Practical Strategies to Address Social Risk Factors

Introduction to Social Determinants of Health Screening and the Impact on Quality of Care and Health Outcomes

June 21, 2023

What do you hope to gain from this series?

REQUIREMENTS BETTER CMS
SDOH SDOH SCREENING
UNDERSTANDING
STRATEGIES RISK KNOWLEDGE
KNOWLEDGE FACTORS PATIENTS PRACTICAL
REGULATIONS LEARN PROCESS UNDERSTAND COMMUNITY
INFORMATION HEALTH IMPROVE
OUTCOMES SOCIAL IMPLEMENTATION
EDUCATION TOOLS BEST PRACTICES NEW USE
IMPLEMENTING QUALITY CARE RESOURCES
CODING COMPLIANCE DATA HELP PATIENT

AzHHA Arizona Hospital and Healthcare Association
cha Colorado Hospital Association
FHA Florida Hospital Association
IHA Illinois Health and Hospital Association
MHA Montana Hospital Association
Cynosure Health

Objectives

- Discuss how social determinants of health screening can improve hospital quality of care and population health outcomes using practical examples.
- Outline regulatory requirements around health equity and screening for social determinants of health screening.
- Review social determinants of health screening screening resources and tools currently available to hospitals.

Today's Presenter

Natalie Graves, MPH

Director, Research and Implementation, Cynosure Health

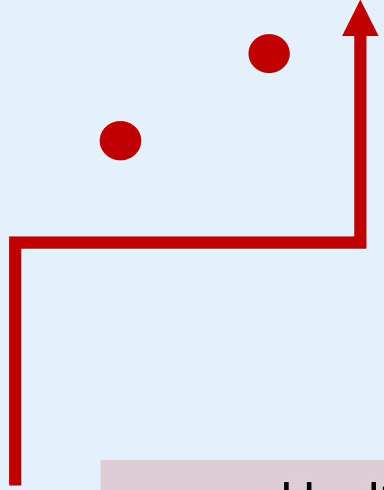
Natalie has over a decade of experience in leading programs to transform healthcare by leveraging quality improvement strategies and promoting peer-to-peer learning. She has collaborated with the Centers for Medicare & Medicaid Services, hospitals, accountable care organizations, state Medicaid agencies, and patient and family advocates to translate ambitious goals into concrete action plans for improvement. Her areas of expertise include value-based care, delivery system transformation, payment reform, quality improvement, project management, and coaching and mentoring.

Health Equity

“Everyone has the opportunity to attain their highest level of health.” – American Public Health Association

Health Disparities

A measure of progress



Social Drivers of Health

A strategy to advance health equity

Health-related social needs
Vs.
Social drivers of health

Credit to: NORC Walsh Center, https://www.norc.org/content/norc-org/us/en/about/departments/walsh-center-rural-health.html

Individuals

- Patient with frequent ED visits related to asthma
- Inability to afford medication due to low income

→ **Health-related social need**

Communities

- Cause of asthma is poor air quality due to proximity to factories

→ **Social driver of health**

- Patients who live in the neighborhood by the factor have high rates of asthma and high ED visit rates compared with patients who live in neighborhoods without factories

→ **Health disparity**

- Difference in health potential because of differences in neighborhood exposure to air pollution

→ **Health inequity**

Housing near factories → Exposure to poor air quality → More asthma → Worse Health Outcomes

What's a hospital to do?

- Diagnose and treat patients in the emergency room
- Prescribe medication
- Use SDOH screening to understand barriers to medication use (affordability). Prevent ED visits!
- Identify patterns in patients with uncontrolled asthma
- Mitigate - Build programs and partnerships to proactively prevent poor health outcomes associated with poor air quality
- Advocate – for different standards, additional resources

