ALLIANT HEALTH SOLUTIONS | SORH State Office of Rural Health
A Division of the Georgia Department of Community Health

GA FLEX Health Equity Improvement Project Monthly Meeting

Health Equity/SDOH Data Collection and Community Partnerships

Rosa Abraha, MPH

July 25, 2023

Featured Speaker

Rosa Abraha, MPH
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Rosa joined Alliant in December 2021 to lead the company's first health equity strategic portfolio and embed health equity in the core of Alliant's work. Rosa has 10 years experience in public health advisory for premier agencies, including the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH) and the Food and Drug Administration (FDA). She holds a master of public health in health policy and management from Emory University.

Data Collection: REaL and SDOH Patient Demographic Data

CMS HCHE

Mandatory CY23

MUC 2021-106

Domain 2A

Our hospital collects demographic information, including self-reported race and ethnicity and/or social determinant of health information on the majority of our patients.

Domain 2B

Our hospital has training for staff in culturally sensitive collection of demographic and/or social determinant of health information.

Domain 2C

Our hospital inputs demographic and/or social determinant of health information collected from patients into structured, interoperable data elements using a certified EHR technology.

TJC

Mandatory 1/1/24

Standard RC.02.01.01

The [medical] record contains information that reflects the [patient's] care, treatment, and services.

EP 28

The medical record contains the patient's race and ethnicity.

Data Collection: 5 CMS Domains of SDOH Screening

1. **Food Insecurity**
   Food insecurity is defined as limited or uncertain access to adequate quality and quantity of food at the household level.

2. **Housing Instability**
   Housing instability encompasses multiple conditions ranging from the inability to pay rent or mortgage, frequent changes in residence including temporary stays with friends and relatives, living in crowded conditions, and actual lack of sheltered housing in which an individual does not have a personal residence.

3. **Transportation Needs**
   Unmet transportation needs include limitations that impede transportation to destinations required for all aspects of daily living.

4. **Utility Difficulties**
   Inconsistent availability of electricity, water, oil, and gas services is directly associated with housing instability and food insecurity.

5. **Interpersonal Safety**
   Assessment for this domain includes screening for exposure to intimate partner violence, child abuse, and elder abuse.

Data Collection: Screening Patients for SDOH

● CMS SDH *Mandatory CY24*	**Screening for Social Drivers of Health MUC2021–136** Numerator: Number of beneficiaries 18 and older screened for food insecurity, housing instability, transportation needs, utility assistance, and interpersonal violence. Denominator: Number of beneficiaries 18 and older in practice (or population). **Screen Positive Rate for Social Drivers of Health MUC2021–134** Numerator: Number of beneficiaries 18 and older that screen positive for food insecurity, housing instability, transportation needs, utility assistance or interpersonal violence. Denominator: Total number of beneficiaries 18 and older screened for food insecurity, housing instability, transportation needs, utility assistance or interpersonal violence.

NOTES:

- *These are both structural measures and the data can come from multiple sources (administrative claims data, electronic clinical data, standardized patient assessments, or patient-reported data and surveys).*
- *Exclusion criteria exists for patients who opt-out of screening and/or patients who are unable to complete the screening during their stay and have no legal guardian or caregiver who can do so on their behalf.*
- *The screen positive rate will result in 5 unique rates for each of the 5 categories of social drivers of health.*

CMS AHC HRSN SDOH Screening Tool

Living Situation

1. **What is your living situation today?**[3]
   - ☐ I have a steady place to live
   - ☐ I have a place to live today, but **I am worried** about losing it in the future
   - ☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

2. **Think about the place you live. Do you have problems with any of the following?**[4]
   CHOOSE ALL THAT APPLY
   - ☐ Pests such as bugs, ants, or mice
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Lack of heat
   - ☐ Oven or stove not working
   - ☐ Smoke detectors missing or not working
   - ☐ Water leaks
   - ☐ None of the above

Food

Some people have made the following statements about their food situation. Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months. [5]

3. **Within the past 12 months, you worried that your food would run out before you got money to buy more.**
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

4. **Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.**
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

Transportation

5. **In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?**[6]
   - ☐ Yes
   - ☐ No

Utilities

6. **In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?**[7]
   - ☐ Yes
   - ☐ No
   - ☐ Already shut off

