for Community Health

# Welcome!

# Voices from The Field Series

## Session One
## Best Practices for Addressing Health-Related Social Needs (HRSN) in Care Coordination

**January 24, 2023**

*This material was prepared by IPRO, a Quality Innovation Network-Quality Improvement Organization under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The content presented does not necessarily reflect CMS policy. Publication #12SOW-IPRO-NJ-TA-AA-23-869.*

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# Welcome!

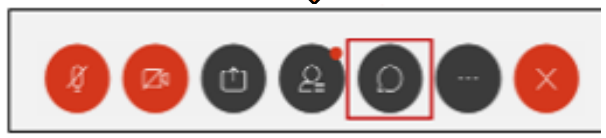
Today's session is being recorded. Access to the recording and presentation slides will be made available on our website.

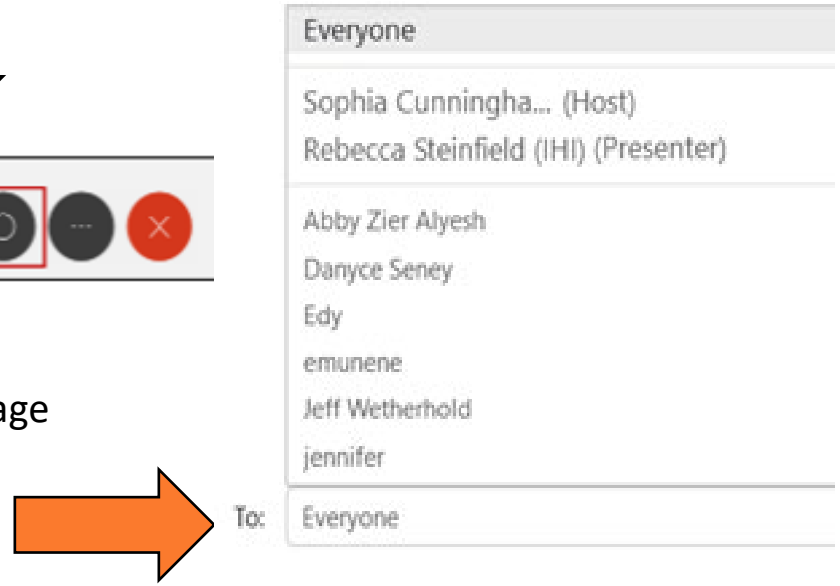
Although we want active participation, we ask that you please keep yourself on "mute" during the presentation.

Please introduce yourself (name, organization & role, location) using the Chat feature.

# How To Use Chat Feature

**Chat Feature Highly Encouraged**






- In the "Send To" or "To" **drop-down list**, select the recipient of the message
  - ***Scroll all the way down***
  - *Select **"Everyone"***
  - ***Do not** select "All Attendees"*
- **Enter** your **message** in the Chat Text Box, then **press Enter** on your keyboard

**Please Enter in Chat:**

- Your Name
- Your Role
- Your Hospital
- Your State

# Topics for Today

- CMS Strategic Plan & Health Equity Framework
- Why Addressing HRSN is Important
- CMS Health Equity Measures
- The Joint Commission Health Equity Guidelines

Today's program will also feature peer-to-peer sharing. You will hear a firsthand account of the successes, challenges, and opportunities to embed health equity in care coordination.

