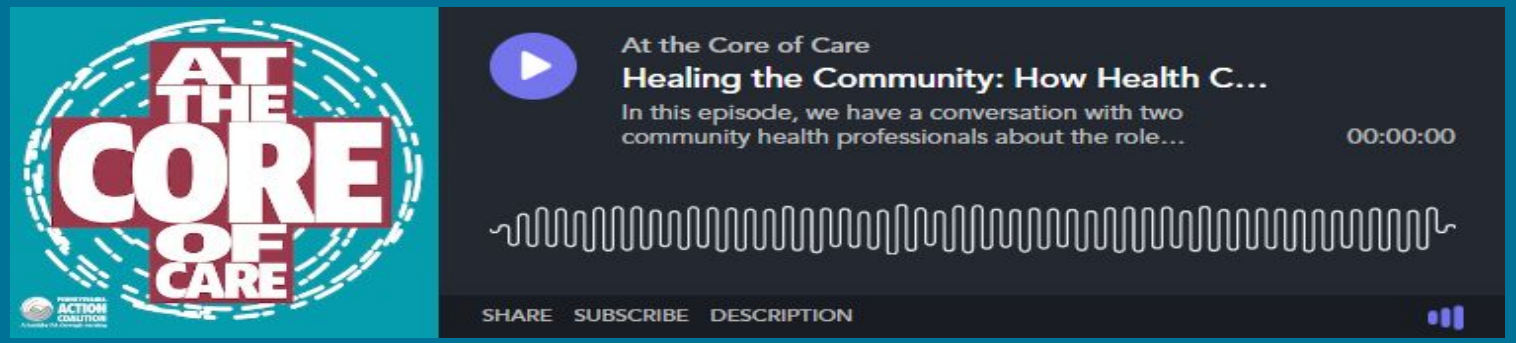
Stratifying Quality Measures by Housing Status/ Location

December 7, 2023



HEALTH CENTER RESOURCE CLEARINGHOUSE

Housekeeping

1 Captions

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Live Transcript

2 Questions

Please add your questions for the speaker and comments for the group into the Chat box.

Chat

3 Technical Issues

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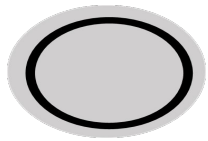
Raise Hand

4 Recording

This session will be recorded and available to view on Vimeo



Recording

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The National Nurse-Led Care Consortium (NNCC) is a nonprofit public health organization working to strengthen community health through quality, compassionate, and collaborative nurse-led care.

We do this through

- -training and technical assistance
- -public health programing
- -consultation
- -direct care

https://nurseledcare.phmc.org/

NNCC NTTAP Team

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Introduction/Welcome
- 5 minutes

Didactic
- 40 minutes

Questions & Wrap-Up
- 15 Minutes

Today’s Agenda

Meet our speaker:

Isaac Kastenbaum, MPA

Vice President,
Training & Technical Assistance
Primary Care Development Corporation

Stratifying Quality Measures by Housing Status and Location

Isaac Kastenbaum

December 7, 2023

Agenda

- Introduction
- Learning Objectives
- Background: Social Drivers of Health / Housing Status Screening
- Practical Uses of Housing Status Data in Quality Improvement
- Closeout / Q&A

PCDC is a Community Development Financial Institution (CDFI) that provides capital financing, expertise, and advocacy to expand primary care access and advance health equity in communities that need it most.

Primary Care Development Corporation

PCDC Overview

Transform.

We partner with health care providers to build capacity and improve services and outcomes.

Invest.

We provide capital to integrate services, modernize facilities, or expand operations.

Advocate.

We promote policies that advance health equity and bring resources and attention to primary care.

Learning Objectives

By the end of this session, attendees should:

1. Understand what social drivers of health are, and how housing status influences health outcomes;
2. Understand the current efforts to screen for social drivers of health (SDoH) and housing status;
3. Gain insight into practical examples of how housing status can be used to drive quality improvement; and
4. Establish ideas – for their health center – on how housing status data might be used to drive improvement

Background:

What are Social Drivers of Health?

