Integrating the Accountable Health Communities Model to Assess and Address SDOH in Home Care

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Health Equity Lead

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Agenda

- The Importance of Patient Data Collection to Address Health Disparities
- Overview of the CMS Accountable Health Communities (AHC) Health-Related Social Needs Screening Tool
- AHC Case Studies for Culturally Responsive Approaches to Screening
- What To Do Once the HRSN Data is Collected
- Challenges to Screening
- Z-Codes
- Discussion

The IPRO QIN-QIO

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

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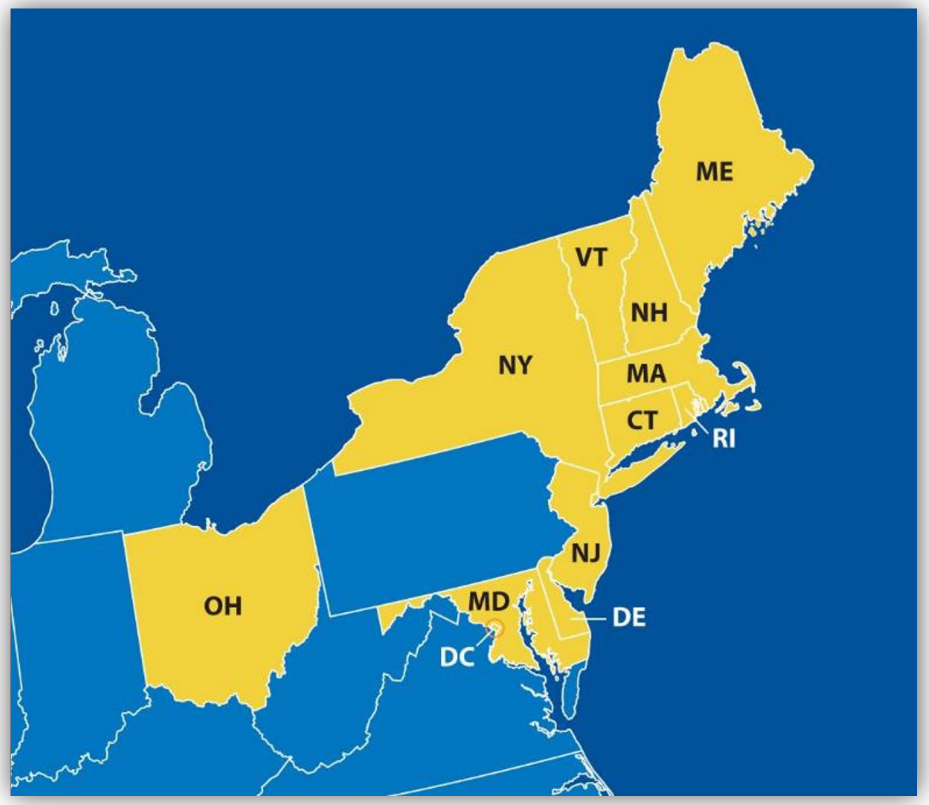

Working to ensure high-quality, safe healthcare for
20% of the nation's Medicare FFS beneficiaries

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Aligning Quality Goals

Improving Care Transitions to Reduce Unnecessary Hospitalization

Reducing Opioid-Related Adverse Events

Promoting Chronic Disease Management

Supporting Immunizations

Enhancing Patient Safety

Advancing Infection Control Strategies & Emergency Preparedness

Partnership for Community Health

Health Equity – Patient & Family Engagement – Health Information Technology

Patient Data is Foundational to Identifying Disparities & Unmet Social Needs

1. Commit to collecting high-quality patient sociodemographic data to identify and address disparities and unmet social needs.

2. Identify opportunities for improvement in your organization's ability to collect, validate, stratify, and analyze patient sociodemographic data to identify and address disparities.

3. Take action by developing and implementing a plan to address the opportunities to improve the collection and utilization of patient sociodemographic data to identify and address disparities.

Sociodemographic Data

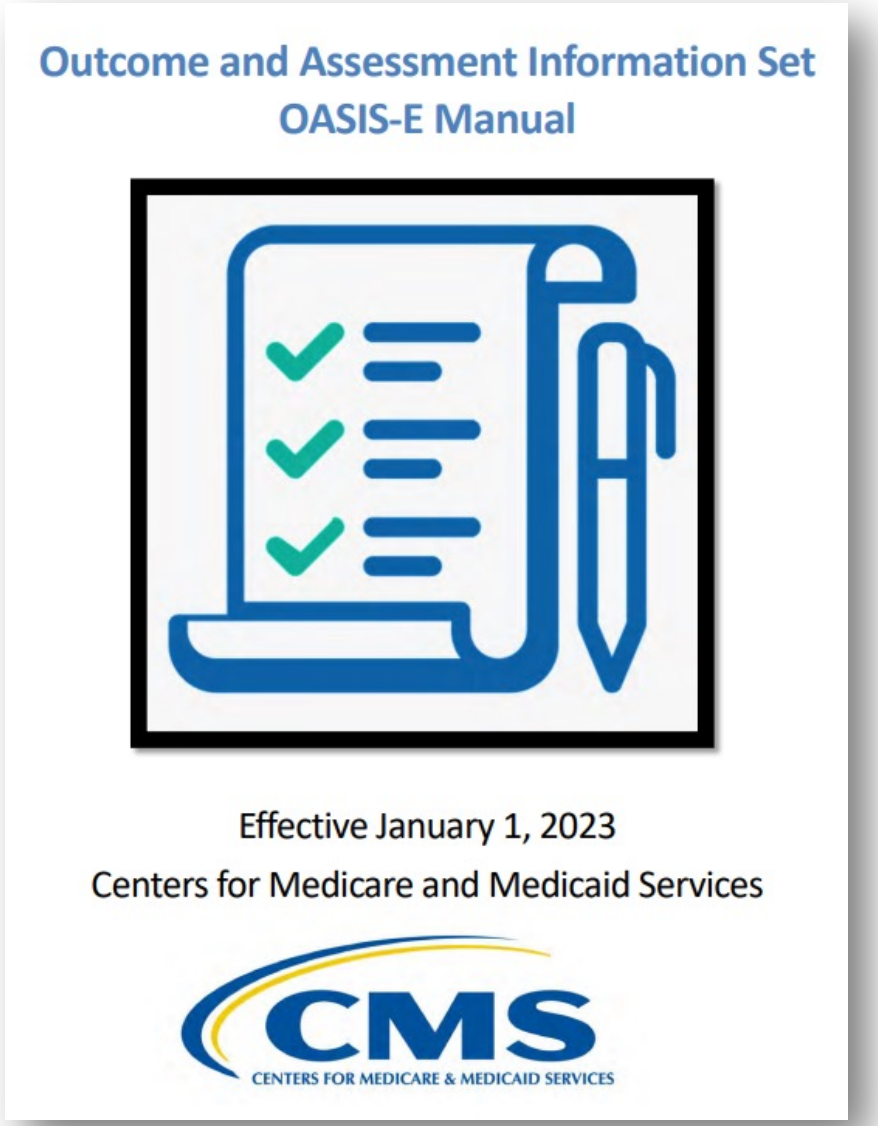
- Race
- Ethnicity
- Sex (assigned at birth)
- Sexual Orientation / Gender Identity (SOGI)
- Preferred Language
- Disability Status