- Q&A

# The IPRO QIN-QIO

## The IPRO QIN-QIO

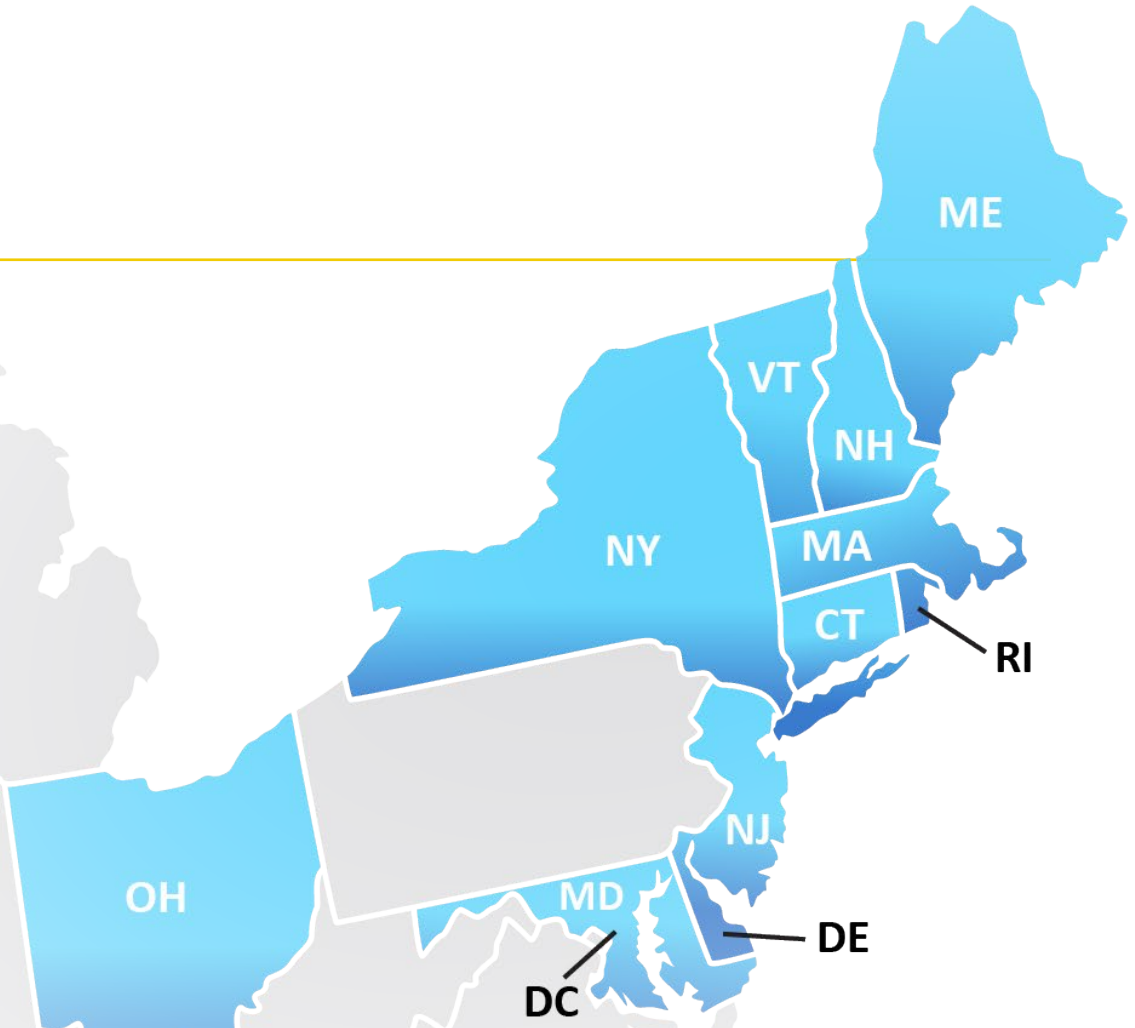
- A federally-funded Medicare Quality Innovation Network – Quality Improvement Organization (QIN-QIO)
- 12 regional CMS QIN-QIOs nationally

**IPRO:**
New York, New Jersey, and Ohio

**Healthcentric Advisors:**
Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont

**Qlarant:**
Maryland, Delaware, and the District of Columbia

Working to ensure high-quality, safe healthcare for
**20% of the nation's Medicare FFS beneficiaries**

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# Aligning Quality Goals

# Laura Benzel, MS, BS, CSSGB

**IPRO QIN-QIO Health Equity Subject Matter Expert**

Health Equity

IPRO QIN-QIO

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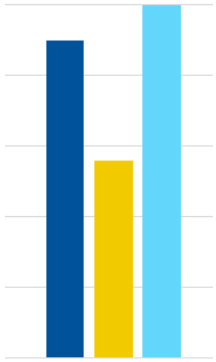
# CMS Strategic Plan


https://www.cms.gov/cms-strategic-plan


CMS Office of Minority Health, CMS Framework for Health Equity 2022-2023
https://www.cms.gov/files/document/cms-framework-health-equity-2022.pdf