Safety

Because violence and abuse happens to a lot of people and affects their health we are asking the following questions. [8]

7. **How often does anyone, including family and friends, physically hurt you?**
   - ☐ Never (1)
   - ☐ Rarely (2)
   - ☐ Sometimes (3)
   - ☐ Fairly often (4)
   - ☐ Frequently (5)

8. **How often does anyone, including family and friends, insult or talk down to you?**
   - ☐ Never (1)
   - ☐ Rarely (2)
   - ☐ Sometimes (3)
   - ☐ Fairly often (4)
   - ☐ Frequently (5)

9. **How often does anyone, including family and friends, threaten you with harm?**
   - ☐ Never (1)
   - ☐ Rarely (2)
   - ☐ Sometimes (3)
   - ☐ Fairly often (4)
   - ☐ Frequently (5)

10. **How often does anyone, including family and friends, scream or curse at you?**
    - ☐ Never (1)
    - ☐ Rarely (2)
    - ☐ Sometimes (3)
    - ☐ Fairly often (4)
    - ☐ Frequently (5)

Link to Screening Tool

Is your hospital already working on or collecting data on any of these five (5) domains? Have you embedded this in your EHR?

Food Insecurity	Housing Instability	Transportation Needs	Utility Difficulties	Interpersonal Safety

Data Analysis and Stratification by Hospital Quality Measures

CMS HCHE *Mandatory CY23*	**MUC 2021-106** **Domain 3A** Our hospital stratifies key performance indicators by demographic and/or social determinants of health variables to identify equity gaps and includes this information on hospital performance dashboards. **Domain 1B** Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews key performance indicators stratified by demographic and/or social factors.
TJC *Mandatory 1/1/24*	**Standard LD.04.03.08** Reducing healthcare disparities for the [organization's] [patients] is a quality and safety priority. **EP 3** The [organization] identifies healthcare disparities in its [patient] population by stratifying quality and safety data using the sociodemographic characteristics of the [organization's] [patients].

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Is your hospital looking at SDOH data by any quality measure (i.e., 30-day readmissions in homeless population)?

Food Insecurity	Housing Instability	Transportation Needs	Utility Difficulties	Interpersonal Safety

Interventions for Patients with SDOH Needs and Health Disparities

CMS HCHE	**MUC 2021-106** **Domain 4A** Our hospital participates in local, regional, or national quality improvement activities focused on reducing health disparities.
CMS HCHE	**MUC 2021-106 Domain 1D** Our hospital strategic plan describes our approach for engaging key stakeholders, such as community-based organizations.
TJC	**Standard LD.04.03.08** Reducing healthcare disparities for the [organization's] [patients] is a quality and safety priority. **EP 2** The [organization] assesses the [patient's] health-related social needs and provides information about community resources and support services.

A Culture of Health Equity: Key Clinical-Community Partnerships

Example Clinical Partners

- Facilities (i.e., hospitals, nursing homes)
- Critical Service Areas (i.e., ED)
- Individual Clinicians and Critical Service Areas (i.e., ED, Case Management Team)
- Dialysis Centers
- Behavioral Health Clinics
- Social Services
- Pharmacies
- EMS

Example Community Partners

- United Way
- Area Agency On Aging
- Area Medicaid Reps
- Faith-Based Organizations
- Local Business (i.e., Barbershops, Grocery Stores)
- Local Employee Retiree Organizations
- Local Senior Centers
- Local Political Organizations
- Local Power Company
- Community Health Workers
- Local Transportation Agencies
- Housing Agencies
- Food Pantries/Shelters
- Literacy Volunteers
- Police and Fire Depts.
- Veterans Association
- Universities/Research Centers

Does your hospital have community partnerships in any of these five (5) domains?