- Social Risk Factors:
  - food insecurity
  - transportation barriers
  - housing instability
  - interpersonal safety
  - utilities difficulties
  - social isolation
  - poverty

Sources of Patient Data

Publicly Available	Internal
• Mapping Medicare Disparities Tool	• EHR/EMR
• Area Deprivation Index (ADI)	• Social Needs Assessments
• Social Vulnerability Index (SVI)	• Medicare Claims Data
• America's Health Rankings	• Proprietary Analytic Platforms
• SDOH Dashboard Action Tool	• Patient / Provider Surveys
• County Health Rankings & Roadmaps	• ICD-10-CM Codes

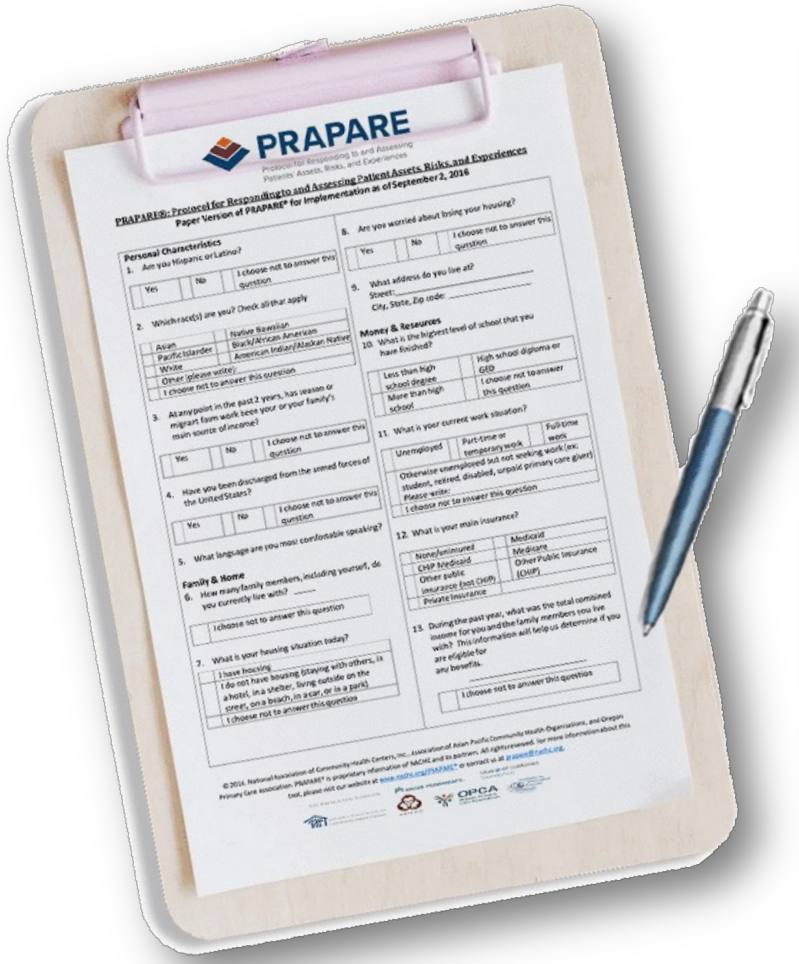
OASIS Section A

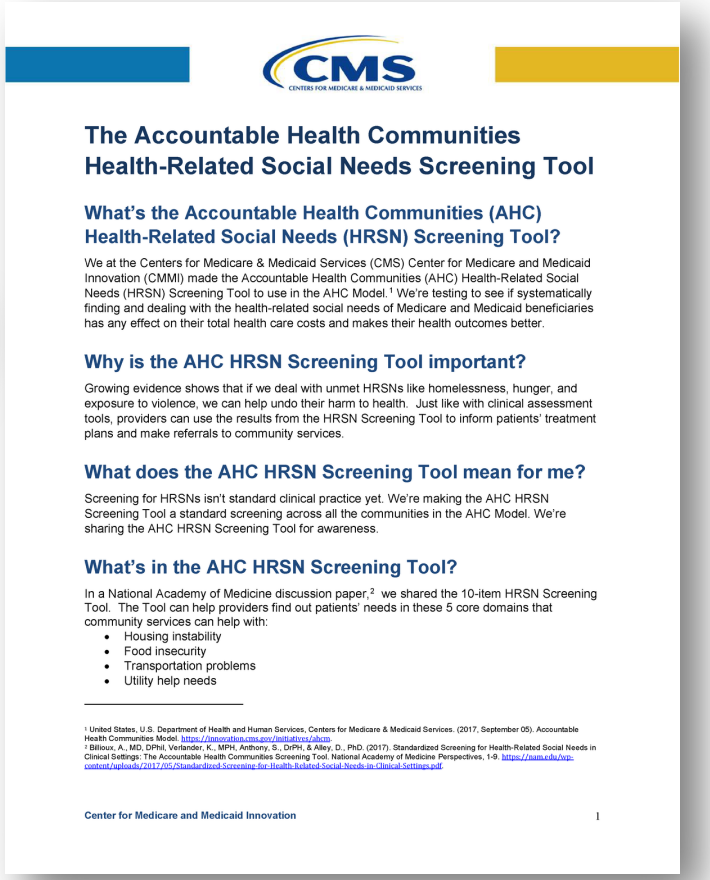


- A1010: Race
- A1005: Ethnicity
- A1110: Language
- M0069: Gender
- A1250: Transportation
- M0150/M0065/M0065: Dual Eligibility
- M0060: Zip Code

https://www.cms.gov/medicare/quality/home-health/oasis-data-sets

Health-Related Social Needs Screening Tools





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The Accountable Health Communities Health-Related Social Needs Screening Tool

What's the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool?

