Building Community Partnerships

Creating connections to serve the whole patient

PRESENTED BY:

Aaryn Manning
Executive Director
Project Place

Nathaniel Buckholz
Team Coordinator for Community Partners Program
Boston Health Care for the Homeless Program

Emily Holzman, MPH
Director, Clinical Transformation
Azara Healthcare

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Today’s Presenters

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Nathaniel Buckholz

Team Coordinator for Community Partners Program

Boston Health Care for the Homeless Program

Aaryn Manning

Executive Director

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Director, Clinical Transformation

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Agenda

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INTRODUCING PROJECT PLACE AND BOSTON HEALTHCARE FOR THE HOMELESS

CURRENT CLIMATE ON COMMUNITY AND HEALTHCARE COLLABORATIONS

PANEL DISCUSSION

DRVS TOOLS TO SUPPORT COMMUNITY PARTNERSHIPS

Project Place and Boston Healthcare for the Homeless

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Project Place

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Boston Health Care for the Homeless Program

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BOSTON HEALTH CARE *for* *the* HOMELESS PROGRAM

Current Climate on Community and Healthcare Collaborations

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Value Based Payment (VBP) Models Acknowledging Health Equity

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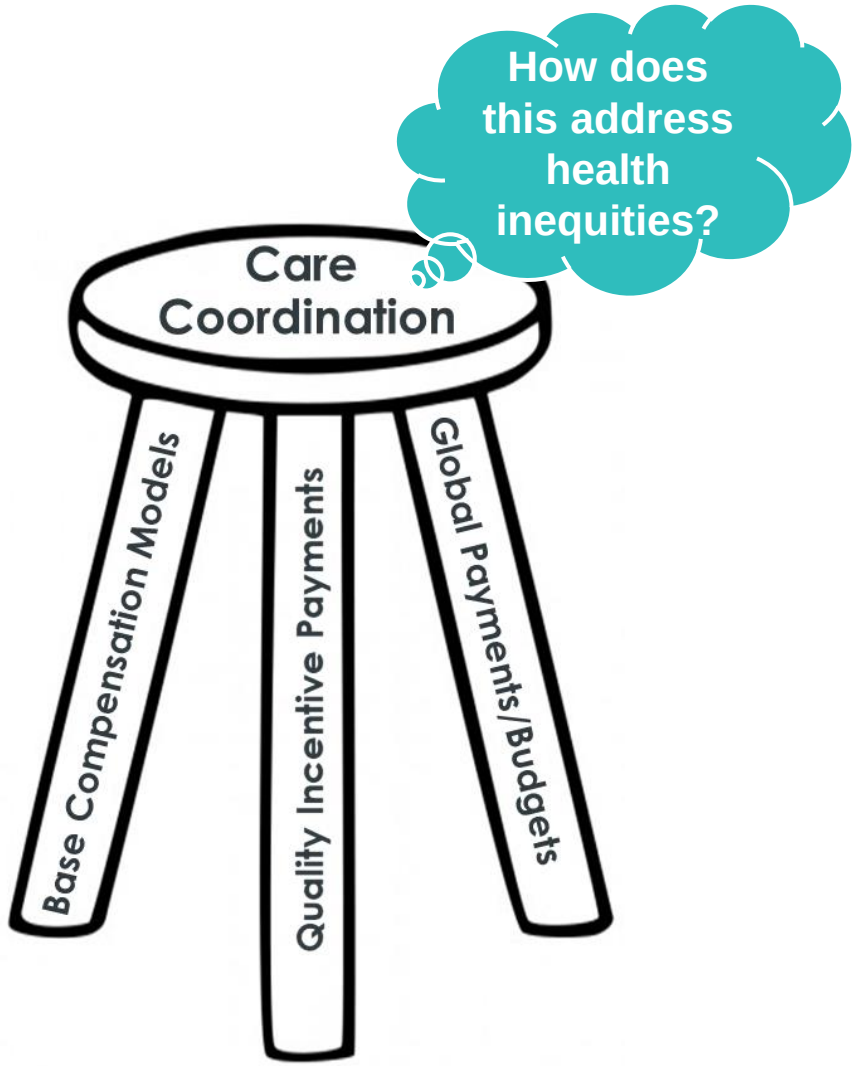
While the shift from Fee-For-Service (FFS) to VBP was welcome and necessary, it had a “Reverse Robinhood” effect[1]:

- Penalized providers who disproportionately serve patients who are worse off from low-income communities who may face barriers to care
- No requirements for health equity
- Disincentivized providers from participation because no upfront payments to address root causes of health inequities – felt that outcome won’t change



1. Society of General Internal Medicine Position Statement on Social Risk and Equity in Medicare’s Mandatory Value Based Payment Programs (JGIM June 2022)