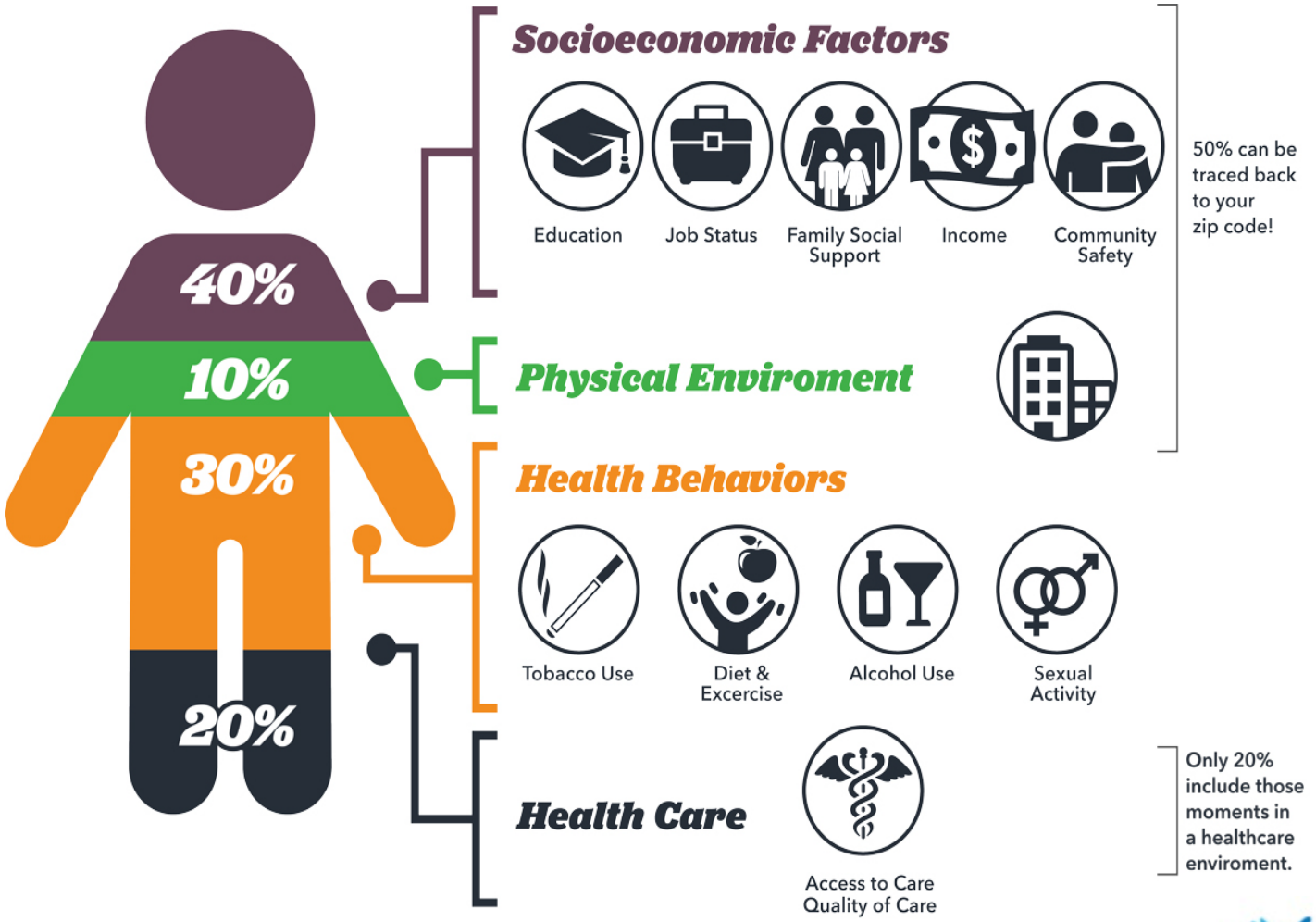
# Polling Question



Is your organization using a systematic process to screen for social risk factors?

*Please enter your response via the CHAT feature*

# Why Screening for Health-Related Social Needs (HRSN) Matters




- **20%** of health outcomes attributable to clinical care
- **80%** of health outcomes influenced by **physical environment**, **social determinants**, and **behavioral factors**
- **15-year** life expectancy gap between **advantaged** and **disadvantaged** individuals

Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries

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# New CMS Health Equity Measures

## CMS Inpatient Quality Reporting Program

- In the FY2023 IPPS/LTCH Final Rule
- 10 new measures, 3 related to health equity:
    - Hospital Commitment to Health Equity
    - Screening for Social Drivers of Health
    - Screen Positive Rate for Social Drivers of Health

https://www.qualityreportingcenter.com/en/inpatient-quality-reporting-programs/hospital-inpatient-quality-reporting-iqr-program/2022-events/iqr9122/

# New CMS Health Equity Measures

## Hospital Commitment to Health Equity

Measure ID: HCHE

- CY 2023 Reporting Period
- CY 2025 Payment Determination
- Structural measure that assesses a hospital's commitment to health equity using five domains of competencies:
  - Equity is a Strategic Priority
  - Data Collection
  - Data Analysis
  - Quality Improvement
  - Leadership Engagement
- Each domain is worth one point, for a total of five possible points.
- Hospitals must attest to all the elements of a domain to receive the point.
- CMS will publicly report the scores for this measure.

https://www.qualityreportingcenter.com/en/inpatient-quality-reporting-programs/hospital-inpatient-quality-reporting-iqr-program/2022-events/iqr9122/

# New CMS Health Equity Measures

## Screening for Social Drivers of Health

Measure ID: HCHE

- CY 2023 Voluntary Reporting
- CY 2024 Mandatory Reporting
- CY 2026 Payment Determination
- Assesses if a hospital screens patients 18 years or older for health-related social needs (HRSNs) at time of admission
- Patients must be screened for five HRSNs:
  - Food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety
- Hospitals can choose the screening tool.
- Numerator: number of patients admitted to an inpatient hospital who are 18 years or older on the date of admission screened for all five HRSNs
- Denominator: number of patients 18 years or older on the date of admission admitted to the hospital

https://www.qualityreportingcenter.com/en/inpatient-quality-reporting-programs/hospital-inpatient-quality-reporting-iqr-program/2022-events/iqr9122/