We at the Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMMI) made the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool to use in the AHC Model.[1] We're testing to see if systematically finding and dealing with the health-related social needs of Medicare and Medicaid beneficiaries has any effect on their total health care costs and makes their health outcomes better.

Why is the AHC HRSN Screening Tool important?

Growing evidence shows that if we deal with unmet HRSNs like homelessness, hunger, and exposure to violence, we can help undo their harm to health. Just like with clinical assessment tools, providers can use the results from the HRSN Screening Tool to inform patients' treatment plans and make referrals to community services.

What does the AHC HRSN Screening Tool mean for me?

Screening for HRSNs isn't standard clinical practice yet. We're making the AHC HRSN Screening Tool a standard screening across all the communities in the AHC Model. We're sharing the AHC HRSN Screening Tool for awareness.

What's in the AHC HRSN Screening Tool?

In a National Academy of Medicine discussion paper,[2] we shared the 10-item HRSN Screening Tool. The Tool can help providers find out patients' needs in these 5 core domains that community services can help with:

- Housing instability
- Food insecurity
- Transportation problems
- Utility help needs

[1] United States, U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. (2017, September 05). Accountable Health Communities Model. https://innovation.cms.gov/initiatives/ahcm.
[2] Billioux, A., MD, DPhil, Verlander, K., MPH, Anthony, S., DrPhil, & Alley, D., PhD. (2017). Standardized Screening for Health-Related Social Needs in Clinical Settings: The Accountable Health Communities Screening Tool. National Academy of Medicine Perspectives, 1-9. https://nam.edu/wp-content/uploads/2017/05/Standardized-Screening-for-Health-Related-Social-Needs-in-Clinical-Settings.pdf.

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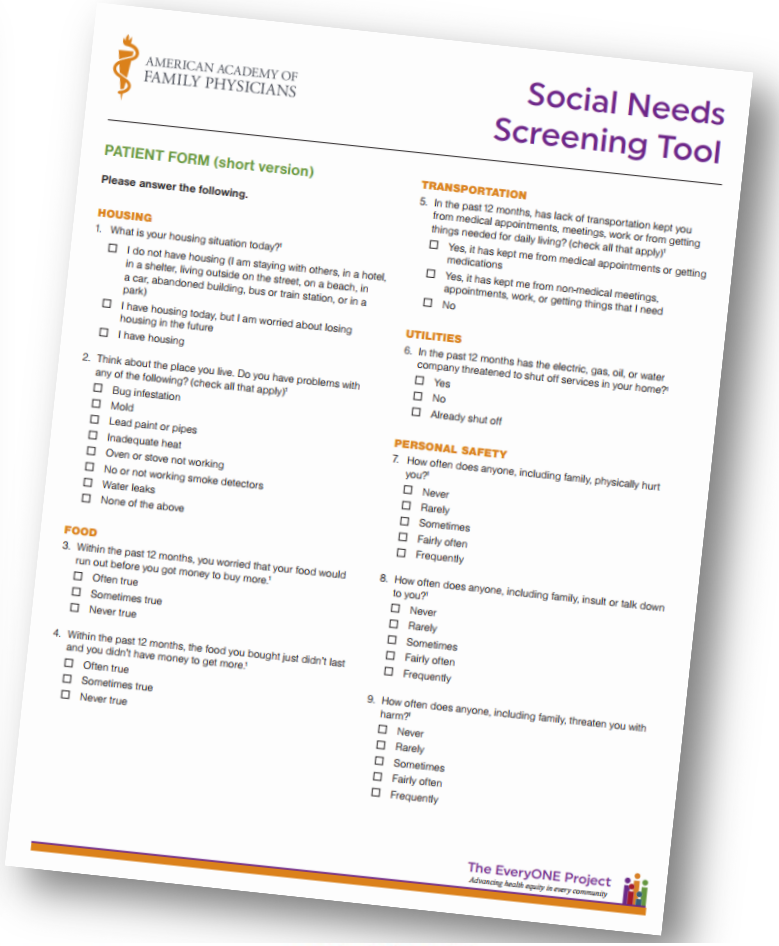

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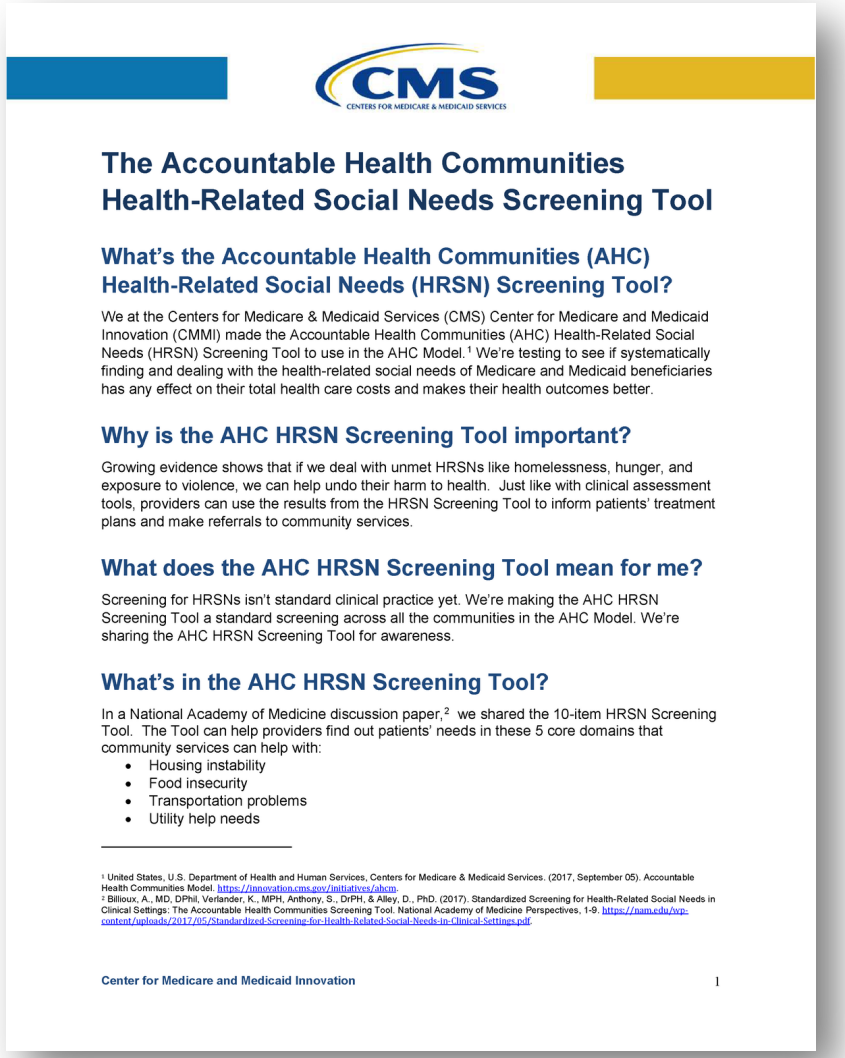
Methods of Collection