Why does housing status influence health outcomes?

Background: What are SDoH?

"the nonmedical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, racism, climate change, and political systems."

Centers for Disease Control and Prevention

Source: CDC SDoH

Social Drivers of Health

- Housing & location of home
- Access to healthy food
- Access to educational, economic, and job opportunities
- Quality of education and job training
- Availability of community-based resources in support of community living and opportunities for recreational and leisure-time activities (parks, green spaces)
- Transportation options

- Racism and Discrimination
- Public Safety
- Social support
- Violence/Trauma
- Socio-economic conditions (e.g., concentrated poverty and the stressful conditions that accompany it)
- Residential segregation
- Language/Literacy
- Culture

Housing as Healthcare

- Homelessness and ill health have been locked in an ongoing cycle of cause and effe
- Poor health puts one at risk for homelessness since it affects the ability to work, function in the world
- Those who are not housed have increased exposure to infection, to the elements, and the violence of the streets
- Lack of control over nutrition, personal hygiene, and/or sleep negatively impacts health
- Some homeless people resort to risky survival behaviors that increase risks of illness, violence, and other trauma
- Being homeless complicates efforts to treat illnesses and injuries
- Homeless people suffer all illnesses at three to six times the rates experienced by others, have higher death rates, and have a dramatically lower life expectancy

Source: https://nhchc.org/wp-content/uploads/2019/08/Housing-is-Health-Care.pdf

Housing as Healthcare

- A clean, dry, secure environment is fundamental to personal hygiene (including wound care and dressing changes), medication storage (refrigeration of insulin, safe storage of needles), and protection from assault and the elements
- Private space allows for the establishment of stable personal relationships
- Has been shown to reduce risky sexual behaviors
- Facilitates effective interaction with others, including treatment providers and social support systems, and increases adherence to treatment plans, including regular meals and keeping appointments
- Housing may reduce anxiety and consequently minimize the risk of disease and the progression of disease

Source: https://nhchc.org/wp-content/uploads/2019/08/Housing-is-Health-Care.pdf

Background:
How / why are health centers collecting Social Drivers of Health data?

Background: SDoH Data Capture

There are many initiatives underway to capture SDoH Data:

- Individual value-based payment of state Medicaid waiver programs;
- CMMI Making Care Primary (anticipated);
- Accountable Health Communities;
- Health equity and disparities reduction programs;
- Care management & health home initiatives; and
- NCQA Patient-Centered Medical Home (PCMH)

Background: SDoH Data Capture, Tools

PRAPARE

Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (NACHC-Supported). Link.

The EveryONE Project
Advancing health equity in every community

American Academy of Family Physicians (AAFP)-supported screening tool to identify SDoH. Link.

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

NC Healthy Opportunities SDoH screening tool. Link.