# New CMS Health Equity Measures

## Screen Positive Rate for Social Drivers of Health

Measure ID: SDOH-2

- CY 2023 Voluntary Reporting
- CY 2024 Mandatory Reporting
- CY 2026 Payment Determination
- Structural measure tracks:
  - % of patients admitted for inpatient hospital stay 18 years or older
  - Patients screened for an HRSN and screen positive for one or more of the five HRSNs
- Numerator: number of patients admitted for inpatient hospital stay 18 years or older who were screened for an HRSN, and who *screen positive* for one or more
- Denominator: number of patients admitted for inpatient hospital stay 18 years or older and are screened for an HRSN during their hospital inpatient stay

https://www.qualityreportingcenter.com/en/inpatient-quality-reporting-programs/hospital-inpatient-quality-reporting-iqr-program/2022-events/iqr9122/

# Summary of Measures

| Measure ID | Measure Name | Hospital IQR Program Fiscal Year 23 | 24 | 25 | 26 | 27 |
|---|---|---|---|---|---|---|
| SDOH-1* | Screening for Social Drivers of Health | | | ✓ | ✓ | ✓ |
| SDOH-2* | Screen Positive Rate for Social Drivers of Health | | | ✓ | ✓ | ✓ |
| HCHE* | Hospital Commitment to Health Equity | | | ✓ | ✓ | ✓ |

* Finalized these measures as voluntary beginning FY 2025 and mandatory with FY 2026.
SDOH=social drivers of health

* Finalized this measure with FY 2025.
HCHE=Hospital Commitment to Health Equity

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# The Joint Commission Health Equity Standards

## The Joint Commission

- New and revised standards released January 2023
    - To help reduce health care disparities and remove barriers to safe, high-quality health care
- A new standard in the Leadership (LD) chapter with 6 new elements of performance (EPs)
- The Record of Care, Treatment, and Services (RC) requirement to collect patient race and ethnicity information

https://www.jointcommission.org/standards/r3-report/r3-report-issue-36-new-requirements-to-reduce-health-care-disparities/#.Y2bA8nbMLIU

# The Joint Commission Health Equity Standards

Leadership (LD) chapter with 6 new elements applies to:

- Critical access hospitals
- Ambulatory health care
- Behavioral health care and human services organizations

Record of Care, Treatment, & Services (RC) requirement applies to:

- All of the above AND
- Hospitals

https://www.jointcommission.org/standards/prepublication-standards/new-and-revised-requirements-to-reduce-health-care-disparities/