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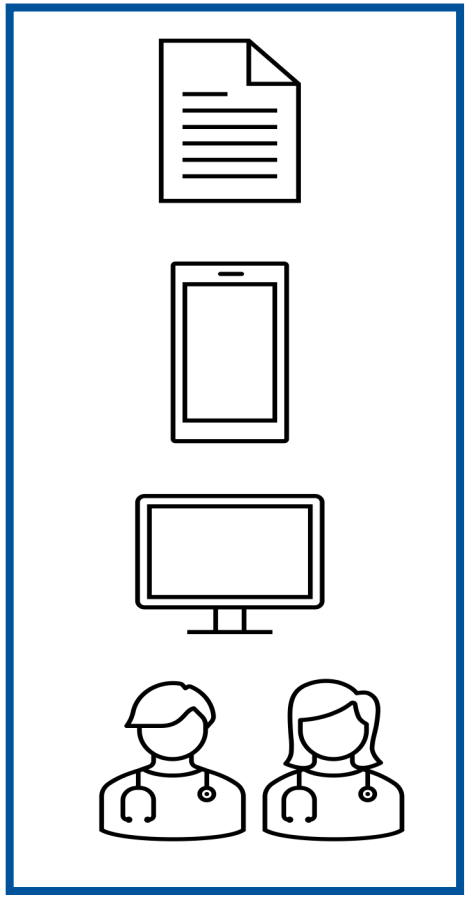
Ways to collect social needs data

- Paper Survey
- Tablet
- Patient Portal
- In-Person



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Discussion Question

Please share your responses in the chat

What methods are your organization using to collect HRSNs data?

- Paper form
- Tablet
- Patient portal
- In-person
- Other method

AHC Screening Tool Core Domains

- Living Situation
- Food
- Transportation
- Utilities
- Safety
- Financial Strain
- Employment
- Family and Community Support
- Education
- Physical Activity
- Substance Use
- Mental Health
- Disabilities

AHC Case Studies

Using Culturally Responsive Approaches to Screening for HRSN

Using Culturally Responsive Approaches to Screening

Identified Need	Solution	Case Study
Patients over age 65 tended to be less receptive to HRSN screening and navigation services.	An engagement strategy to highlight the value of HRSN screening in a way that resonates with this population and improves engagement.	Accountable Health Communities Model awardees communicate the value of addressing health-related social needs
Empowering and inspiring clinical site staff to address HRSNs and educating them on how and why to do so.	Staff participated in simulation activities to increase awareness of the impacts of poverty on individuals' lives and day-to-day decisions. Following the training, offers to screen increased by 160 percent.	A Spotlight on Aligning Clinical Partners to a Collective Vision to Address Health-Related Social Needs
How to continue HRSN screening during the COVID-19 public health emergency.	Launched an email campaign to conduct HRSN screening remotely. Used patient's preferred language and the screening tool was beneficiary-specific to increase trust, included PCP name, and was accessible by mobile devices. Result: four-fold increase in % of patients who identified a HRSN.	You've Got Mail! A Spotlight on Using Email to Screen for Health-Related Social Needs
Identifying promising practices to better engage patients for screening.	Met in-person for patients who prefer this method of contact, used motivational interviewing that focuses on patients' strengths and self-efficacy, and used multiple methods of contact for those patients with housing insecurity.	Promising Strategies For Community Service Navigation: Lessons From Health Quality Innovators

Using Culturally Responsive Approaches to Screening

Identified Need	Solution	Case Study
How to use technology to advance health equity.	• Provides access to culturally competent screening tools and referral resources in languages appropriate to the community. • Collects, stores, and analyzes race, ethnicity, and language data to understand patient population and existing disparities. • Offers internships to surrounding schools and recruits bilingual interns. Bilingual staff are helpful in reaching non-English-speaking beneficiaries and connecting them to community resources.	Advancing Screening, Referral, and Navigation Beyond the AHC Model
How to foster trust and build confidence in patients to increase HRSN screenings.	• Uses customized scripts to engage patients in screening. • Co-creates scripted language with screening staff to help staff set the right tone with patients in a way that reflects their personal style and increases the chance that a patient will agree to participate in screening. • Developed introductory screening scripts to describe the screening programs to better enlist patients in screening.	A Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tool: Updated August 2022 Promising Practices and Key Insights

CMS AHC Promising Practices and Key Insights

Population	Screening-Related Challenges	Strategies
Patients with behavioral health needs	Patients may lack trust in the staff, providers, or health care system, and it may take longer to screen them.	• Train staff on communication strategies (for example, active listening and trauma-informed care) and draw on partnerships with peer supports, behavioral health providers, and community services to build trust and rapport with patients. • Ensure staff are prepared to spend extra time assisting patients with behavioral health needs.
Elderly patients	Patients may refuse screening because of stigma, fear of losing independence, or privacy concerns.	• Train screeners on using empathic inquiry and active listening techniques to engage elderly patients. • Enlist student or elderly volunteers who may be able to spend more time with patients.
Patients with disabilities	Staff may have unconscious biases or make assumptions based on patients' ability.	• Enlist the expertise of diversity and inclusion committees to train staff on respectfully engaging patients with disabilities. • Ensure that staff allow extra time to accommodate visual, hearing, or cognitive impairments.
Patients with low literacy	Patients needing assistance may not feel comfortable asking for it.	• Train staff on how to identify patients with low literacy and offer assistance by reading questions.

A Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tool: Updated August 2022 Promising Practices and Key Insights

CMS AHC Promising Practices and Key Insights

Population	Screening-Related Challenges	Strategies
Patients from racial or ethnic groups that differ from staff	Staff may have unconscious biases or make assumptions based on patients' physical appearance or race/ethnicity.	• Enlist the expertise of diversity and inclusion committees to help staff recognize cultural differences, biases, and assumptions, and to promote cultural sensitivity.
Non-English speakers	The AHC screening tool is publicly available in English, Spanish, Portuguese, Arabic, Chinese, Japanese, Korean, Vietnamese, Tagalog, German, and Ilocano. Note: the non-English translations were made using the multiuse version of the screening tool.	• Translate the AHC HRSN Screening Tool and any related materials to languages commonly spoken in the community. When developing translations, engage a native speaker in the process to ensure quality and be sure to consider the dialect. • Hire bilingual screeners who represent common languages in the population served, and use telephonic interpreting services.
Sexual and gender minorities (SGM)	Patients may not feel accepted at the screening site.	• Promote an inclusive and welcoming culture, train staff on SGM needs and hold staff accountable for creating a safe space. • Use signs, stickers, or flags to signal that the site is SGM friendly. • Note that the proxy and multiuse versions of the AHC HRSN Screening Tool include gender-neutral and inclusive language.

A Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tool: Updated August 2022 Promising Practices and Key Insights

What Should You Do Once You Have the HRSN Data?

Have a Plan in Place

- Prior to initiating HRSN screenings:
  - Train staff.
  - Establish a referral workflow or process.
  - Create and sustain partnerships with community-based organizations.
  - Identify social service providers (e.g., social workers, care managers, patient navigators)..
  - Identify appropriate resources and services.
    - All screening and referral staff should be aware of and have access.

[A Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tool: Promising Practices and Key Insights]

[American Hospital Association: Screening for Social Needs: Guiding Care Teams to Engage Patients]

When a Patient Screens Positive

- Ask the patient if they would like support
  - Through shared-decision making, offer to help them prioritize their needs.
  - Consider using trauma-informed techniques, empathic inquiry, and culturally appropriate language when discussing HRSNs.
  - Ensure sufficient time to discuss the HRSN(s) with patients.
  - Consider developing tailored scripts to address different HRSNs, different languages, and cultural differences.
- Anticipate challenges
  - Shame, fear, stigma, trauma associated with HRSNs.
  - Perceived power imbalance between staff and patient.
  - Social and cultural norms.

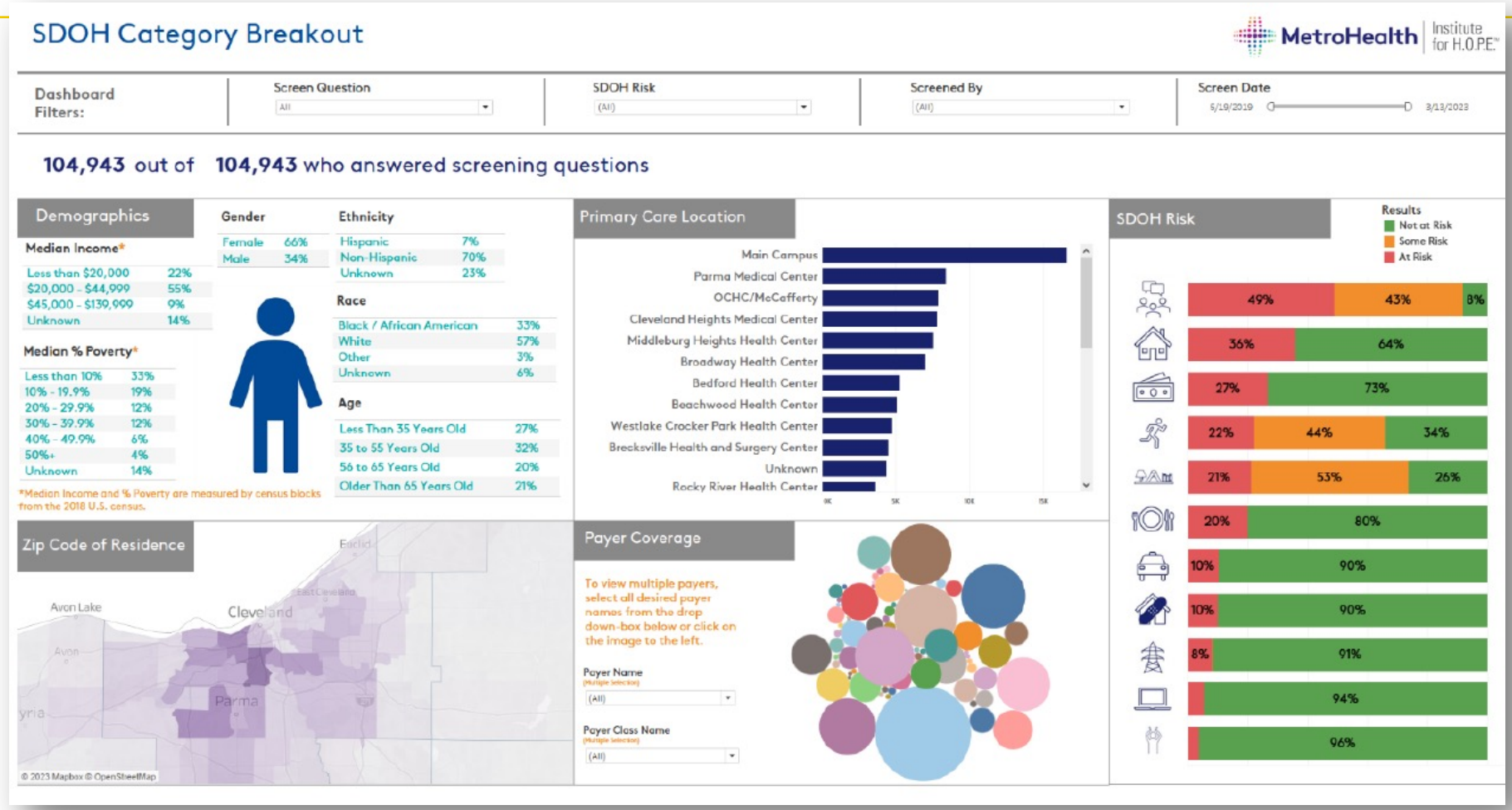
Once the Patient is Referred

- Document HRSNs using ICD-10 Z-codes.
- Follow closed loop procedures to ensure the patient is connected to appropriate resources or services and are not lost in the process.
- Use bidirectional data sharing between your agency and community partners to better understand outcomes such as whether:
  - Patients used the service(s) offered;
  - Patients' experience with the service/resource.
- Rescreen patients at regular intervals to determine whether the HRSN has resolved or if they need additional support.

Leveraging HRSN Data

- Review aggregate HRSN data across patients regularly to:
  - Understand overall trends in HRSNs including reductions in HRSNs over time among those patients screened.
  - Identify at-risk populations allowing for a targeted approach to improve screening and support of identified at-risk populations.
  - Reassess and recalibrate your approach to address HRSNs to meet evolving patient needs.
  - Prioritize development of new community partnerships, social services, and other resources.