CMS Health Equity Framework

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Priority 1

Expand the Collection, Reporting, and Analysis of Standardized Data

Priority 2

Assess Causes of Disparities Within CMS Programs and Address Inequities in Policies and Operations to Close Gaps

Priority 3

Build Capacity of Health Care Organizations and the Workforce to Reduce Health and Health Care Disparities

Priority 4

Advance Language Access, Health Literacy, and the Provision of Culturally Tailored Services

Priority 5

Increase All Forms of Accessibility to Health Care Services and Coverage

The White House's SDOH Playbook

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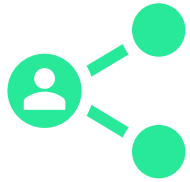
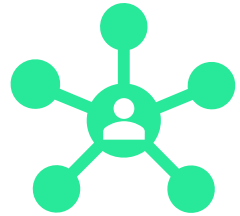


Expand Data Gathering and Sharing

Advance data collection and interoperability among health care, public health, social care services, and other data systems to better address SDOH with federal, state, local, tribal, and territorial support.

Support Flexible Funding to Address Social Needs

Identify how flexible use of funds could align investments across sectors to finance community infrastructure, offer grants to empower communities to address HRSNs, and encourage coordinated use of resources to improve health outcomes.



Support Backbone Organizations

Support the development of community backbone organizations and other infrastructure to link health care systems to community-based organizations.

https://www.whitehouse.gov/wp-content/uploads/2023/11/SDOH-Playbook-3.pdf

HHS Call to Action

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Addressing Health-Related Social Needs in Communities Across the Nation

Example Actions

- **Community-Based Organizations:** Develop and/or expand capacity to serve as a Community Care Hub and/or participate as a partner organization in a CBO network led by a Hub organization.
- **Health Systems and Clinicians:** Engage community partners on needs assessments and in shared decision making, enlist the expertise of backbone organizations such as Community Care Hubs, and consistently identify patients with HRSNs and connect them with community resources.
- **Payers:** Consider covering and paying for allowable services, incentivize health care providers to screen and refer patients for HRSNs, and establish partnerships with backbone organizations.
- **Public Health Departments:** Leverage community health assessments and multi-sector partnerships, forge relationships with backbone organizations, and support the health care sector's work on SDOH and HRSNs through public health's population health expertise.
- **Health Information Technology:** Partner with other sectors in planning and implementing interoperable, community- and person-centric approaches to electronic social care referrals and care coordination, and adopt and advance the use of open data standards.

HHS Call to Action: Addressing Health-Related Social Needs in Communities Across the Nation | ASPE

Unprecedented Movement in HE + SDOH

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Accountable Health Communities Model

(Completed)

Housing and Services Partnership Accelerator

(Recruiting)

CMS Final Rule 2024

(Codes for Health Integration and SDOH Risk Assessments)

CMS & CMMI Programs

1115 Waivers

HEDIS Measures and Accreditation Program

Medicaid 1115 Waiver

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Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve **experimental, pilot, or demonstration projects** that are found by the Secretary to be likely to assist in **promoting** the objectives of the **Medicaid program**. The purpose of these demonstrations, which give states additional **flexibility to design and improve** their programs, is to **demonstrate and evaluate** state-specific policy approaches to better serving Medicaid populations.

Currently, **7 states** have approved 1115 waivers which include **housing and nutrition support.**

A way for Medicaid programs to address and pay for SDOH

HEDIS Social Needs Measures

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SDOH Focus Area	Measure Title
Food	Social Need Screening Food - (HEDIS MY2023 SNS1) - Certified
	Social Need Screening and Intervention Food - (HEDIS MY2023 SNS2) - Certified
Transportation	Social Need Screening Transportation (HEDIS MY2023 SNS5) - Certified
	Social Need Screening and Intervention Transportation - (HEDIS MY2023 SNS6) - Certified
Housing	Social Need Screening Housing - (HEDIS MY2023 SNS3) - Certified
	Social Need Screening and Intervention Housing - (HEDIS MY2023 SNS4) - Certified

Where Are Collection Rates?

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In 2023 the average rate of annual SDOH screening across all DRVS centers was 15%