# IPRO Health Equity Resources

# Join Us: IPRO CLAS Series

Health Equity

**CLAS = Culturally and Linguistically Appropriate Services**

Helps make healthcare services

Understandable | Respectful | Effective | Equitable

**How Can You Start Implementing CLAS?**

Complete the IPRO CLAS Assessment

IPRO Assessment of Cultural and Linguistic Services

Learn where your organization is implementing CLAS

Educational Series starting February 8th at noon

REGISTRATION

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# Today's Guest Speakers


## Amy Shideler, MSW, LISW-S

Manager of Primary Care Social Work

Cleveland Clinic | Connected Care

shidela@ccf.org

## J. Chase Holmes, M.Ed.

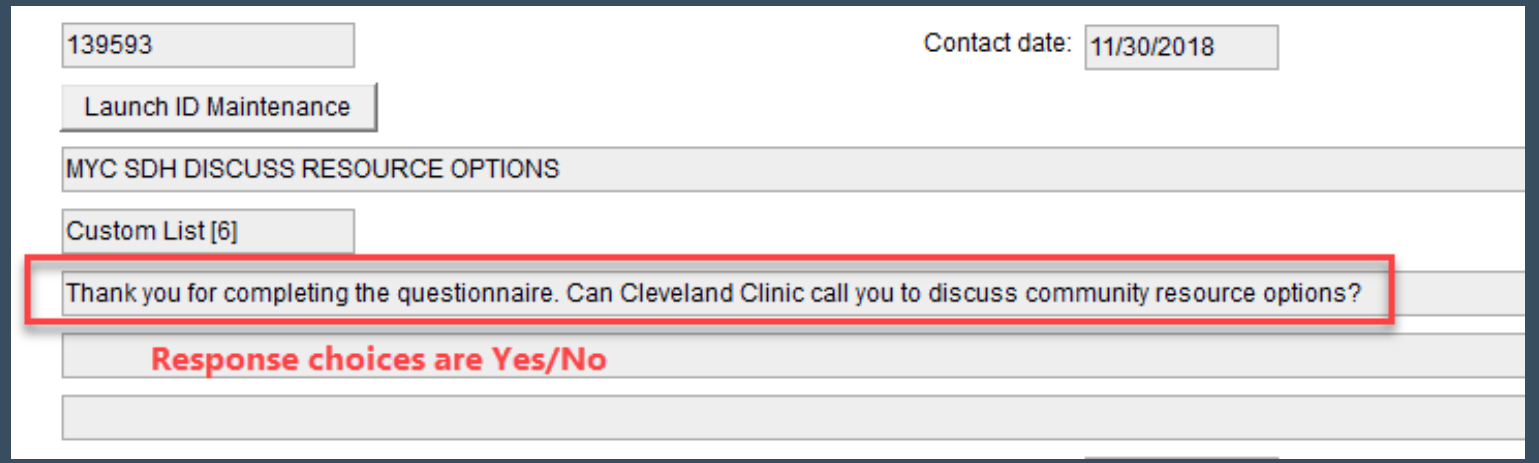
Program Manager

Cleveland Clinic | Community Health

holmesj2@ccf.org

# Health Related Social Need Screening

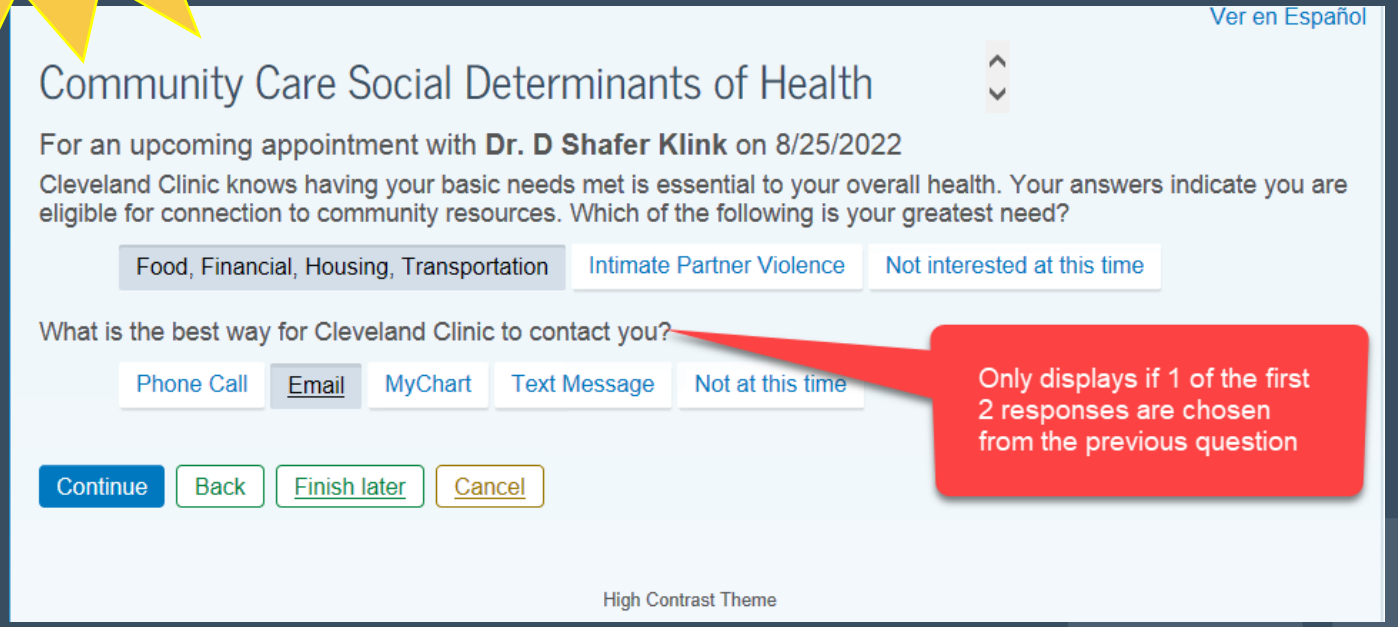
- Annual screening
- Population Health
- Epic 11/2019
- MyChart



# Health Related Social Need Screening

- Annual screening
- Population Health
- Epic 11/2019
- MyChart

Updated 2022



# Health System Challenges to Addressing HRSN

- Need volume & caregiver capacity
- Workflow barriers
- Community Benefit Organization (CBO) access & capacity
- Systemic barriers
- Limited access to survey

