HIE Office Hours

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OKSHINE CONNECTION FEE ASSISTANCE

- 2023 Oklahoma Legislature passed SB 32X
  - Empowers providers and organizations to create a more complete patient record in the state designated HIE
- $30 million legislative appropriation
- Funding is not guaranteed beyond 6/30/25
- Any organization that employs licensed Health Care providers in the State of Oklahoma is eligible to receive assistance.

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Apply for Connection Fee Assistance

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Health Care Authority

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OKSHINE

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OKSHINE Connection Fee Assistance

In an effort to advance the ability for systems to exchange health information and create more complete patient health records, the Oklahoma Legislature passed SB 32X in 2023. This bill enabled funding for a one-time connection fee for providers to connect to the Health Information Exchange through the State Designated Entity (SDE), MyHealth Access Network.

The Office of the State Coordinator has developed an application for health care providers to request assistance with the one-time connection fee. Please note this assistance only applies to the fees associated with getting connected to the HIE, it does not cover the on-going subscription fees.

Before beginning the Connection Fee Application process, an application to connect with the SDE must be submitted

Connection Fee Assistance
> View Flyer

Connection Fee Application
> Apply Now

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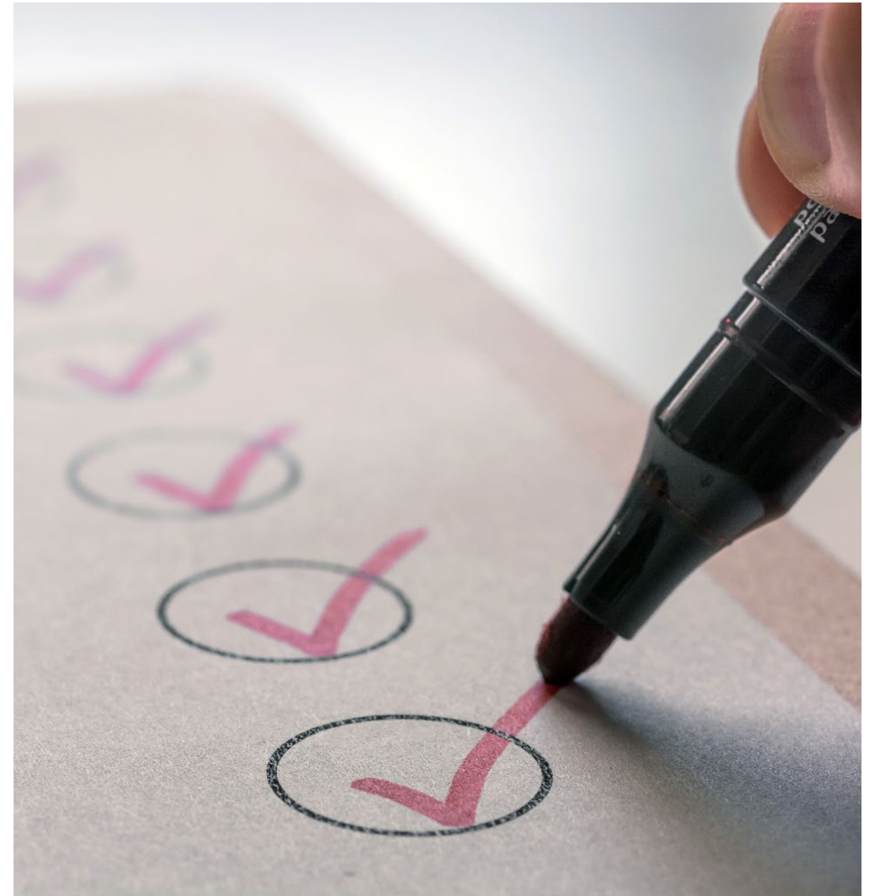
OKSHINE Connection Fee Assistance (oklahoma.gov)

Agenda

- Definitions
- Reporting Requirements
- Data Collection
- Data Submission
- Referrals



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Definitions

- **<u>Social Drivers (Determinants) of Health – SDOH</u>**
  - The conditions in the environments where people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks
  - The way communities and individuals experience health and health care is not just based on access to medical services – it is also impacted by other factors that may support or create barriers to health and well-being

Social Determinants of Health

Social Determinants of Health Healthy People 2030

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Definitions

- **Health-Related Social Needs (HRSNs)**
  - Social and economic factors that can impact a person's ability to maintain their health and well-being
  - Can contribute to poor health outcomes, lapses in care access and coverage, and higher medical costs
  - Examples include lack of stable or affordable housing and utilities, financial strain, lack of access to healthy food, personal safety, and lack of access to transportation.

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Why do we need to address SDOH?