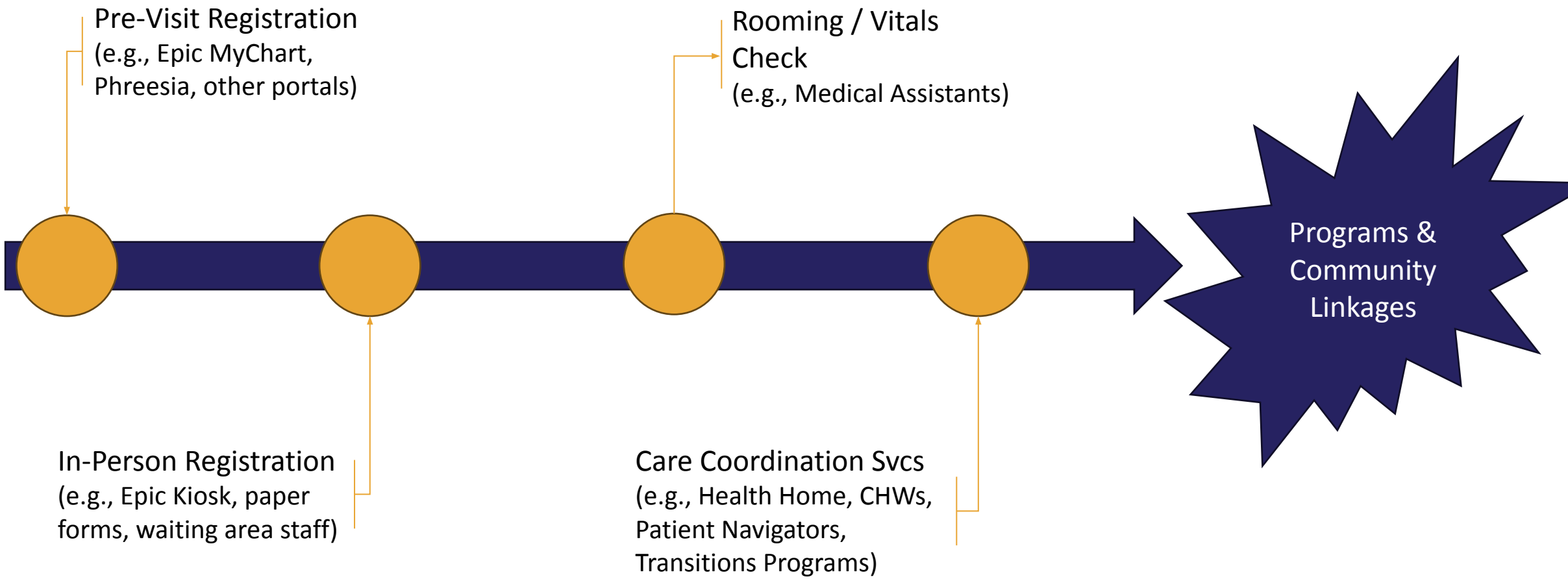
Background: SDoH Data Capture, Tools

	Yes	No
Food		
1. Within the past 12 months, did you worry that your food would run out before you got money to buy more?		
2. Within the past 12 months, did the food you bought just not last and you didn't have money to get more?		
Housing/ Utilities		
3. Within the past 12 months, have you ever stayed: outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else's home (i.e. couch-surfing)?		
4. Are you worried about losing your housing?		
5. Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed?		
Transportation		
6. Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living?		

Creates data points to inform planning, outreach, etc.

Source: North Carolina SDoH Screening Tool

Background: SDoH Data Capture, Workflows



You may also be capturing SDoH / housing status data elsewhere…

1. Care Management, Care Coordination, Patient Navigation, Community Health Worker, and other outreach program documentation;

2. Registration – regularly updated patient addresses or contact information;

3. Coding – Use of Z codes to document non-medical needs

Practical Examples:

