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Emerging Community-Clinical Teams

November 7, 2024 | 2:00-3:30 p.m. ET

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A Few Reminders

- ✓ Please introduce yourself and your organization in the chat
- ✓ Recording and slides will be shared following this session of the Health Equity Learning Collaborative
- ✓ Please keep yourself muted unless you have a question. We will have time for questions, but feel free to raise your hand at any time.
- ✓ A live transcript of the meeting is available. To turn on closed captioning, click on the upward arrow next to Live Transcript and select “Captions.” The Captions option may also be available under the icon labeled “More.”

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Agenda

1. Welcome and Introductions
2. Identifying priority populations that are disproportionately impacted by HRSNs
3. Discussion
4. Next Steps and Survey: https://forms.gle/sUd1Mu7DGHNQJEZZ8

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NCQA HEDIS Measure

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2023 HEDIS® SDOH Measure

- The percentage of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing and transportation needs, **and** received a corresponding intervention if they screened positive.
- **Percentage of members that screen positive and receive a corresponding intervention within 1 month of identifying a need**
- Key SDOH Categories
  - Food
  - Housing
  - Transportation

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SNS-E Social Need Domains

Food Insecurity

Uncertain, limited, or unstable access to food that is: adequate in quantity and in nutritional quality; culturally acceptable; safe and acquired in socially acceptable ways.

Housing Insecurity

Housing Instability or homelessness

Behind on rent or mortgage, cost burden, risk of eviction, in temporary housing due to financial difficulty or living in environment not meant for human habitation.

Inadequate Housing

Housing does not meet habitability standards

Transportation Insecurity

Uncertain, limited, or no access to safe, reliable, accessible, affordable, and socially acceptable transportation infrastructure and modalities necessary for maintaining one's health, well-being, or livelihood.

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NCQA SNS-E Measure: Food Insecurity Screening

- The percentage of members who are screened for food insecurity.

$$\frac{\text{Number of members that were } \textbf{screened}}{\text{Universe of health plan members – exclusions}} \times 100$$

Exclusions: Hospice, I-SNP, Long term Care Insurance

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NCQA SNS-E Measure: Food Insecurity Intervention

- The percentage of members who received an intervention after a positive screen.

$$\frac{\text{Number of members that received an } \textbf{intervention } \textbf{within 30 days} \text{ of a positive screen}}{\text{Universe of health plan members with a positive screen}} \times 100$$

Exclusions: Hospice, I-SNP, Long term Care Insurance

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Exclusions: Hospice, I-SNP, Long term Care Insurance

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NCQA SNS-E Measure: Transportation Insecurity Screening

- The percentage of members who are screened for transportation insecurity.

$$\frac{\text{Number of members that were screened}}{\text{Universe of health plan members – exclusions}} \times 100$$

Exclusions: Hospice, I-SNP, Long term Care Insurance

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Exclusions: Hospice, I-SNP, Long term Care Insurance

Data Reporting Methods

- Primary method: Electronic Clinical Data Systems
  - Enrollment data
  - Claims (Z-Codes, LOINC, SNOMED)
  - Encounter
  - Electronic Health Records
  - Disease Registries
  - Case Management Notes

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Acceptable Intervention Actions for Data Reporting

- Assessment
- Assistance
- Coordination
- Counseling
- Education
- Evaluation of eligibility
- Provision
- Referral
- *Actions can be reported as SNOMED and LOINC codes

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Crosswalk Examples

Intervention Category	Example Intervention
Assessment	Assessment of contributing factors to HRSN. Assessment of barriers to implementing a HRSN care plan.
Assistance	Assistance with completing an application for assistance (i.e., SNAP, Heating Assistance, Medicaid Waiver, etc.).
Coordination	Coordination with HCBS providers according to the care plan.
Counseling	Counseling to determine problem solving skills and goal setting skills to overcome barriers to addressing HRSNs.
Education	Education about area resources for Food, Housing, Trans, etc.
Evaluation of Eligibility	Evaluation of the eligibility criteria for housing programs.
Provision	Provision of home-delivered meals.
Referral	Submission of a referral to a Social Service agency for assistance.