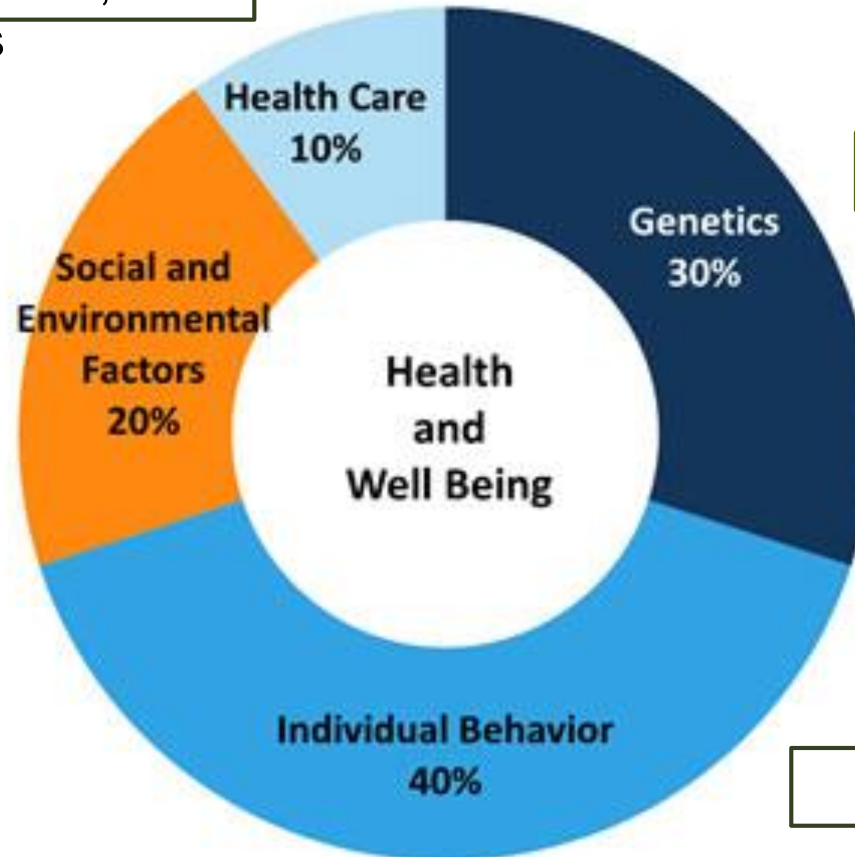
Housing near factories ➔ Exposu

Impact of Different Factors on Risk of Premature Death

Quality Improvement, Treatments

Inheritance, Susceptibility

Transportation, Housing, Viruses



Smoking, Exercise, Obesity

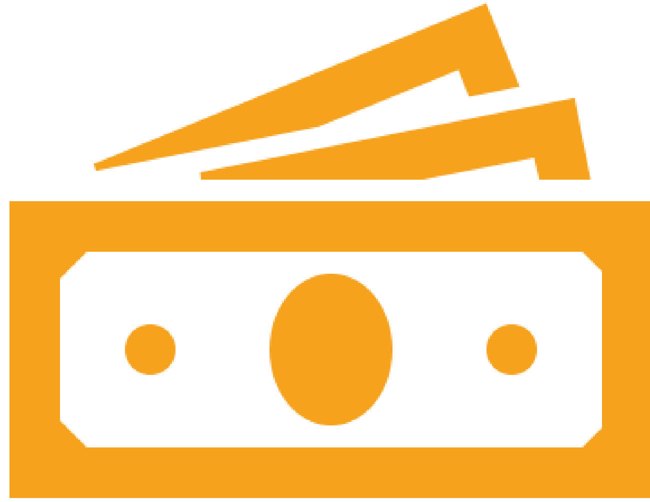
SOURCE: Schroeder, SA. (2007). We Can Do Better — Improving the Health of the American People. *NEJM*. 357:1221-8.

THE HENRY J. KAISER FAMILY FOUNDATION

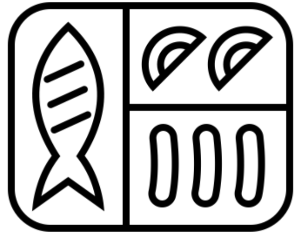
What’s Your “Why”?

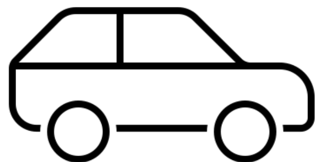
Alignment with Multiple Requirements & Priorities

- Community benefit
- Community health needs assessment
- Advancing health equity
- Improving quality (such as readmissions)
- Patient-centered care
- Something else?