Understand the Data



Eramo, Lisa. (May 9, 2023). "How Health Information Professionals Can Help Their Organization Leverage SDOH Data." https://journal.ahima.org/page/how-health-information-professionals-can-help-their-organization-leverage-sdoh-data

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Example HRSN Services

Food/Nutritional Insecurity	Utilities/Housing Instability	Transportation Barriers
• Supplemental Nutrition Assistance Program (SNAP) • Medically tailored meals • General meal services • Food vouchers / food cards • Home-delivered meals • Congregate meal settings	• Subsidies for utilities • Subsidies for rent or assisted living communities • Structural home modifications • Family & martial counseling • Access to companion care • Events to address isolation	• Parking / bus passes • Non-emergency / non-medical transportation • Local discount transportation services • Reimburse for transportation • Transportation vouchers: taxi, Uber, Lyft

Screening Challenges - Staff

- Staff may be reluctant to screen patients due to:
  - Discomfort or lack of confidence discussing social needs with patients.
  - Time required to appropriately and responsibly screen for and discuss HRSNs with patients.
  - Lack of a standardized process to screen patients and track referrals among those who screen positive.
  - Inability to adequately address patients' social needs.
  - Limited knowledge of available resources and/or lack of available resources.
  - Insufficient training on how to properly screen for and discuss HRSNs with patients.

Addressing Staff Reluctance

Screening Challenge	Best Practices
Staff discomfort	• Train staff on motivational interviewing and cultural sensitivity. • Educate on the importance of collecting HRSN data. • Share patient success stories.
Time required	• Integrate screening into workflows. • Encourage use of multiple modalities: phone, in-person, or via portal.
Lack of standardized process	• Select evidence-based screening tools such as PRAPARE and AHC HRSN. • Conduct Z-Code training and designate staff for data entry.
Inadequate IT infrastructure	• Select a platform with a central database that tracks referrals to community-based organizations.
Inability to address the need	• Engage social workers, case managers, and community health workers as appropriate.
Lack of knowledge about resources	• Collaborate with community-based organizations to identify available resources and educate staff on the resources.

Patient Screening Challenges

- Patients may be reluctant to answer screening questions or discuss their social needs due to:
  - Shame or embarrassment.
  - Concerns about how the information will be used and potential consequences of screening positive for a social need.
  - Stigma and bias from others and/or the community.
  - Perception of unequal power dynamic between the patient and person/agency collecting the data.
  - Systemic racism and discrimination in the healthcare system.
  - Discomfort sharing struggles or needs due to social and cultural beliefs.

Addressing Patient Reluctance

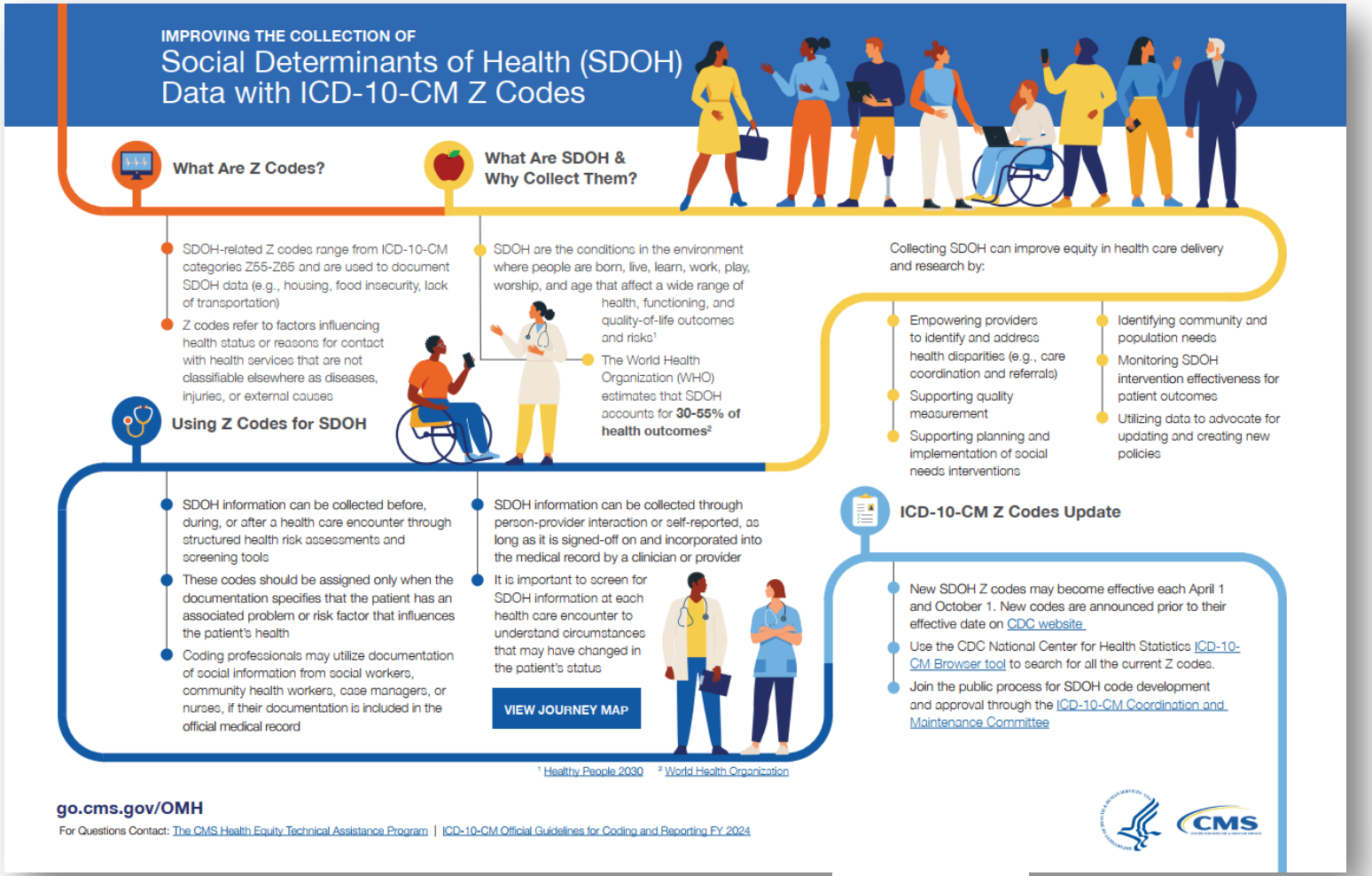
- Provide training and hire appropriate staff
  - Use empathic and motivational interview approaches, racial inequity, cultural competence, trauma-informed care.
  - Consider using community health workers from patients' communities.
- Build collaborative relationships with communities
  - Understand social and cultural differences, potential stigma, and bias around screening.
- Create a safe space
  - Discuss patient privacy and confidentiality of their data.
  - Offer to screen or discuss positive screening results in different settings (phone, telehealth, in-person).
  - Listen and learn from the patient to understand their concerns.