How to use housing status data for quality improvement

Use of Housing Status Data

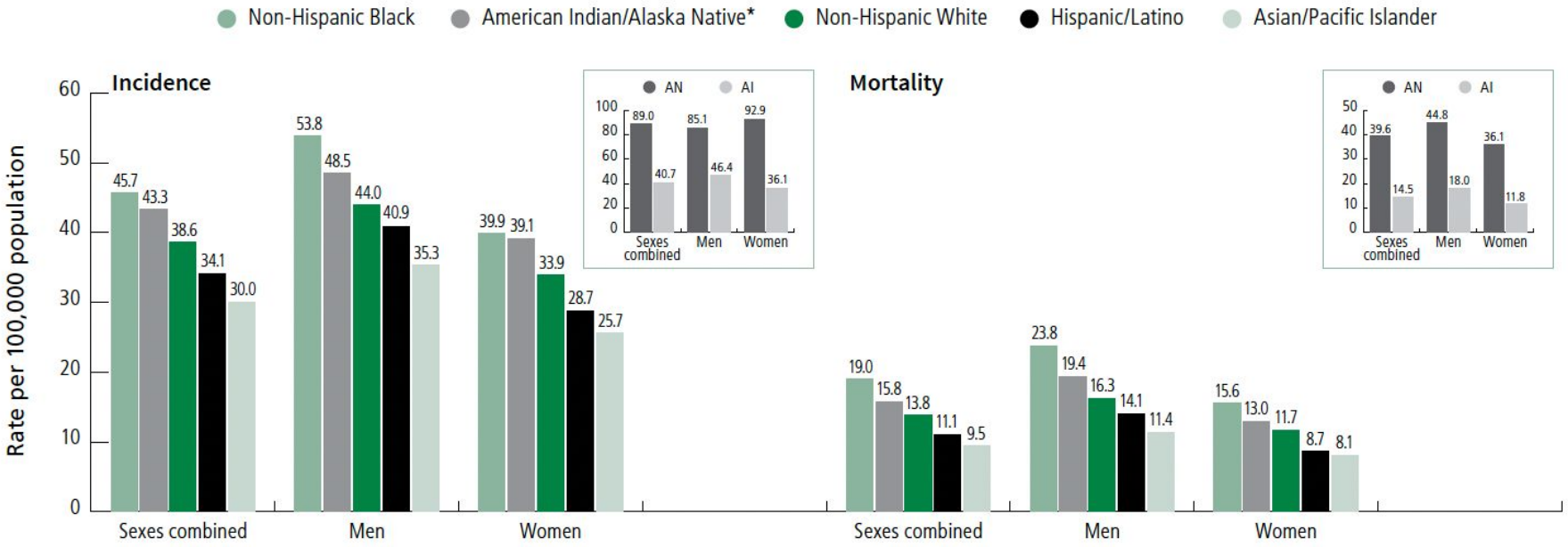
Community Health Needs Assessment	Grants and Fundraising	QI & PDSA Efforts	Care Model Design	Health Center Location & Development
HRSA requirement; informs broader planning endeavors (every 3 years)	Opportunity to highlight the specific needs of your community to Foundations, Funders, and Gov't Grants	Identify sub-populations that may not receive equal access to care	Develop programs & service partnerships specific to the population	Bring health center (or mobile units) directly to the population in-need

Health Centers Participate in Many Competing "Quality Programs"

- HRSA Uniform Data System
- Health Plan Pay-for-Performance Programs
- Health Plan Total Cost of Care Programs
- Medicare Shared Savings Program ("ACOs")
- Independent Practice Association (IPA) & Clinically Integrated Network (CIN) Incentives
- Leadership "Pet Projects"
- State Department of Health Initiatives (e.g., New Jersey Cancer Education and Early Detection)
- Grant-Funded Programs
- Ryan White or HIV Funding Streams
- Community Health Needs Assessment-Informed Priorities
- Internally-Developed/Prioritized Initiatives
- NCQA PCMH Reporting Requirements

Progress To-Date: Stratifying Data by REaL

Figure 5. Colorectal Cancer Incidence (2012-2016) and Mortality (2013-2017) Rates by Race/Ethnicity and Sex, US



AI: American Indian, excluding Alaska; AN: Alaska Native. Rates are age adjusted to the 2000 US standard population. *Statistics based on data from Purchased/Referred Care Delivery Area (PRCDA) counties. AI/AN incidence rates exclude data from Kansas and Minnesota. Incidence rates for Alaska Native men and women are not statistically significantly different.

Source: Incidence – NAACCR, 2019. Mortality – NCHS, 2019.