- SDOH and HRSNs are what commonly lead to *health disparities* – different health outcomes among different groups of people.
- Addressing these issues is an important component of efforts to overcome disparities and achieve *health equity* for individuals and communities
  - Health equity – the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of demographic and socioeconomic factors that affect access to care and health outcomes.

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Reporting Requirements

- Joint Commission
  - Requirements to reduce health care disparities
    - Engagement with stakeholders, customers, and experts
    - Record of care, treatment and services
- Centers for Medicare & Medicaid Services
  - Commitment to establishing a culture of equity
  - Screening and identification of HRSNs

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- Requirements to reduce health disparities (*Effective January 1, 2023*)
  - **EP1**: Designate an individual(s) to lead activities to reduce health care disparities for patients
  - **EP2**: Assess HRSNs and provide information about community resources and support services
  - **EP3**: Identify health care disparities in patient populations by stratifying quality and safety data using sociodemographic characteristics
  - **EP4**: Develop a written action plan that describes how to address at least one health care disparity identified in the patient population
  - **EP5**: Act when you do not achieve or sustain goals in your action plan to reduce disparities
  - **EP6**: Annually, inform key stakeholders about progress to reduce disparities (*leaders, licensed practitioners and staff*)
  - **Record of Care, Treatment and Services**: The medical record contains the patient's race and ethnicity

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The Joint Commission

CMS - Hospital Commitment to Health Equity Measure

- Assess hospital commitment using a suite of equity-focused organizational competencies aimed at achieving health equity for minority groups
- Attest to five domains:
  1. Strategic planning (4 elements)
  2. Data collection (3 elements)
  3. Data analysis (1 element)
  4. Quality improvement (1 element)
  5. Leadership engagement (2 elements)

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Domain 1: Equity is a Strategic Priority

- Hospital must attest to having a strategic plan that includes the following:
  1. Identifies priority populations who currently experience health disparities
  2. Identifies healthcare equity goals and discrete action steps to achieving these goals
  3. Outlines specific resources which have been dedicated to achieving equity goals
  4. Describes approach for engaging key stakeholders, such as community-based organizations

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Domain 1: Equity is a Strategic Priority

- Identifying Priority Populations
  - Conduct community health needs assessments
    - Create and identify ways, both formal and informal, to get feedback from your community
  - Utilize internal and external data
    - Internal – EHR reports, demographics reports, etc.
    - External – census data, health rankings data, shortage areas
      - https://www.census.gov/quickfacts/
      - https://data.hrsa.gov/tools/shortage-area
      - https://www.americashealthrankings.org/explore/states/OK
      - https://www.countyhealthrankings.org/

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Domain 1: Equity is a Strategic Priority

- <u>Identifying Healthcare Equity Goals</u>
  - Leadership buy-in is key!
  - Share federal requirements with your staff
  - Tie equity into the organization's strategic plan and department level goals
  - Review organizational policies/procedures/workflows from an equity perspective

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- Outlining Resources for Health Equity Goals
  - Financial resources
  - Staff time (Health equity champion/committees)
  - Resources for planning:
    - American Hospital Association
      - https://www.aha.org/heal
    - Healthy People 2030
      - https://health.gov/healthypeople/priority-areas/social-determinants-health
    - Medicare & Medicaid
      - https://www.cms.gov/priorities/health-equity/minority-health/equity-programs/framework
    - Joint Commission
      - https://www.jointcommission.org/our-priorities/health-care-equity/accreditation-resource-center/
      - https://www.jointcommission.org/our-priorities/health-care-equity/

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Domain 1: Equity is a Strategic Priority

- Engagement of Key Stakeholders
  - Identify and participate with local Community-Based Organizations (CBOs)
    - Leadership service on boards
    - Volunteer work by employees
    - Collaboration on community events
  - Connect with organizations that align with your mission and/or meet a need for your underserved patient populations

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Domain 2: Data Collection

- Hospital must attest to collecting valid and reliable demographic and SDOH data on patients
  - Collect demographic info, including self-reported race/ethnicity, and/or SDOH data
  - Train staff on culturally sensitive collection of demographic and/or SDOH info
  - Input demographic and/or SDOH info collected from patients into structured, interoperable data elements using a certified EHR technology (CEHRT)