SDOH Z Codes

SDOH-related Z codes ranging from Z55-Z65 are the ICD-10-CM encounter codes used to document SDOH data.

Z55 Problems related to education and literacy	Z60 Problems related to social environment
Z56 Problems related to employment and unemployment	Z62 Problems related to upbringing
Z57 Occupational exposure to risk factors	Z63 Other problems related to primary support group
Z58 Problems related to physical environment	Z64 Problems related to certain psychosocial circumstances
Z59 Problems related to housing & economic circumstances	Z65 Problems related to other psychosocial circumstances

New CMS OMH Resource



IMPROVING THE COLLECTION OF Social Determinants of Health (SDOH) Data with ICD-10-CM Z Codes

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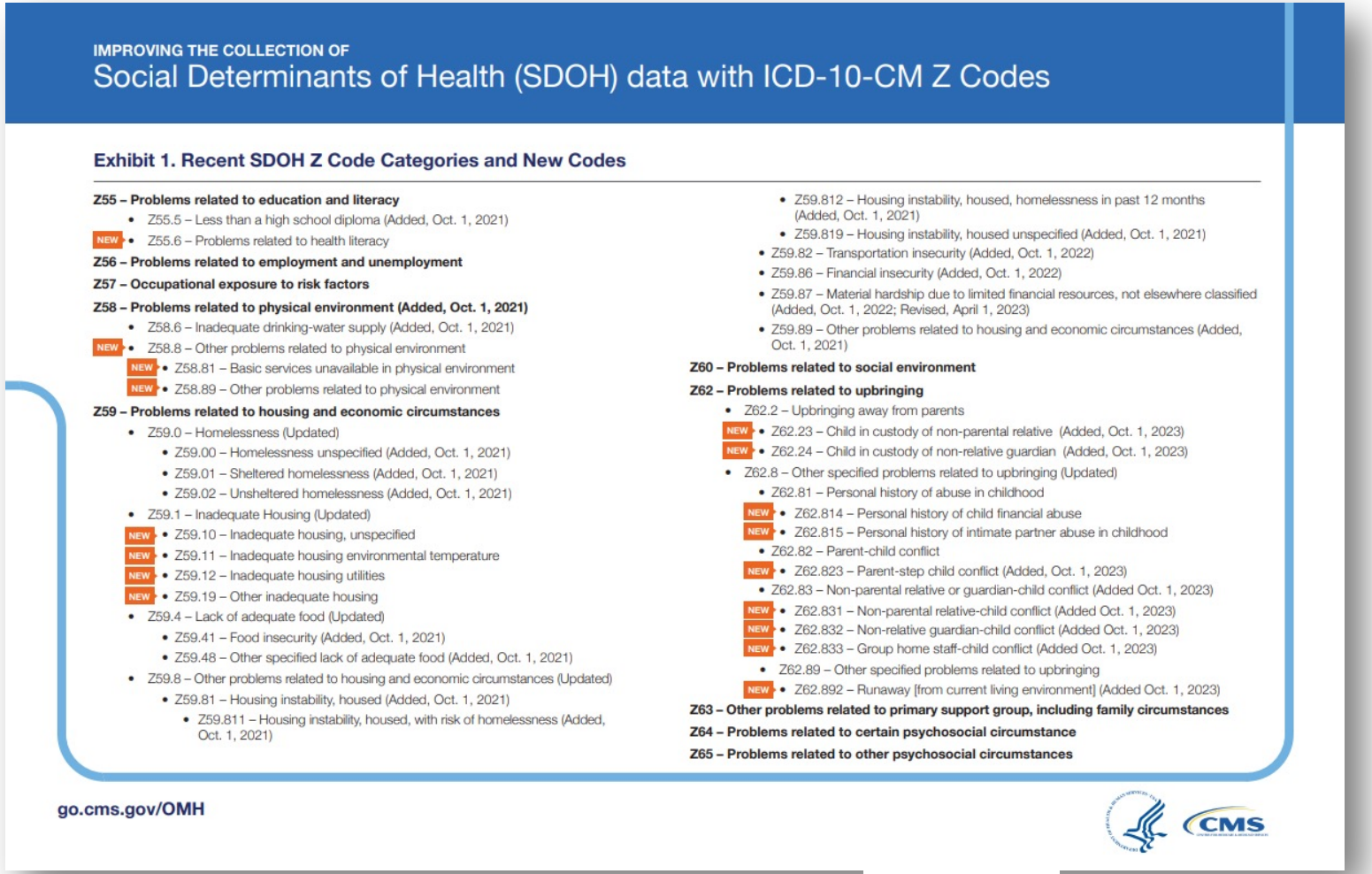

IMPROVING THE COLLECTION OF
Social Determinants of Health (SDOH) data with ICD-10-CM Z Codes

Exhibit 1. Recent SDOH Z Code Categories and New Codes

Z55 – Problems related to education and literacy
- Z55.5 – Less than a high school diploma (Added, Oct. 1, 2021)
- NEW • Z55.6 – Problems related to health literacy

Z56 – Problems related to employment and unemployment

Z57 – Occupational exposure to risk factors

Z58 – Problems related to physical environment (Added, Oct. 1, 2021)
- Z58.6 – Inadequate drinking-water supply (Added, Oct. 1, 2021)
- NEW • Z58.8 – Other problems related to physical environment
  - NEW • Z58.81 – Basic services unavailable in physical environment
  - NEW • Z58.89 – Other problems related to physical environment