Panel Discussion

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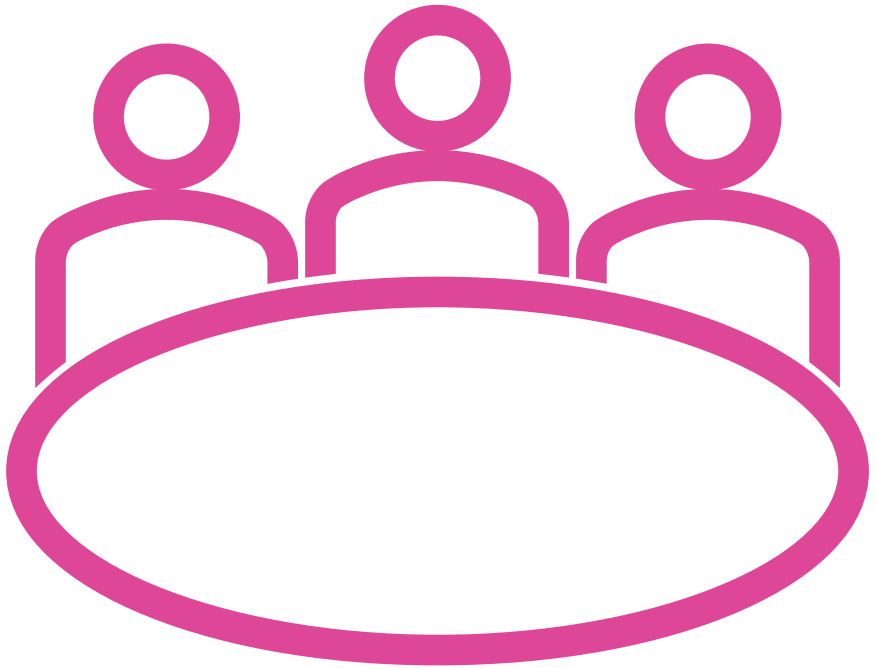

DRVS Tools to Support SDOH Collection and Utilization

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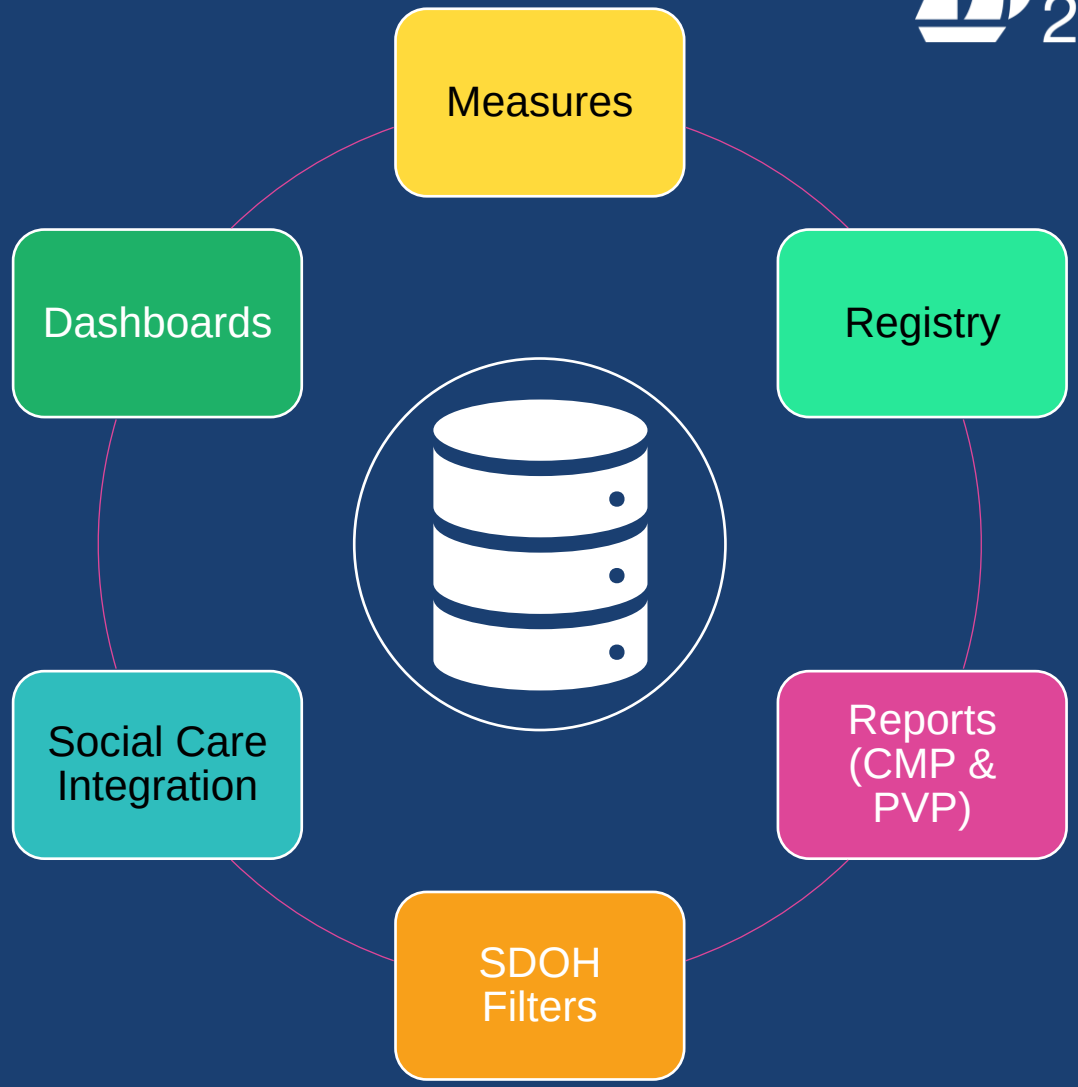
SDOH Information in DRVS