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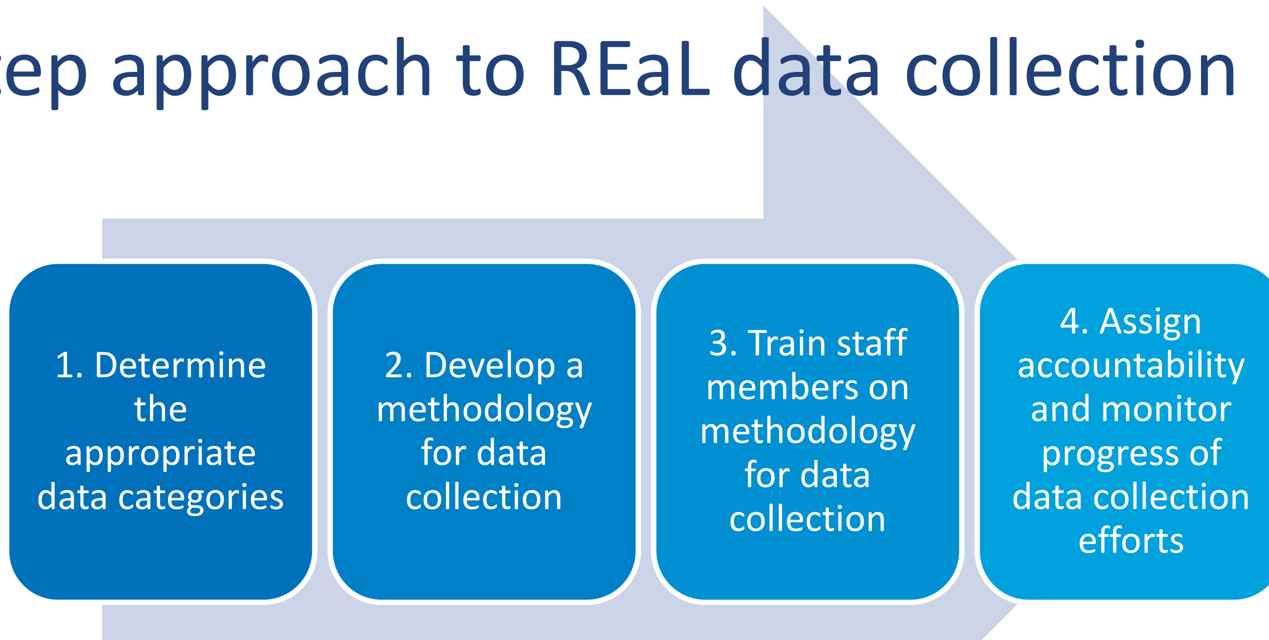
Domain 2: Data Collection

- 4-step approach to REaL data collection



Minimum data standards:
https://minorityhealth.hhs.gov/explanation-data-standards-race-ethnicity-sex-primary-language-and-disability

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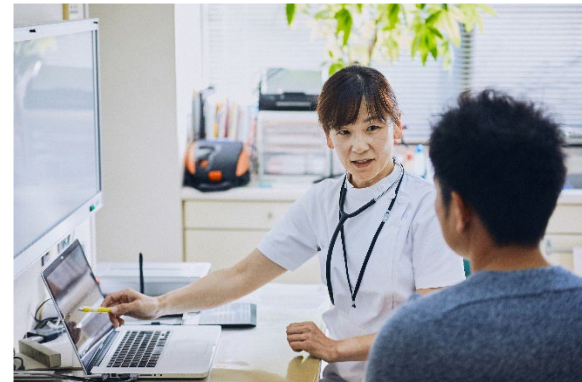
Domain 2: Data Collection

- Collecting Health-Related Social Needs (HRSN) Data:
  - Food insecurity
  - Housing instability
  - Transportation needs
  - Utility difficulties
  - Interpersonal safety



Data Collection Options

- CMS and Joint Commission do not specify a specific tool or method that must be used for screening
- Options include:
  - Accountable Health Communities (AHC) screening tool
  - PRAPARE screening tool
    - Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences
  - Tools built-in to your EHR systems
  - Third-party tools

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MyHealth Social Drivers of Health Screening

- MyHealth provides a mobile screening system that helps individuals with needs find assistance and services within their community
- Individuals receive a text message with a link to a screening that invites the person to seek assistance with one or more HRSNs.
  - Provides a customized list of resources/services based on location
  - No additional work for healthcare partner staff
  - Eligible individuals have a chance to receive Navigation services through the Tulsa or OKC County Health Departments
- Contact info:
  - Phone: (918)703-4766
  - sdoh@myhealthaccess.net
  - Fax: (918)236-3435

Domain 2: Data Collection

- Training Staff
  - Increases compliance
  - Ensures data integrity
  - Improves patient buy-in

- Tools:
  - The Health Research & Educational Trust (HRET) toolkit
    - https://www.aha.org/hretdisparities/toolkit

Domain 3: Data Analysis

- Hospital must attest to:
  - Stratifying key performance indicators by demographic and/or social determinants of health variables to identify equity gaps and include the information on hospital performance dashboards

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Domain 4: Quality Improvement