Z59 – Problems related to housing and economic circumstances
- Z59.0 – Homelessness (Updated)
  - Z59.00 – Homelessness unspecified (Added, Oct. 1, 2021)
  - Z59.01 – Sheltered homelessness (Added, Oct. 1, 2021)
  - Z59.02 – Unsheltered homelessness (Added, Oct. 1, 2021)
- Z59.1 – Inadequate Housing (Updated)
  - NEW • Z59.10 – Inadequate housing, unspecified
  - NEW • Z59.11 – Inadequate housing environmental temperature
  - NEW • Z59.12 – Inadequate housing utilities
  - NEW • Z59.19 – Other inadequate housing
- Z59.4 – Lack of adequate food (Updated)
  - Z59.41 – Food insecurity (Added, Oct. 1, 2021)
  - Z59.48 – Other specified lack of adequate food (Added, Oct. 1, 2021)
- Z59.8 – Other problems related to housing and economic circumstances (Updated)
  - Z59.81 – Housing instability, housed (Added, Oct. 1, 2021)
    - Z59.811 – Housing instability, housed, with risk of homelessness (Added, Oct. 1, 2021)
    - Z59.812 – Housing instability, housed, homelessness in past 12 months (Added, Oct. 1, 2021)
  - Z59.819 – Housing instability, housed unspecified (Added, Oct. 1, 2021)
  - Z59.82 – Transportation insecurity (Added, Oct. 1, 2022)
  - Z59.86 – Financial insecurity (Added, Oct. 1, 2022)
  - Z59.87 – Material hardship due to limited financial resources, not elsewhere classified (Added, Oct. 1, 2022; Revised, April 1, 2023)
  - Z59.89 – Other problems related to housing and economic circumstances (Added, Oct. 1, 2021)

Z60 – Problems related to social environment

Z62 – Problems related to upbringing
- Z62.2 – Upbringing away from parents
  - NEW • Z62.23 – Child in custody of non-parental relative (Added, Oct. 1, 2023)
  - NEW • Z62.24 – Child in custody of non-relative guardian (Added, Oct. 1, 2023)
- Z62.8 – Other specified problems related to upbringing (Updated)
  - Z62.81 – Personal history of abuse in childhood
    - NEW • Z62.814 – Personal history of child financial abuse
    - NEW • Z62.815 – Personal history of intimate partner abuse in childhood
  - Z62.82 – Parent-child conflict
    - NEW • Z62.823 – Parent-step child conflict (Added, Oct. 1, 2023)
  - Z62.83 – Non-parental relative or guardian-child conflict (Added Oct. 1, 2023)
    - NEW • Z62.831 – Non-parental relative-child conflict (Added Oct. 1, 2023)
    - NEW • Z62.832 – Non-relative guardian-child conflict (Added Oct. 1, 2023)
    - NEW • Z62.833 – Group home staff-child conflict (Added Oct. 1, 2023)
  - Z62.89 – Other specified problems related to upbringing
    - NEW • Z62.892 – Runaway [from current living environment] (Added Oct. 1, 2023)

Z63 – Other problems related to primary support group, including family circumstances

Z64 – Problems related to certain psychosocial circumstance

Z65 – Problems related to other psychosocial circumstances

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[IMPROVING THE COLLECTION OF Social Determinants of Health (SDOH) Data with ICD-10-CM Z Codes]

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Q&A

Discussion Question

Please share your responses in the chat

What obstacles has your organization encountered when screening for health-related social needs?

Discussion Question

Please share your responses in the chat

Has your organization experienced any successes in terms of your processes or approaches to screening?

Discussion Question

Please share your responses in the chat

How is your organization leveraging its HRSN screening data to improve health equity?

Resources On Data Collection and Scripting

Center for Medicare & Medicaid Services (CMS)

- Accountable Health Communities Health-Related Social Needs Screening Tool https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf
- Accountable Health Communities Model Website https://www.cms.gov/priorities/innovation/innovation-models/ahcm
- Disparities Impact Statement https://www.cms.gov/about-cms/agency-information/omh/downloads/disparities-impact-statement-508-rev102018.pdf

National Association of Community Health Centers®

- PRAPARE®: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences https://prapare.org/the-prapare-screening-tool/

Fenway Institute

- SOGI Data Collection Resources https://www.lgbtqiahealtheducation.org/resources/in/collecting-sexual-orientation-and-gender-identity-data/

The Physicians' Foundation

- Take 5 Conversation Starter https://physiciansfoundation.org/take-five/

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- Social Determinants of Health: A Guide for Getting Started https://qi-library.ipro.org/2023/01/31/social-determinants-of-health-sdoh-a-guide-for-getting-started-for-getting-started/

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Have Questions? Contact us!

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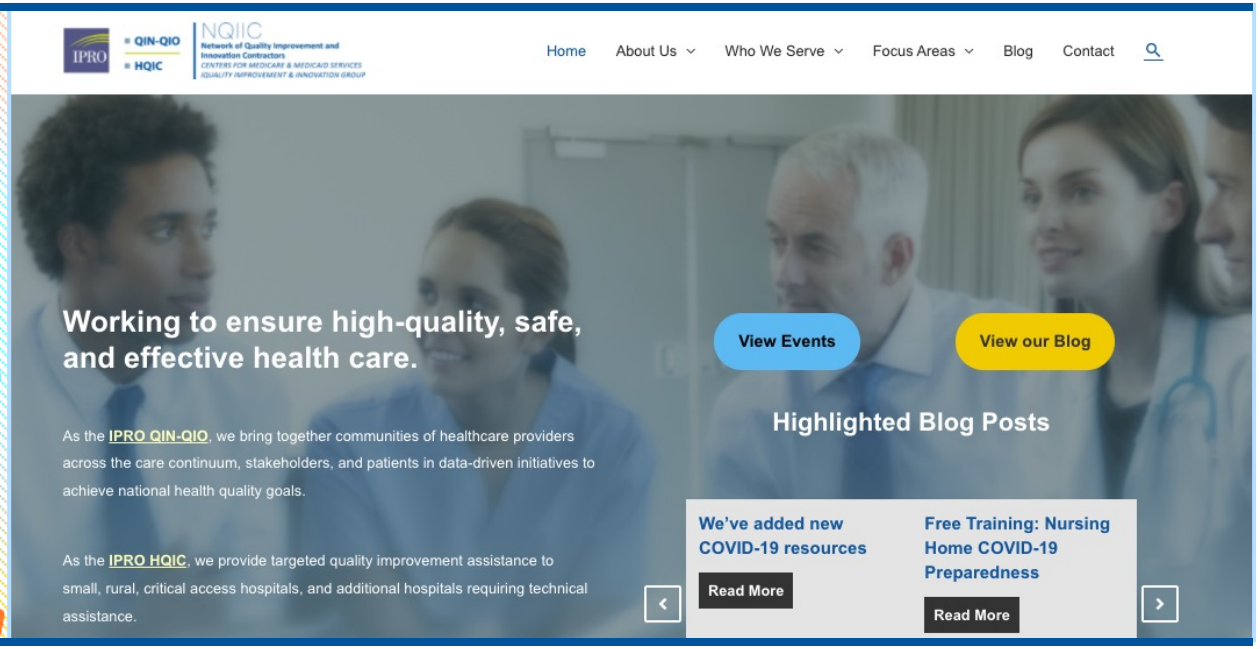

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