Food Insecurity	Housing Instability	Transportation Needs	Utility Difficulties	Interpersonal Safety

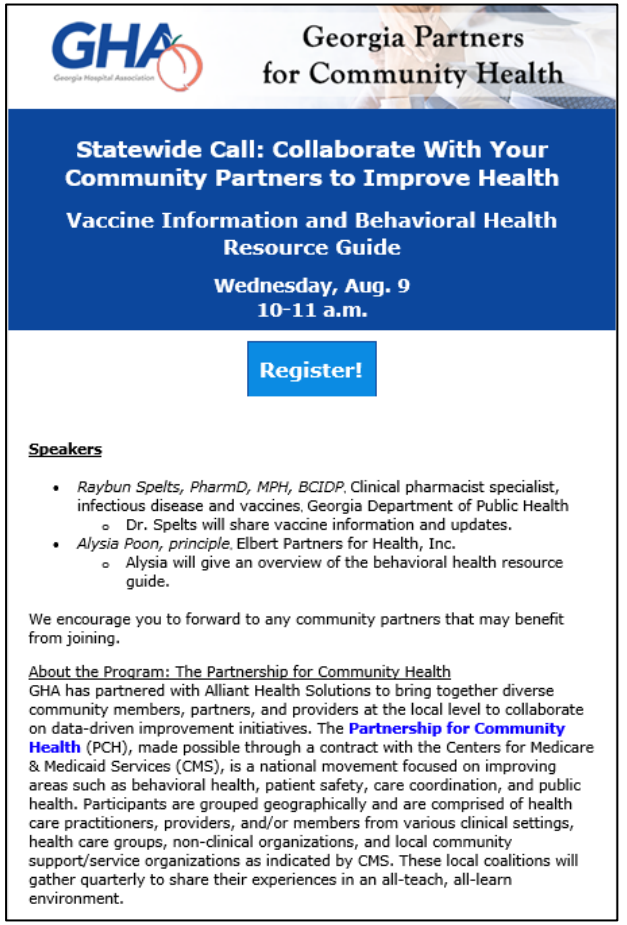
Ways to Engage with Community Coalitions/PCHs

- Attend PCH meeting to learn what community outreach is occurring in your region or state
- Engage with affinity or work groups – share best practices
- Use coaching calls to get questions answered
- Attend regional and statewide community coalition meetings
- GA State Contact:

  Mel Brown (melody.brown@allianthealth.org)

Next meeting:

Wednesday, August 9, 2023 from 10-11 a.m. EST



GHA Georgia Partners for Community Health

Statewide Call: Collaborate With Your Community Partners to Improve Health

Vaccine Information and Behavioral Health Resource Guide

Wednesday, Aug. 9
10-11 a.m.

Register!

Speakers

- *Raybun Spelts, PharmD, MPH, BCIDP*, Clinical pharmacist specialist, infectious disease and vaccines, Georgia Department of Public Health
  - Dr. Spelts will share vaccine information and updates.
- *Alysia Poon, principle*, Elbert Partners for Health, Inc.
  - Alysia will give an overview of the behavioral health resource guide.

We encourage you to forward to any community partners that may benefit from joining.

About the Program: The Partnership for Community Health
GHA has partnered with Alliant Health Solutions to bring together diverse community members, partners, and providers at the local level to collaborate on data-driven improvement initiatives. The **Partnership for Community Health** (PCH), made possible through a contract with the Centers for Medicare & Medicaid Services (CMS), is a national movement focused on improving areas such as behavioral health, patient safety, care coordination, and public health. Participants are grouped geographically and are comprised of health care practitioners, providers, and/or members from various clinical settings, health care groups, non-clinical organizations, and local community support/service organizations as indicated by CMS. These local coalitions will gather quarterly to share their experiences in an all-teach, all-learn environment.

Resource Links to Download for Full CMS Guidance on Health Equity

File Name	File Type	File Size	
Attestation Guidance for the Hospital Commitment to Health Equity Measure (12/2022)	PDF	481 KB	Download
Hospital Commitment to Health Equity Structural Measure Specifications (12/2022)	PDF	251 KB	Download
Screening for Social Drivers of Health Measure and the Screen Positive Rate for Social Drivers of Health Measure (December 2022)	PDF	122 KB	Download
Frequently Asked Questions: Social Drivers of Health (SDOH) Measures	PDF	281 KB	Download