- Hospitals must attest to:
  - Participating in local, regional, or national quality improvement activities focused on reducing health disparities
- Do you participate in or contribute to any of the following?
  - County consortiums or coalitions
  - Regional consortia
  - State workgroups
  - CMS – Hospital Quality Initiative

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Domain 5: Leadership Engagement

- Hospitals must attest to:
  - Hospital senior leadership annually reviewing strategic plan for achieving health equity
  - Hospital senior leadership reviewing key performance indicators stratified by demographic and/or social factors
- Ways to engage leadership:
  - Create a work group or committee for annual reviews
  - Assign an organizational leader as a member or liaison
  - Include expectation of review within strategic plan

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- HCHE Measure:
  - Hospital must attest to engaging in each element in all five domains
    - Each domain will be represented as a point
    - Total of 5 possible points
  - Attestation will be completed on QualityNet
    - https://qualitynet.cms.gov/
  - Data will be publicly reported on HHS Compare tool
  - **Mandatory reporting for CY 2023***
    - **(HCHE measure only)**

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Screening for Social Drivers of Health Measure

- Measures whether a hospital implements screening for all inpatients 18 years of age or older for 5 HRSNs:
  - Food insecurity
  - Housing instability
  - Transportation needs
  - Utility difficulties
  - Interpersonal safety

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Screening for SDOH Calculation

$$\frac{\text{\# of patients admitted for inpatient hospital stay } \textbf{who are screened for HRSNs}}{\text{\# of patients admitted for inpatient hospital stay}}$$

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Screen Positive for Social Drivers of Health Measure

- Measures the *percentage of patients 18 and up* admitted for an inpatient hospital stay who were screened for an HRSN, and who *screened positive* for one or more HRSNs.

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Screen Positive Rate for SDOH Calculation

$$\frac{\text{\# of patients admitted for inpatient hospital stay \textbf{who screen positive} for an HRSN}}{\text{\# of patients admitted for inpatient hospital stay who are screened for an HRSN}}$$

*Calculated as five separate rates

Measure Exclusions

- Patients who decline or opt out of screening
- Patients unable to complete the screening during inpatient stay with no legal guardian/caregiver able to do so on their behalf

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Data Submission

- Web-based Reporting
  - Data is reported through the Hospital Quality Reporting (HQR) System
    - https://hqr.cms.gov/hqrng/login
  - Screening for SDOH is submitted as one rate
  - Screen Positive Rate for SDOH is submitted as 5 separate rates
    - One for each of the 5 HRSNs

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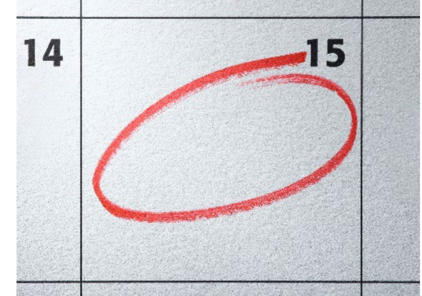
Data Submission

- **<u>SDOH-1 & SDOH-2</u>**
  - Data collection period:
    - Full Calendar Year - January 1 – December 31
  - *Voluntary* Reporting Deadline:
    - April 1, 2024 – May 15, 2024
  - *Mandatory* Reporting Deadline:
    - April 1, 2025 – May 15, 2025
  - *Impacts Fiscal Year 2026 payment



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Implementing SDOH Screening

Create a team	Identify goals	Create a Plan	Staff training	PDSA Cycles
• Identify champions • Include clinicians	• Target population • Start small and scale-up • Data collection and utilization	• Select a screening tool • Design your workflow • Documentation and data analysis • Create referral processes	• Screening workflows • Privacy considerations • Communication skills	• Plan, Do, Study, Act • Roll out plan & repeat • Institute for Healthcare Improvement (IHI)

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Documenting SDOH

- SDOH can be documented within the problem list, diagnosis list, patient or client history, or provider notes
- Z-codes: ICD-10-CM encounter reason codes used to document SDOH

https://www.cms.gov/files/document/cms-2023-omh-z-code-resource.pdf

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SDOH Referrals

- Three different approaches:
  1. Direct referrals - directly contact service agency on behalf of the patient
  2. Specific referrals - made to specific community-based organizations
  3. Tailored resource list
- Develop a bi-directional process to close referral loops

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SDOH Referrals

- Patients may have more than one need, ask about prioritizing SDOH needs
- Utilize community resources
  - Social workers, community health workers, etc.
- Connect patients to community resources
  - Oklahoma 211
    - https://211eok.org/211-oklahoma/
  - Oklahoma Network of Care
    - https://oklahoma.networkofcare.org/mh/services/index.aspx

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We Are Here To Help!

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