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Case Study: Mary

- Mary is screened by a community health worker and it is identified that she has housing insecurity on January 5th.
- On February 25th: A housing navigator meets with Mary to discuss options for housing.

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Case Study: John

- John was screened by the hospital on March 1st and it is determined that John has food insecurity.
- A referral is made to a food pantry on March 2nd.
- The Food Pantry has a waiting list and the food pantry gets back with John on June 1st. John is notified on June 1st that he can obtain assistance with food now that the waiting list have reduced in size.

Case Study: Susan

- Susan reports that she has difficulty getting to her appointments because of issues with transportation on July 7th.
- The CHW tries to reach Susan to address her transportation issues but is unable to reach her. The CHW leaves several messages for Susan to call back.
- On September 5th, Susan calls back and reports that she was admitted to the hospital during this time and just had an opportunity to call back. Susan reports that she still has issues with transportation.

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SNP Plan Requirement

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MA SNP Plan CY2024 Requirement

- CMS SNP Memo Quote:
  - "The purpose of this memorandum is to provide guidance on the screening instruments available for Medicare Advantage (MA) special needs plans (SNPs) to meet the new requirement to include one or more questions on housing stability, food security, and access to transportation in their health risk assessments (HRAs) beginning in contract year (CY) 2024."
- Regulation: All MA SNP HRAs must include at least one question from a list of screening instruments specified by CMS in sub-regulatory guidance on each of three domains (housing stability, food security, and access to transportation) beginning in CY 2024

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MA SNP Plan CY2024 Requirement Compliance

- Options for compliance:
  - Use a state-required screening instrument that includes questions on the required domains.
  - Select questions on the required domains from validated, health information technology (IT)- encoded screening instruments.
- Required Domains: a) Food Security, b) Housing Stability, and c) Access to Transportation
- Approved Tool: Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool
- Screening Outcome reporting to plans: Option – Z-Code Reporting.
  - Requires the ability to do the screen and submit claims

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Z-Code Reporting

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HRSN Screening Process and Tool

- Evidence-Based HRSN Screening Tool
  - CMS AHC HRSN Tool
  - https://www.cms.gov/priorities/innovation/files/worksheets/ahcm-screeningtool.pdf
- Domains Screened (10 Core Questions)
  - Housing Instability
  - Food Insecurity
  - Transportation problems
  - Utility help needs
  - Interpersonal safety

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Data Capture and Reporting – Housing Instability

Inadequate, inadequacy	Instability	Lack of	Person without	Problem related to
1. Environmental temperature Z59.11 2. Heating Z59.11 3. Space Z59.19 4. Utilities Z59.12 5. NEC Z59.19 (NEC = Not Elsewhere Classifiable)	1. Unstable housed Z59.819 2. Housed but hx of homelessness in past 12 months Z59.812 3. Risk of homelessness Z59.811	1. Permanent housing Z59.10 2. Lack of adequate housing Z59.10 3. Living in shelter, motel, or scattered site housing Z59.01	1. w/o adequate housing Z59.10 2. w/o air conditioning Z59.11 3. w/o environmental temperature Z59.11 4. w/o heating Z59.11 5. w/o adequate space Z59.19 6. w/o permanent housing (temp.) Z59.00	1. Housing Z59.9 2. Inadequate housing 3. Isolated Z59.89 4. NEC Z59.89 5. Restriction of housing space Z59.19

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Data Capture and Reporting – Food Insecurity

- ICD-10-CM Lookup Tool: https://icd10cmtool.cdc.gov/?fy=FY2024

Description	Code(s)
Food Insecurity (Limited supply of food)	Z59.41
Inadequate food supply (Have food but not the supply does not meet my needs)	Z59.48
Lack of adequate food (Have access to the wrong types of food)	Z59.48