SDOH + DRVS Alignment

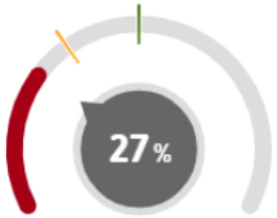
SDOH Goal	DRVS Functionality
Promote social needs screenings across care teams	SDOH Alerts
Identify positive SDOH triggers during patient visits	SDOH section on PVP
Evaluate SDOH screening program (frequency, completeness, appointment types, etc.)	SDOH Measures & SDOH Dashboards
Refer patients to social care organizations	Social Care Integration (findhelp/UniteUs)
Identify patients with positive SDOH triggers for proactive outreach and engagement	SDOH Registry
Evaluate top SDOH triggers across complete patient population to understand high-level needs	SDOH Dashboards
Identify health disparities across CQMs due to positive SDOH triggers	SDOH filters

Social Needs Assessed
DASHBOARD

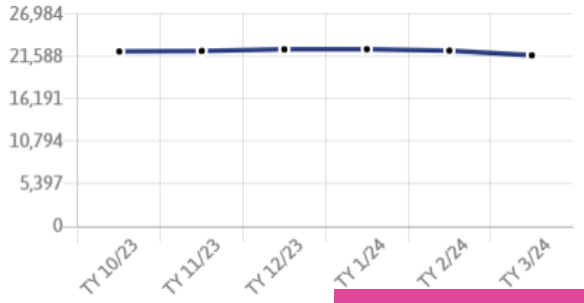
FILTER 1

FILTERS: TY March 2024

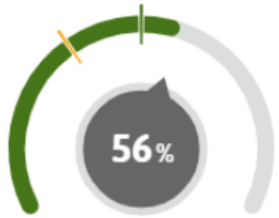
Social Needs Assessed



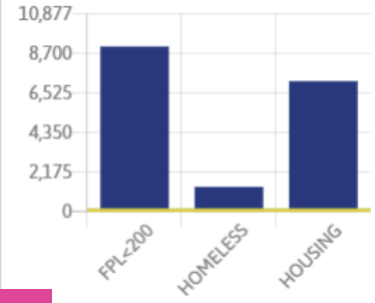
Needs Assessed Trend



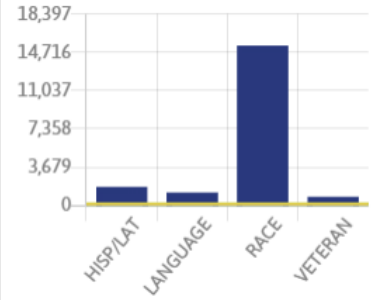
Core +1 Assessed



Housing & Income



Personal Characteristics



Use to evaluate who's been screened and the completeness of the screening.

>12 SDOH

160

Pts who had qualifying encounter and completed

8-12 SDOH

1,786

Pts who had qualifying encounter and completed SDOH assessment in the

4-7 SDOH

9,018

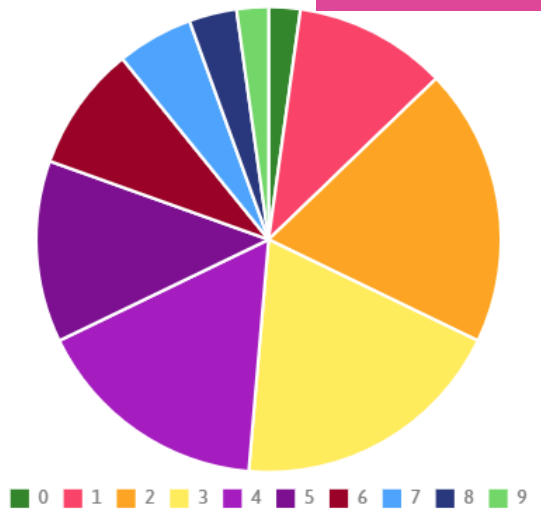
Pts who had qualifying encounter and completed SDOH assessment in the