REASON A. CMS (AND OTHER PAYERS)





CMS Final Rule: Screening for 5 Social Drivers of Health / Health Related Social Needs (HRSN)

Food Insecurity

Housing Instability

Transportation Needs

Utility Difficulties

Interpersonal Safety

Source: 2022-16472.pdf (federalregister.gov), page 1220

SDOH-1: SDOH Screening Rate

Adult Inpatients Screened for All 5 Non-medical Health Related Social Needs (HRSN)

Adult Inpatients

SDOH-2: SDOH Screen Positive Rate

Adult Inpatients With a Positive Health Related Social Needs Screening (HRSN)

Reported as 5 separate rates

Adult Inpatients Screened for All 5 Non-medical Health Related Social Needs (HRSN)

Domain 1: Equity is a Strategic Priority

1

Your hospital has a strategic plan for advancing healthcare equity that:
- o Identifies priority populations who currently experience health disparities
- o Establishes healthcare equity goals and discrete action steps to achieving those goals
- o Outlines specific resources which have been dedicated to achieving your equity goals
- o Describes your approach for engaging key stakeholders, such as community partners

Domain 2: Data Collection

2

Your hospital is actively engaged in 3 key data collection activities:
- o Collecting demographic information, including self-reported race and ethnicity and/or social determinant of health (SDOH) information on the majority of your patients
- o Training staff in culturally sensitive collection of demographic and/or SDOH information
- o Inputting demographic and/or SDOH information collected from patients into structured, interoperable data elements using a certified EHR technology

Domain 3: Data Analysis

3

Your hospital is stratifying key performance indicators by demographic and/or SDOH variables to identify equity gaps and including this information on hospital performance dashboards

Domain 4: Quality Improvement

4

Your hospital participates in local, regional, or national quality improvement activities focused on reducing health disparities

Domain 5: Leadership Engagement

5

Your senior leadership, including your chief executives and your entire hospital board of trustees, demonstrates a commitment to equity through 2 activities:
- o Annual reviews your strategic plan for achieving health equity
- o Annual reviews of key performance indicators stratified by demographic and/or social factors

Hospital Commitment to Health Equity Measure

Source: https://blog.medisolv.com/articles/a-guide-to-cms-new-health-equity-measure

	HCHC	SDOH-1 and SDOH-2
Reporting Process	Inpatient Quality Reporting program: https://qualitynet.cms.gov/inpatient/iqr	
Optional Reporting Period	N/A	CY2023
Mandatory Reporting Period	CY2023	CY2024
Publicly Reported?	Yes	No
IQR Guidance Docs/FAQ	https://qualitynet.cms.gov/files/6481de126f7752001c37e34f?filename=AttstGdnceHCHEMeas_v1.1.pdf	https://qualitynet.cms.gov/files/643473d9a484cd0017883d92?filename=SDOH_Measure_FAQs_April2023.pdf
IQR Specifications	https://qualitynet.cms.gov/files/6481de2304f753001cd056d1?filename=HCHEStrctMeasSpecs_v2.1.pdf	https://qualitynet.cms.gov/files/643473c59920e9001651eddf?filename=ScrnSocDrvrs_Scrn_Pos_Specs.pdf
Resources	https://blog.medisolv.com/articles/a-guide-to-cms-new-health-equity-measure	https://blog.medisolv.com/articles/intro-cms-sdoh-measures

How the SNS Measure Works

The SNS measure looks at six indicators, one each for screening and intervention across three social needs. It measures the percentage of members who, during the measurement period, were:

- **Screened** via a **pre-specified instrument** at least once for unmet needs related to
  - Food.
  - Housing.
  - Transportation.
- Members who **screen positive** receive a corresponding intervention.

Source: https://www.ncqa.org/blog/social-need-new-hedis-measure-uses-electronic-data-to-look-at-screening-intervention/

REASON B. JOINT COMMISSION (AND OTHER ACCREDITORS)

R³ Report | Requirement, Rationale, Reference

A complimentary publication of The Joint Commission

Issue 36, Date June 20, 2022

Published for Joint Commission-accredited organizations and interested health care professionals, *R3 Report* provides the rationale and references that The Joint Commission employs in the development of new requirements. While the standards manuals also may provide a rationale, *R3 Report* goes into more depth, providing a rationale statement for each element of performance (EP). The references provide the evidence that supports the requirement. *R3 Report* may be reproduced if credited to The Joint Commission. Sign up for email delivery.

New Requirements to Reduc

Effective January 1, 2023, new and revis
in the Joint Commission's ambulatory he
hospital, and hospital accreditation prog

- A new standard in the Leadership (L
  developed to address health care di
  to the following Joint Commission–a
  - All critical access hospitals and
  - Ambulatory health care organiza
    ambulatory health care program
    care, dental services, or surgica
  - Behavioral health care and hum
    Treatment," "Intellectual Disabil
    Physical Health Care" services
- The Record of Care, Treatment, and
  information has been revised and wi
  - Ambulatory health care (Standa
  - Behavioral health care and hum
  - Critical access hospital (Standar
- The Rights and Responsibilities of th
  RI.01.01.01, EP 29) will apply to all
  behavioral health care and human s

Engagement with stakeholders, custo
In addition to an extensive literature revi
guidance from the following groups:

- Technical Advisory Panel (TAP) of su
  organizations and professional asso
- Standards Review Panel (SRP) comp
  ground" point of view and insights i

The prepublication version of the requirements to reduce health care disparities will be available online until December 31, 2022. After January 1, 2023, please access the new requirements in the E-dition or standards manual.