# HEAL, HIRE, INVEST

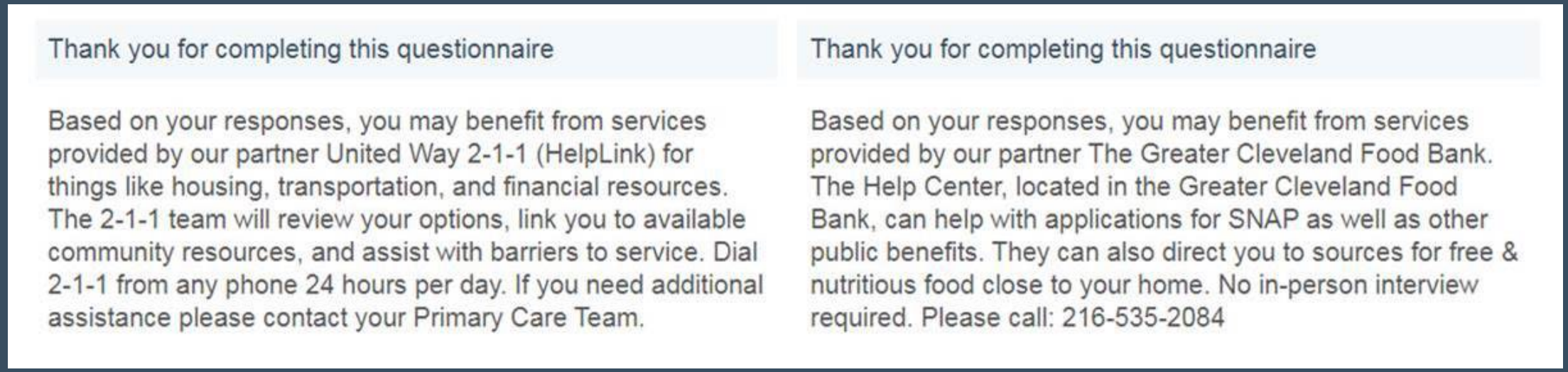
## Create the healthiest communities for everyone

| Reduce Barriers to Health | Improve Community Conditions | Engender Trust |
| --- | --- | --- |
| • Community Health Needs Assessment | • Healthcare Anchor Institution | • Community voice |

# Community Collaboration

- Resources on discharge forms
- CMS Accountable Health Communities grant 2016-2022
- Greater Cleveland Food Bank
- United Way of Greater Cleveland

# After Visit Summary (AVS) Resources



Thank you for completing this questionnaire

Based on your responses, you may benefit from services provided by our partner United Way 2-1-1 (HelpLink) for things like housing, transportation, and financial resources. The 2-1-1 team will review your options, link you to available community resources, and assist with barriers to service. Dial 2-1-1 from any phone 24 hours per day. If you need additional assistance please contact your Primary Care Team.

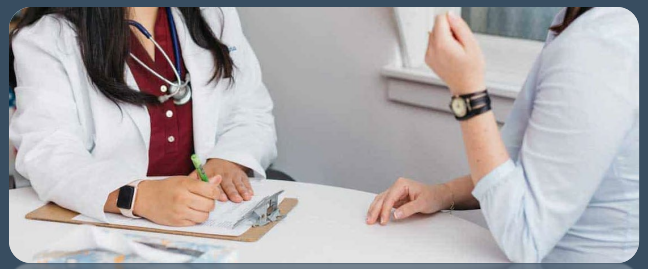
Thank you for completing this questionnaire

Based on your responses, you may benefit from services provided by our partner The Greater Cleveland Food Bank. The Help Center, located in the Greater Cleveland Food Bank, can help with applications for SNAP as well as other public benefits. They can also direct you to sources for free & nutritious food close to your home. No in-person interview required. Please call: 216-535-2084

United Way of Greater Cleveland will be provided to individuals identified as high risk for Financial, Housing, and Transportation Insecurity on the SDOH screening tool domains.

Greater Cleveland Food Bank will be provided to individuals identified as high risk for food insecurity on the SDOH screening tool.

# Patient Survey

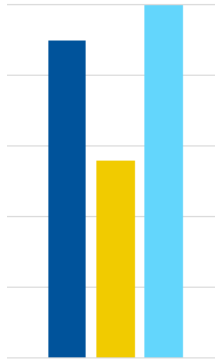


- **Did you receive information on your AVS about the United Way of Greater Cleveland and Greater Cleveland Food Bank?**
- **Did you like receiving this information?**

# AVS Challenges

- 1% of patients surveyed recalled receiving resources.
- Community partners had limited capacity to identify AVS driven referrals.
- Health system data analytic barriers

# Polling Question



Are you tracking the status outcome of patients identified with social risk factors who have been referred to community-based resources?