<4 SDOH

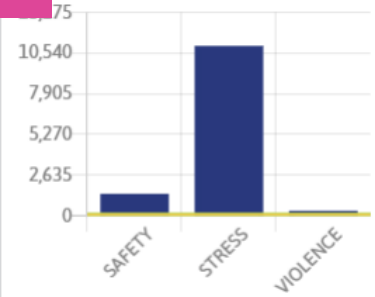
10,746

Pts who had qualifying encounter and completed SDOH assessment in the period

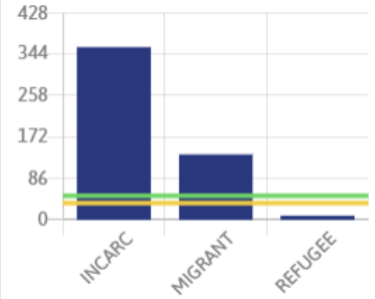
SDOH Count Distribution

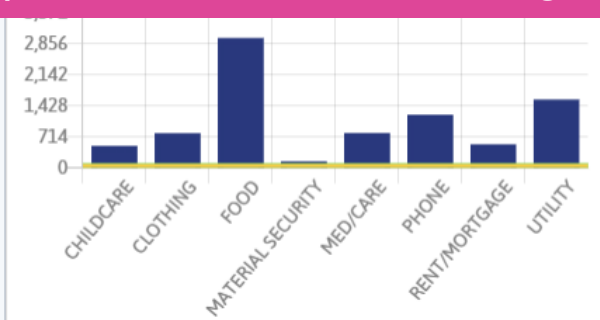


ence & Stress



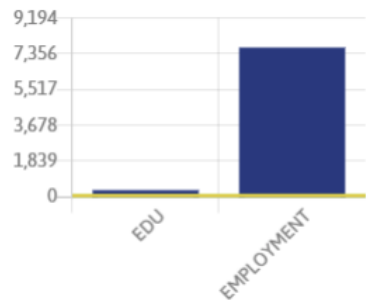
Migrant-Incarc-Refugee (Situational)