© 2022 The Joint Commission

Requirement

EP 2: The [organization] assesses the [patient's] health-related social needs and provides information about community resources and support services.

Note 1: [Organizations] determine which health-related social needs to include in the [patient] assessment. Examples of a [patient's] health-related social needs may include the following:

- Access to transportation
- Difficulty paying for prescriptions or medical bills
- Education and literacy
- Food insecurity
- Housing insecurity

Note 2: Health-related social needs may be identified for a representative sample of the [organization's] [patients] or for all the [organization's] [patients].

Source: https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_disparities_july2022-6-20-2022.pdf

REASON C. STATE REQUIREMENTS

Implementation Guidance

For Screening for Social Determinants of Health in an Electronic Health Record

JANUARY 2021

Chat in your resources!

REASON E. YOUR PATIENTS!

Improving care transitions and reducing readmissions

REASON E. YOUR COMMUNITIES

Community health needs assessments & implementation plans

GETTING STARTED

What We're Learning

This is new and complex

Engage community members, patients, and families in every step

Identify and align with other resources

Start small

Screening won't solve all challenges, but it will shine a light on needs

Patients (and staff!) want to know why you're asking

Hospitals face common challenges

- Staff availability and systems to collect, analyze, and use data
  - The right people – local context is important
  - The right training – scripting and sensitivity with patients
  - The right tools – EHR, tablet, paper tool, post-discharge call or all of the above
- Availability of community resources and capacity to support patients who are referred
  - Tracking databases are emerging
  - Availability of resources varies
- Data collection & documentation… determining a disparity is complex

Source: 10/27/2022 Cynosure Health webinar chat question: What is the greatest challenge you face in setting up SDOH screening?

Getting Started

Actions

- **Set a vision** – what does success look like?
- **Convene stakeholders** – nursing, quality, case managers/social workers, IT, population health, education/marketing, patient family partners
- **Identify existing resources**

Resources

- Existing screening tools- SIREN
- Your Electronic Medical Record (EMR) capabilities
- Existing partnerships and organizations with whom you have not yet partnered
- Perspectives and ideas from patient family partners who have experienced SDOH screening

Engaging PFPs in SDOH Screening Programs

VS

Without PFP

- Use data to identify highest community needs
- Develop screening program internally
- Develop public messaging
- Implement program
- Evaluate program

With PFP

- Use data to identify highest community need
- Validate data with lived experiences
- Learn about community resources from the people who are accessing them
- PFPs inform community messaging
- PFPs co design scripting, inform timing and evaluate screening programs.

Considerations

- Do your staff and providers have a common understanding of why you’re screening patients and how you will use the information?
- How will you explain to patients why you are asking questions about SDOH?
- Do the staff who are completing the screenings have the time, training, and resources to do so effectively?
- If a patient screens positive, what will your response be?
- How will you analyze data over time to identify patterns and to proactively address high priority needs in your community?
- How do you know your screening results are accurate?

Tips for Screening: Building Trust

- In the inpatient setting, face-to-face conversations are best
- Let the patient know why you're asking
- Ask the same question multiple ways and give context
- Scripting helps, but so does practices
- It's ok to ask even if you don't have all of the answers or a clear solution

Resources to Get Started

- **Cynosure Health SDOH Online Community:** https://clic.thinkific.com/communities/Q29tbXVuaXR5LTMxODc5/
  - Peer discussion board
  - Webinars
  - "Storming Sessions" & Summary Documents
  - Upcoming Lunch & Learn on Z-codes and a mini-course on building trust
- **SIREN:** https://sirenetwork.ucsf.edu/tools/evidence-library
- **CMS Accountable Health Communities Model:** https://innovation.cms.gov/innovation-models/ahcm