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Data Capture and Reporting - Transportation

- ICD-10-CM Lookup Tool: https://icd10cmtool.cdc.gov/?fy=FY2024

Description	Code(s)
Excessive Transportation Time (2 hour trip to dialysis)	Z59.82
Inaccessible Transportation	Z59.82
Inadequate Transportation	Z59.82
Insecure Transportation	Z59.82
Lack of Transportation	Z59.82
Unaffordable Transportation	Z59.82
Unreliable Transportation	Z59.82
Unsafe Transportation	Z59.82

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Data Capture and Reporting - Utilities

- ICD-10-CM Lookup Tool: https://icd10cmtool.cdc.gov/?fy=FY2024

Inadequate, inadequacy	Person without
1. Environmental temperature Z59.11 2. Heating Z59.11 3. Space Z59.19 4. Utilities Z59.12 5. NEC Z59.19	1. w/o adequate housing Z59.10 2. w/o air conditioning Z59.11 3. w/o environmental temperature Z59.11 4. w/o heating Z59.11

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Example Screening Process - Housing

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

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Additional Relevant Z-Codes

Description	Code
Problems related to education and literacy	Z55
Problems related to employment and unemployment	Z56
Occupational exposure to risk factors	Z57
Problems related to physical environment	Z58
Problems related to housing and economic circumstances	Z59
Problems related to social environment	Z60
Problems related to upbringing	Z62
Other problems related to primary support group, including family circumstances	Z63
Problems related to psychosocial circumstances	Z64

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Best Practice

- Develop a process to segment the population to target persons that are most at risk or would benefit the most from social needs interventions.
- Data can be cross referenced with clinical data.
- Cross referencing HRSNs with demographic and clinical data can show specific trends to support targeting priority populations.

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Data Cross References

- Persons with HRSNs and a clinical diagnoses that are disparity sensitive.
- Demographic cross references: race, gender, ethnicity, rural status.
- Clinical cross references: recent hospital admission, diagnosis group, behavioral health condition, SUD history, disease indicators.
- Examples of disease indicators: HgbA1C, Blood pressure, etc.

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Disparity Data

CMS Study on the Impact of Social Determinants

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Examining the Potential Effects of Socioeconomic Factors on Star Ratings*

Center for Medicare

September 8, 2015

*The research presented is sponsored by CMS under contract HHSM-500-2013-00283G and performed by the RAND Corporation. The RAND Team included the work of Melony Sorbero, Ann Haas, Cheryl Damberg, Marc Elliott, and Susan Paddock.

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Orange Measures: Statistically Significant Results Showing a negative effect of being LIS/DE

Likelihood of Receiving Recommended Care or Outcomes

HEDIS Measure (MA Contracts)	LIS/DE Adjustment Odds Ratio	Disability Adjustment Odds Ratio
Adult BMI Assessment	1.11***	0.93***
Rheumatoid Arthritis Management	0.85***	1.17***
Breast Cancer Screening	0.69***	0.72***
Controlling High Blood Pressure	0.99	1.02
Diabetes Care – Blood Sugar Controlled	0.68***	0.63***
Diabetes Care – Eye Exam	0.93***	0.68***
Diabetes Care – Kidney Disease Monitoring	0.93***	0.69***
Colorectal Cancer Screening	0.87***	0.47***
Osteoporosis Management in Women who had a Fracture	0.71***	0.56***
Plan All-Cause Readmissions#	0.87***	N/A&
Annual Flu Vaccine	0.85***	0.72***

NOTE: Separate analyses conducted for LIS/DE and Disability adjustment. Models control for between-contract differences.
Measure is reverse-coded to make interpretation of Odds Ratio the same as other measures.
* Significant at p<0.05 ** Significant at p<0.01 *** Significant at p<0.001
Blue Odds Ratio greater than 1.0 indicates a significant positive effect of being LIS/DE or Disabled.
Orange Odds Ratio less than 1.0 indicates a significant negative effect of being LIS/DE or Disabled.
Black Odds Ratio indicates no significant effect.
& Not further adjusted for Disability. Readmissions is adjusted for factors that might be part of a person's reason for Disability.