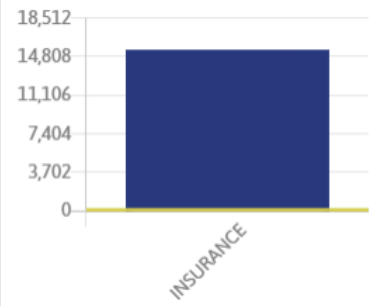


Transportation & Isolation

Education & Employment



Insurance



SDOH Filters

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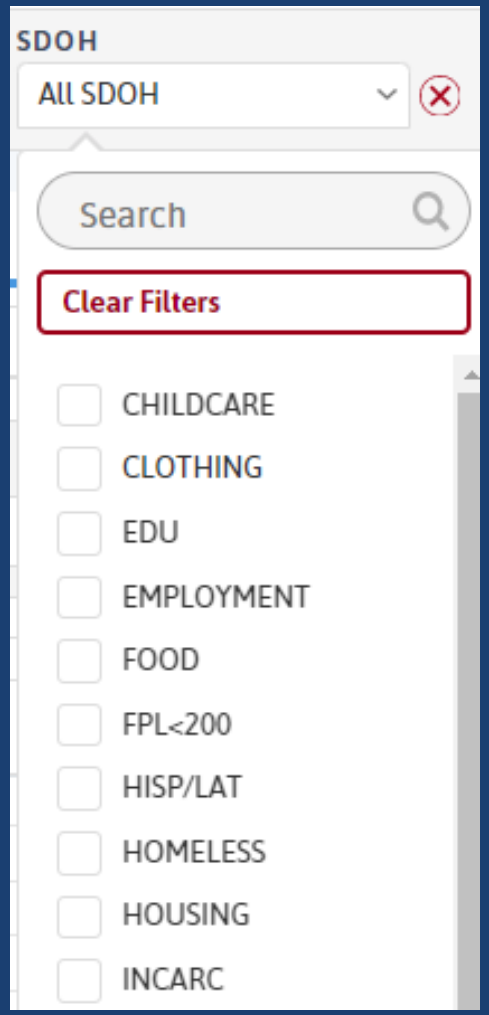
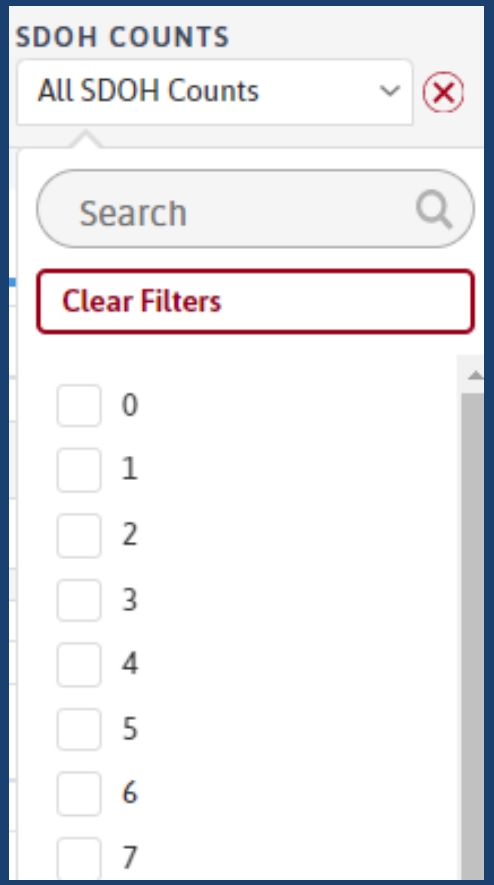
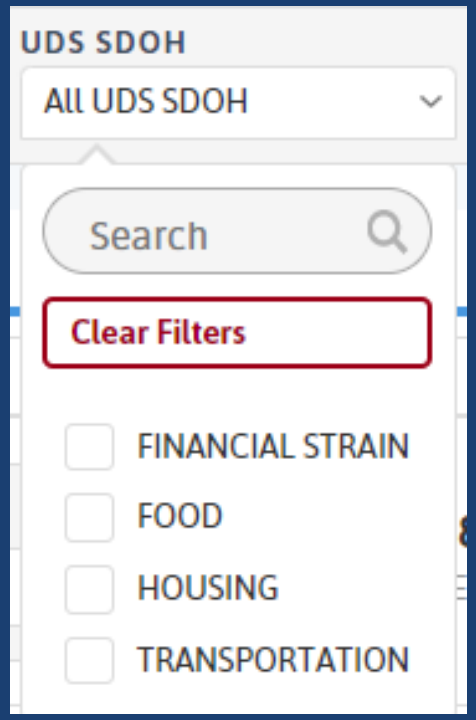
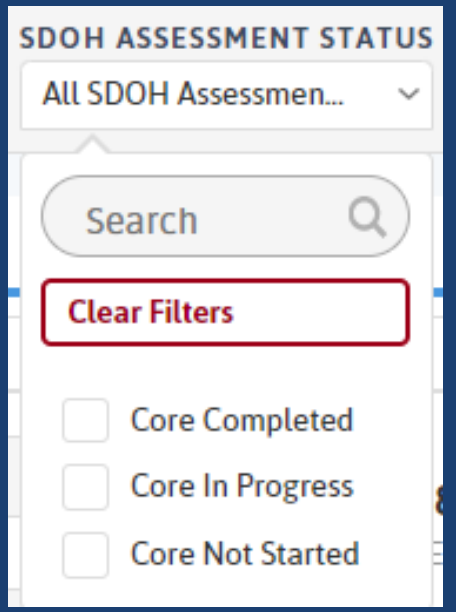
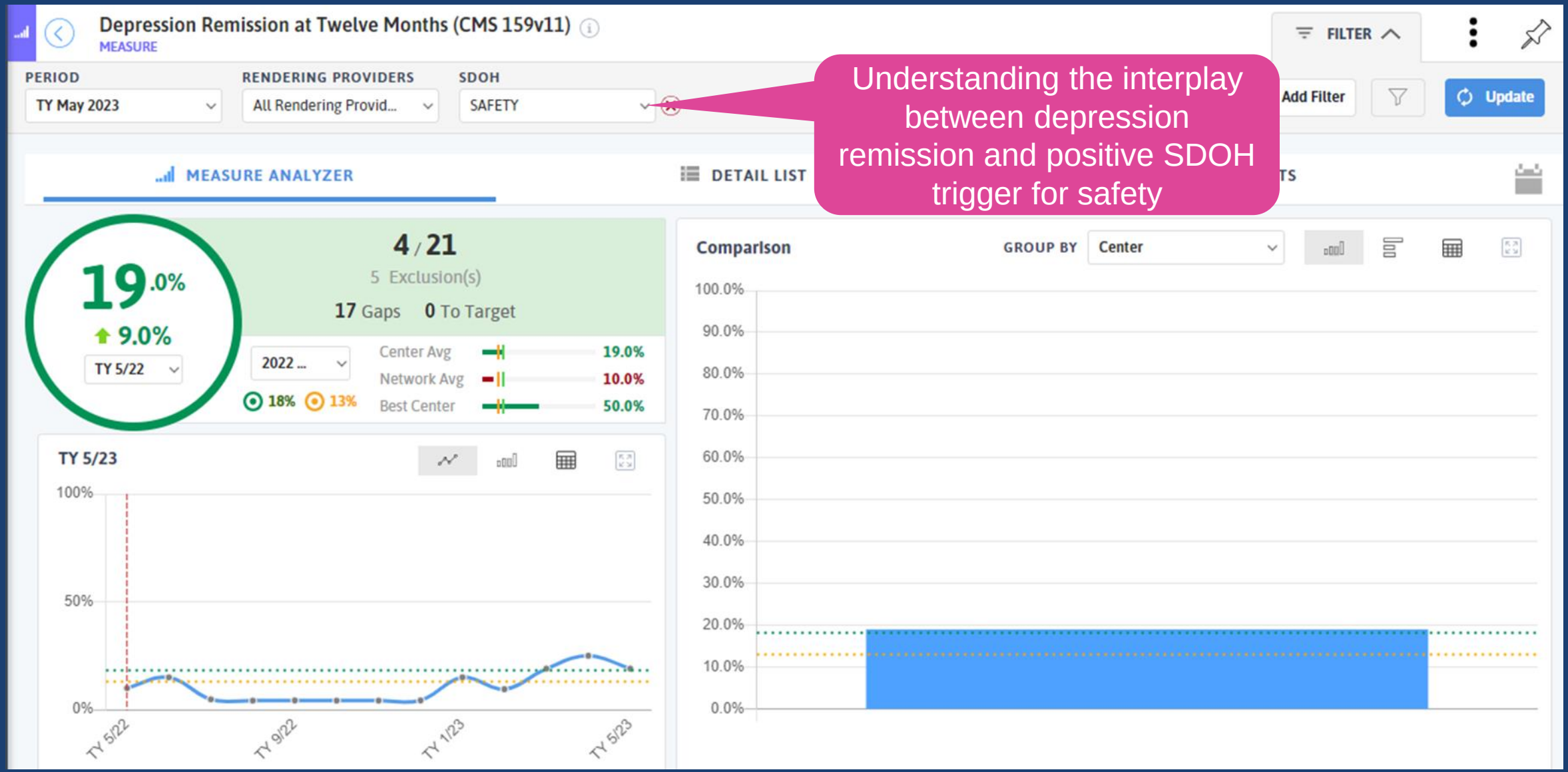