*Please enter your response via the CHAT feature*

# Community Collaboration Opportunities

- 1 of 10 cities nationally
- Health care facilities
- Standardized HRSN screening tool
- Navigation support


https://innovation.cms.gov/innovation-models/ahcm

# Accountable Health Communities

- Model tests whether addressing health-related social needs impacts total health care costs and utilization.
- Eligible Patients: Social Need, Cuyahoga County resident, Medicare/Medicaid, 2 ED visits/year
- United Way 211 navigator in ED

# Opt In Volume by Site, Discharge to Home, Acute Care, Critical Access, or Home Health

| | Delay | Opt In | Opt In Total | Opt Out | Unable | Missing | Not Started | Total |
|---|---|---|---|---|---|---|---|---|
| ED 1 | 94 | 188 | **282** | 660 | 80 | 94 | 579 | 1695 |
| ED 2 | 27 | 77 | **104** | 647 | 71 | 281 | 540 | 1643 |
| ED 3 | 45 | 125 | **170** | 936 | 211 | 106 | 60 | 1483 |
| ED 4 | 17 | 367 | **384** | 672 | 165 | 110 | | 1331 |

Source: Epic reports on Opt In Status of AHC-eligible patient visits-January 2021

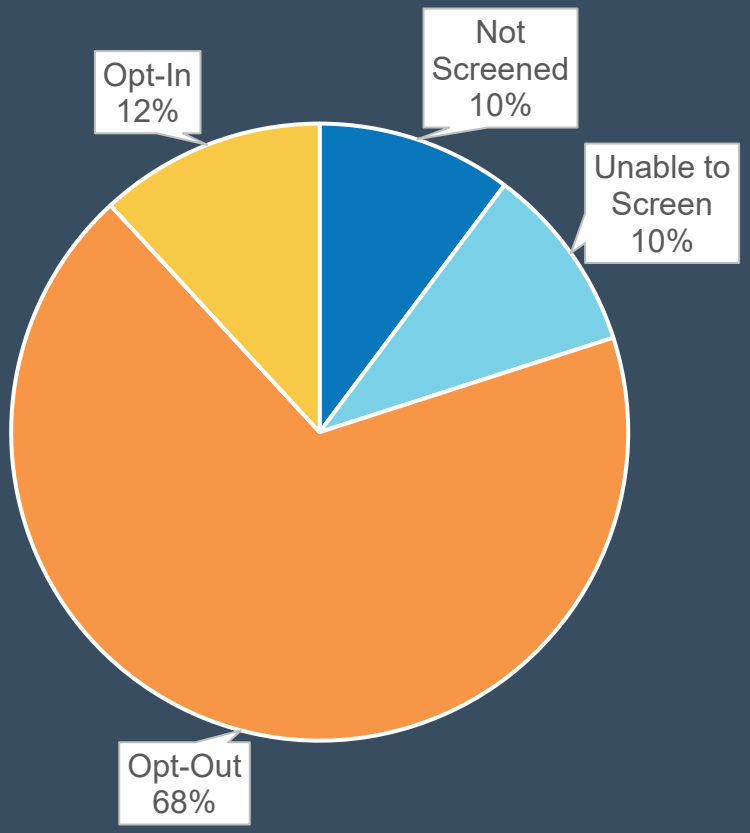
# Accountable Health Communities

*Last Updated: 01/12/21*

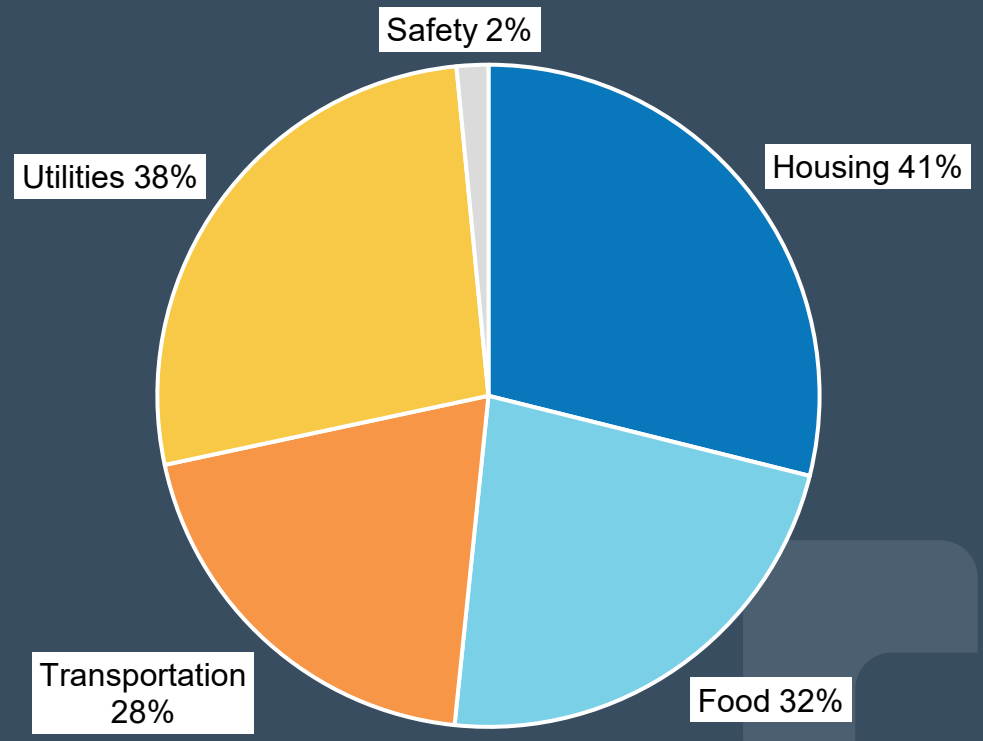
| Objectives | Key Results & Measures of Success | Target | Performance | |
|---|---|---|---|---|
| Addressing vulnerable populations; screening for social needs and gap closure | • 100% of referrals from PCSW are screened for food, transportation, housing, and finance issues<br>• # and % of those who have reported a need will opt into AHC Program and referred to UW<br>• # and % of those referred were high risk<br>• # and % of those who were high risk will be connected to a resource<br>• # and % gap closure for those who have been connected to a resource | • 100% Complete<br>• 50%<br>• TBD<br>• 30%<br>• 30% | 100%<br>47%<br>15%<br>82%<br>21% | |