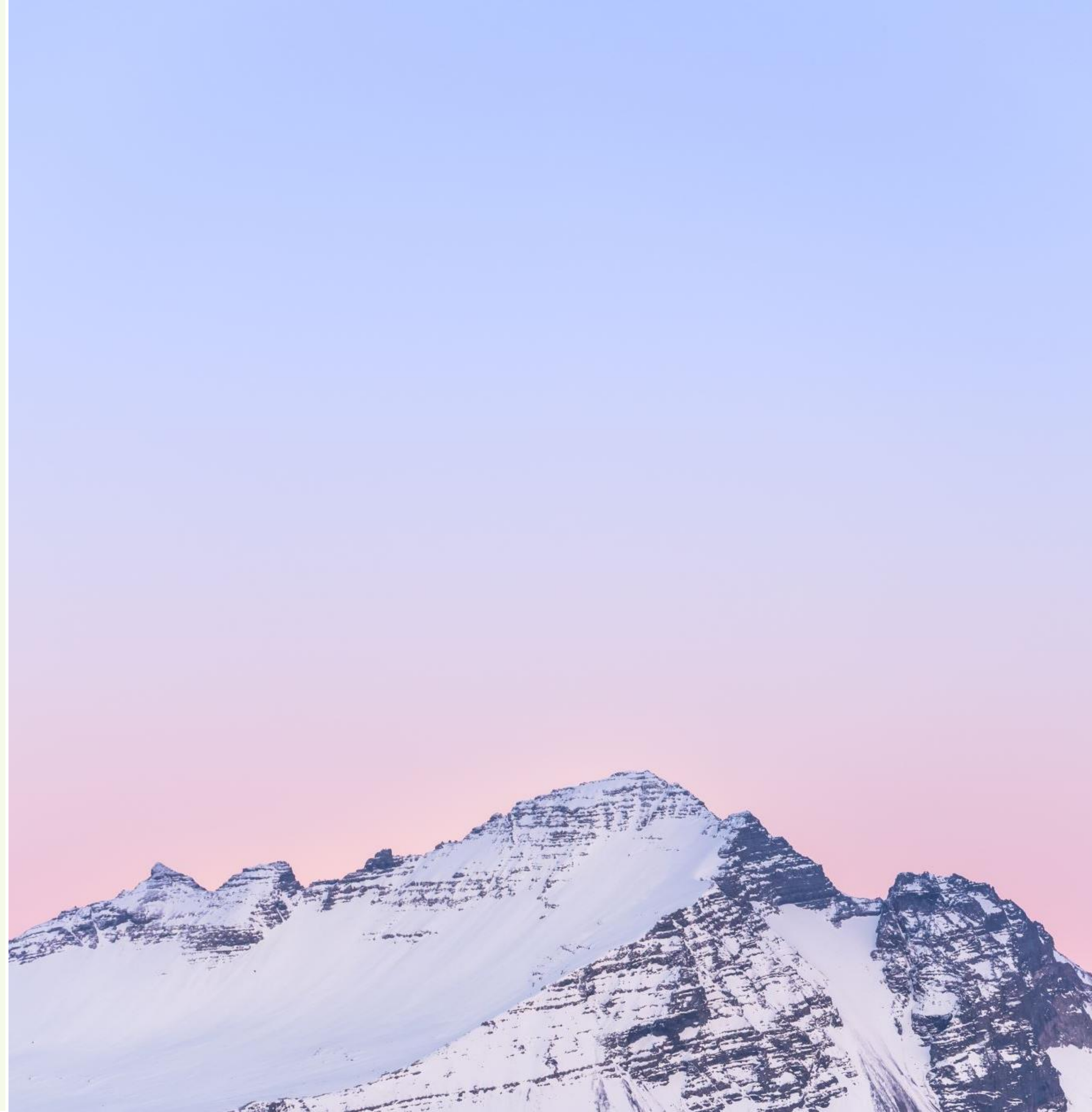
“It is about the kind of world we want to live in, the people we want to be, and the communities we want to build.”

- Don Berwick, MD, MPP, FRCP | *Institute for Health for Healthcare Improvement President Emeritus and Senior Fellow*

Read the full blog post here.

THANK YOU

Natalie Graves, MPH
Director, Research & Implementation
ngraves@cynosurehealth.org



Questions?

Thank you!

Join us for our next session on July 12 at

11:00 PT/12:00 PT/1:00 CT/2:00 ET for

Session 2: Practical Strategies for Implementing SDoH Screening & Addressing Social Risk Factors

Register here!

Questions?

Email: HealthEquity@team-iha.org

Evaluation Survey

https://www.surveymonkey.com/r/Session1SDOH