Utilizing Filters



PVP SDOH Documentation

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3:08 AM Thursday, May 4, 2023 — Visit Reason: **Injury No Show**

Lykens, Luis
MRN: 1100838
DOB: 1/28/1994 (29)

Sex at Birth: M
GI: Female
SO: Straight (not lesbian or gay)

Phone: 978-203-0269
Lang: German
Risk: Low (10)

Portal Access: 07/29/2022
Cohorts: Diab & HTN & Homeless no A1c, Test Cohort

PCP: Bridgewater, Bill
Payer: Medicaid
CM: Paula Silvia

Demo data

DIAGNOSES (7)

ASCVD	Asthma	CAD
CAD/No MI	CP	HTN-NE
IVD		

RISK FACTORS (1)

Chronic Opioid Tx

SDOH (9)

FOOD	FPL<200%	HISP/LAT
INSURANCE	LANGUAGE	MATERIAL
MIGRANT	RACE	SECURITY

RAF GAPS DIAGNOSIS CATEGORIES (3)

Cardiovascular	Pulmonary	DD

ALERT	MESSAGE	DATE	RESULT	OWNER
LDL	Missing			

	Front Desk
15.00	MA

ORDERED DATE	APPT. DATE
6/6/2023	6/12/2023
7/29/2022	
7/29/2022	8/21/2022

SDOH (9)

FOOD	FPL<200%	HISP/LAT
INSURANCE	LANGUAGE	MATERIAL
MIGRANT	RACE	SECURITY

Connecting Needs to Resources

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- Patient Visit Planning (PVP)
- Care Management Passport (CMP)
- Any measure detailed patient list (right click)
- ACC – Care Management Clinical Tab
- ACC – Care Coordination Task and Clinical Tab

findhelp

UNITE US

Social Care is One Click Away

Questions?

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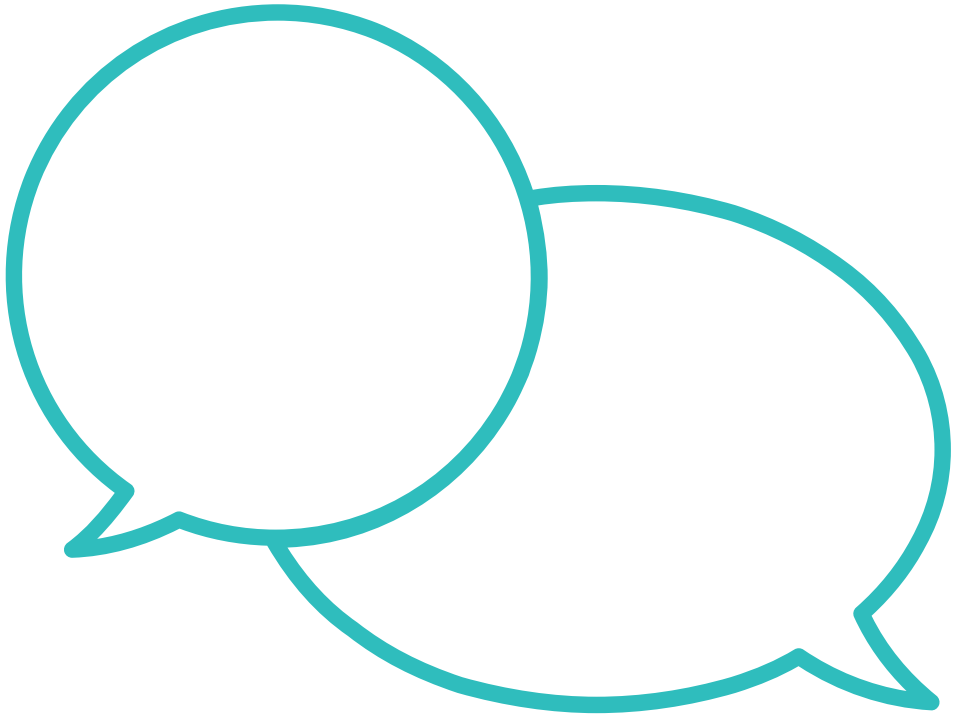