# Challenges of HRSN Screening

## Screen Eligible Patients




## National AHC Identified Need



# Community Collaboration Challenges

- CBO excluded from HIPAA protections:
  - Legal Contract
    - Business Associate Agreement
    - Memorandum of Understanding
  - Corporate Compliance
    - Consent process

# What is Unite Us?

**Unite Us** connects patients and community residents with identified social needs to Community Based Organizations (CBOs) to deliver integrated whole person care through a shared technology platform

# Goals of Unite US

- ✓ Increase patient access to CBO services through electronic referrals
- ✓ Increase collaboration between health systems and CBOs (securely share patient information)
- ✓ Efficiently track referral outcomes to measure health related social needs (gap closure)
- ✓ Unified community approach to address social needs

# Unite Us

- CBO Barriers:
  - Infrastructure
  - Staffing
  - Workflow
  - Competing Priorities
  - Community Trust
- Platform Barriers:
  - Data Delivery
  - IT Solutions
  - Operationalizing Workflows for Different Institutes

# Connecting People to Care

## Screening

John Doe shows up at Cleveland Clinic.

Sue screens John and identifies that he has additional social needs.

## Referral

Sue uses Unite Us to first gain digital consent and electronically refers John to multiple community partners. Through the platform, Sue can seamlessly communicate with the other providers in real time and securely share John's information.

## Resolution

## Feedback

As John receives care, Sue receives real-time updates and tracks John's outcomes through EPIC or a web-based platform.

# Community Advisory Council

- A collaboration of hospital systems, community stakeholders, and reps from community-based organizations to come together and provide strategic guidance on ways of improving Unite Us platform.

**CAC Focuses On:**

1. User experience
2. Network growth
3. Data/evaluation

Cleveland Clinic

Every life deserves world class care.

# Questions

*Please enter your questions for our speakers via the CHAT feature or take yourself off mute*

# Resources

## IPRO QIN-QIO

- Resource Library
  https://www.cms.gov/about-cms/agency-information/omh/downloads/omh_readmissions_guide.pdf
- SDoH Getting Started Guide
  https://qi-library.ipro.org/2022/07/07/social-determinants-of-health-sdoh-a-guide-for-getting-started-for-getting-started/
- A Guide to Screening Patients for Food Insecurity
  https://qi-library.ipro.org/2022/10/25/a-guide-to-screening-patients-for-food-insecurity/
- A Guide to Screening Patients for Social Isolation/Loneliness
  https://qi-library.ipro.org/2022/11/15/a-guide-to-screening-patients-for-social-isolation-and-loneliness/
- A Guide to Screening Patients for Transportation Barriers
  https://qi-library.ipro.org/2022/11/15/a-guide-to-screening-for-transportation-barriers/

## CMS Office of Minority Health

- Guide to Reducing Disparities in Readmissions
  https://www.cms.gov/about-cms/agency-information/omh/downloads/omh_readmissions_guide.pdf
- Utilization of Z Codes for Social Determinants of Health among Medicare Fee-for-Service Beneficiaries, 2019
  https://www.cms.gov/files/document/z-codes-data-highlight.pdf

## HHS Think Cultural Health

- National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health & Health Care
  https://thinkculturalhealth.hhs.gov/clas

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# Added-Value Resources

IPRO QIN-QIO Website: https://qi.ipro.org/

IPRO QIN-QIO Resource Library: https://qi-library.ipro.org/#

Data-Driven Quality Improvement: A Guide to IPRO QIN-QIO Data Dashboards & Reports: https://drive.google.com/file/d/1HH4q8CH7n1-wyxqpaMxKwPiOxHtdaz9L/view?usp=sharing

Social Determinants of Health–a Guide for Getting Started: https://drive.google.com/file/d/1NUEHyVsQ95-noR55ULTEUgPiZzgwkXcM/view?usp=sharing

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# We Want Your Feedback…

- Please take a moment to complete the survey following this presentation.

- Today's presentation will be available on our website.

# *Thank You for Attending!*

## Connect With Our Team


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