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Orange Measures: Statistically Significant Results Showing a negative effect of being LIS/DE

Likelihood of Receiving Recommended Care or Outcomes

HOS and PDE Measure (MA Contracts)	LIS/DE Adjustment Odds Ratio	Disability Adjustment Odds Ratio
Monitoring Physical Activity	0.98	1.34***
Reducing the Risk of Falling	1.67***	1.32***
Medication Adherence for Diabetes Medications^	0.94***	0.75***
Medication Adherence for Hypertension^	0.86***	0.72***
Medication Adherence for Cholesterol^	0.94***	0.79***

NOTE: Separate analyses conducted for LIS/DE and Disability adjustment. Models control for between-contract differences.
* Significant at p<0.05 ** Significant at p<0.01 *** Significant at p<0.001
Blue Odds Ratio greater than 1.0 indicates a significant positive effect of being LIS/DE or Disabled.
Orange Odds Ratio less than 1.0 indicates a significant negative effect of being LIS/DE or Disabled.
Black Odds Ratio indicates no significant effect.
^The sample sizes for PDE were very large, so very small differences become statistically significant

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Disparity Sensitive Measures

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National Quality Forum (NQF) High-Impact Medicare Conditions

1. Major Depression 2. CHF 3. Ischemic Heart Disease 4. Diabetes 5. Stroke 6. Alzheimer's disease 7. Breast cancer	8. COPD 9. Heart attack 10. Colorectal Cancer 11. Hip/Pelvic Fracture 12. CKD 13. Prostate Cancer 14. Arthritis 15. A-Fib

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Example Population: Women with a Hip Fracture

- NCQA HEDIS Measure: Osteoporosis Management in Women Who Had a Fracture: Assesses women 67–85 years of age who suffered a fracture and who had either a bone mineral density test or a prescription for a drug to treat osteoporosis in the six months after the fracture.
- Coordination of transportation to prioritize bone density testing and/or prescription assistance with obtaining drug to treat osteoporosis in the six months after a fracture.
- Impact of HRSNs:
  - Transportation Insecurity
  - Housing Insecurity

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Targeting HRSN Interventions

- Impact of HRSNs:
  - Transportation Insecurity
  - Medication Access
  - Housing Insecurity

- Coordination of transportation to prioritize bone density testing within six months of fracture. Accessible transportation coordination may be a priority.
- Assistance with obtaining prescriptions required to treat osteoporosis in the six months after a fracture.
- Housing inadequacy if it cannot meet accessibility requirements.

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Next Steps

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UPDATE: We want to hear from you!

- **Survey re: HELC Curriculum and Close Out: https://forms.gle/dugxC7VGSUbDGvAT9**
- **November HELC Sessions**
  - **November 21** @ 2:00-3:30 p.m. ET, HELC ECHO Session for **ADVANCED Community Clinical Teams**

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Learning Collaborative Resources

- HELC ECHO Sessions Recordings & Resources: https://www.partnership2asc.org/healthequity/helc-resources/
- Partnership CHI/PIN Implementation Resources and Events: https://www.partnership2asc.org/implementation-resources/
- Freedmen's Health Consulting Implementation Resources: https://communityintegration.info

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More Information About the HELC

- Overview: www.partnership2asc.org/heathequity/
- FAQ: www.partnership2asc.org/FAQ
- Example: https://www.partnership2asc.org/healthequity/example-participating-market/
- Health Plan Outcomes: https://www.partnership2asc.org/healthequity/healthplanoutcomes/
- CHI Implementation: https://www.partnership2asc.org/healthequity/chiimplementation/

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Thank you!

Tim McNeill, RN, MPH

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