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@AzaraDRVS

Achieve, Celebrate, Engage!

ACE'd it? Share your DRVS success story and become an Azara ACE!

Show your organization has used DRVS to **A**chieve measurable results, **C**elebrate improvement in patient health outcomes, and effectively **E**ngage care teams and/or patients. Stories should showcase how DRVS helped your organization overcome a challenge, the tools and solutions used to drive improvement and details of the successes that resulted from your initiatives. ACEs should be able to provide examples that quantify quality improvement, cost savings, operational efficiency or patient health improvement.

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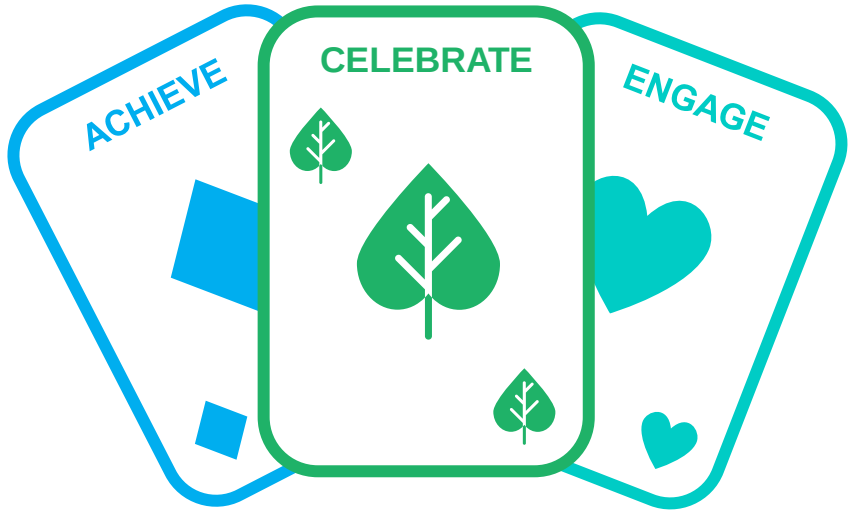
ACE Program



Benefits:

- Azara will help tell your story and provide a client-branded version for your use
- Potential to create a 2-4 minute video or hour-long Azara-hosted webinar
- Win Azara swag!

Submit your success story by completing the form at this link or scan our QR code:

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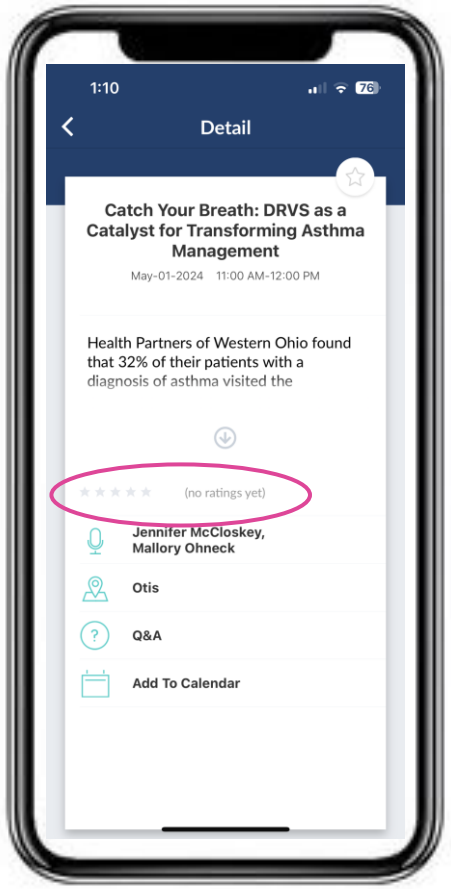

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