Source: https://qualitynet.cms.gov/inpatient/iqr/measures#tab2

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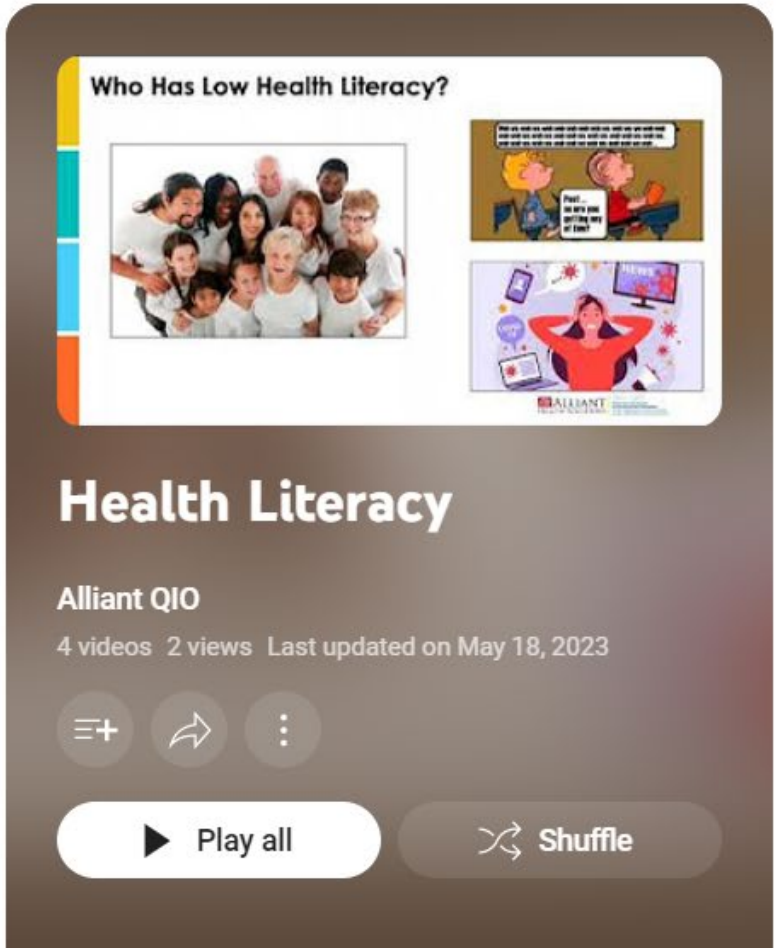
Training Staff on CLAS Standards (*Alliant CLAS Videos*)



1 

Health Literacy with Dr. Iris Feinberg, PhD, CHES

Alliant QIO • 116 views • 3 months ago

2 

Bite-Sized Learning: Using Teach-Back

Alliant QIO • 26 views • 8 days ago

3 

Bite-Sized Learning: CLAS 101

Alliant QIO • 37 views • 1 month ago

4 

Bite-Sized Learning: CLAS Implementation

Alliant QIO • 38 views • 1 month ago

Source: Link

Alliant Health Solutions Health Equity Coaching Package

HEALTH EQUITY COACHING PACKAGE

Purpose: Use the evidence-based best practices and resources to create quality improvement action plans.

Category	Best Practices/Interventions	Links to Resources, Toolkits, Webinars, Etc.
Beginning Health Equity Journey	Begin health equity journey with planning and preparation	Roadmap for Success: Implementing Equitable Care (HSAG HQIC, 2021) Health Equity Snapshot: A Toolkit for Outcomes The Health Equity Roadmap (AHA/IFDHE)
	Become familiar with federal and private sector definitions, standards and requirements for hospital health equity	CMS New SDOH Standards - Remington Report
		NPSG.16.01.01 Improving health care equity for the hospital's patients is a quality and safety priority
		CMS Health Equity Fact Sheet
		CMS Health Equity Programs
		CMS Framework for Health Equity 2022 - 2032
		The Joint Commission Health Equity R3 Report
	Conduct an equity of care gap analysis	Health Equity Organizational Assessment (MHA)
	Review resources on best practices for effective hospital health equity implementation	A Practical Guide for Implementing Hospital Health Equity - AHS HQIC LAN
		AHS Health Equity Presentation to Alabama Hospital Association
		Change Path of Health Equity Resources (Feb 28, 2023)
		Building an Organizational Response to Health Disparities (CMS, 2020)* *Contains links to other resources

https://quality.allianthealth.org/wp-content/uploads/2023/04/2023-Coaching-Package-Health-Equity_508.pdf


Questions?
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