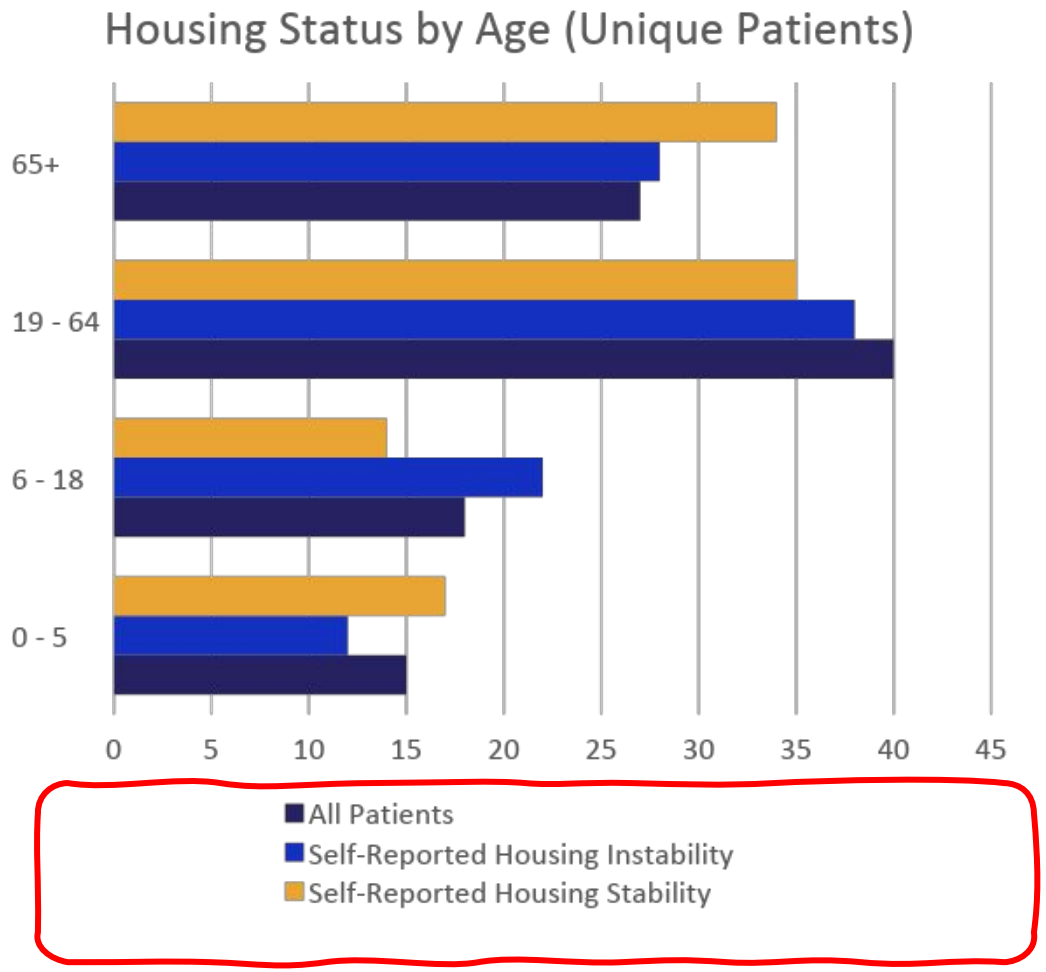
REaL = Race, Ethnicity, and Language

Further Potential: Stratify by Housing Status

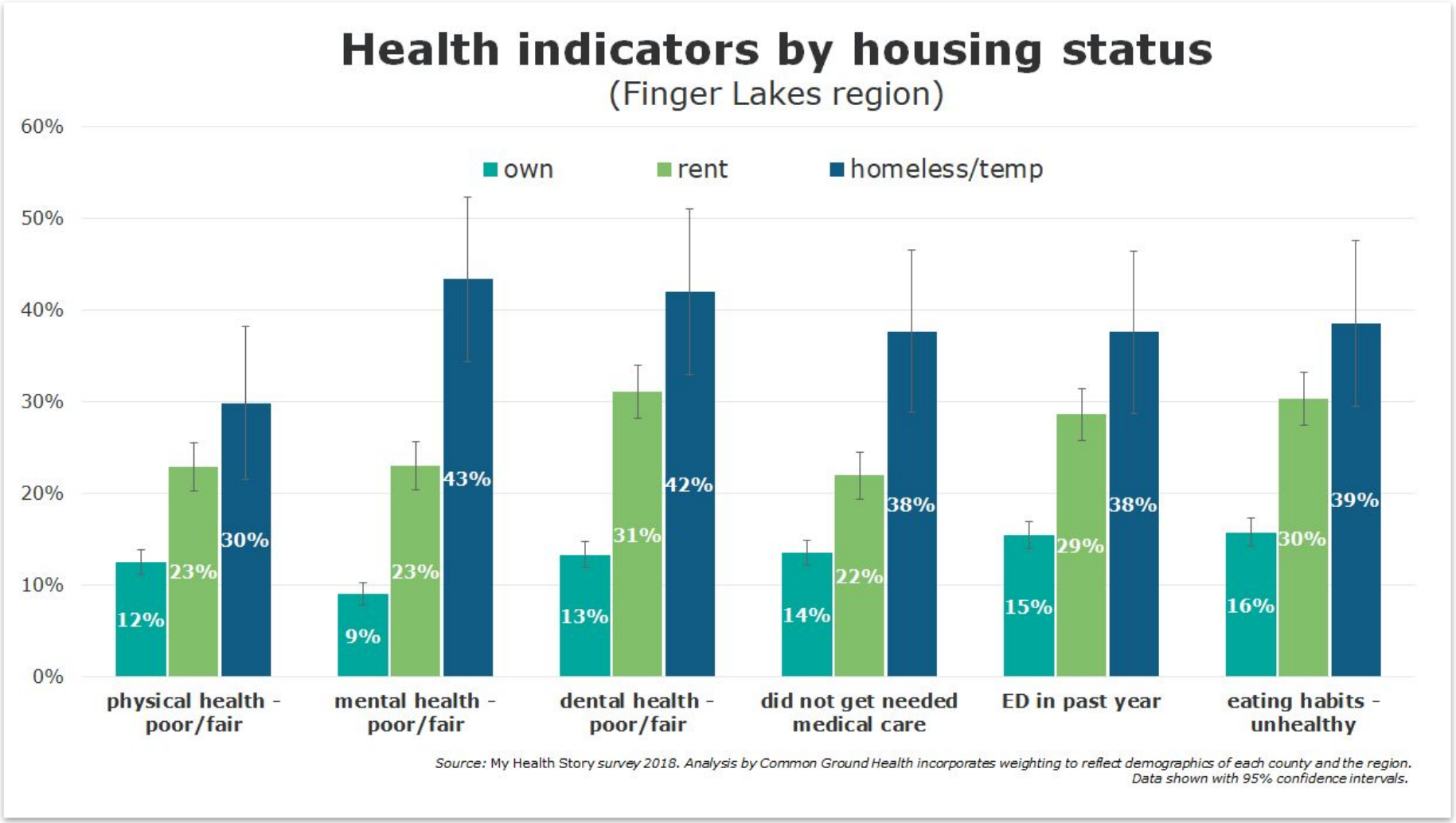
Potential methods to use data to identify patients experiencing housing instability

Source(s)	Data Specifics	Notes
Practice Management System	Patient Address: • Regular changes in address of record • Address of known shelter or other housing resource	**Inferred.** May require creative querying of semi-structured data. Not perfect.
Electronic Health Record (EHR) or Pre-Visit Registration	• Self-reported SDoH screening tools (e.g., PRAPARE) • Standardized, structured care team assessments	**Patient-Reported.** Most structured, clear source of data. Often informed by checkboxes or dropdowns.
EHR Notes	• Provider & care team notes (non-structured) • **Z codes** (depending on how they're determined)	**Inferred.** May require Natural Language Processing (NLP) or other technology to aggregate data. Not perfect.

Stratify by Housing Status, Examples

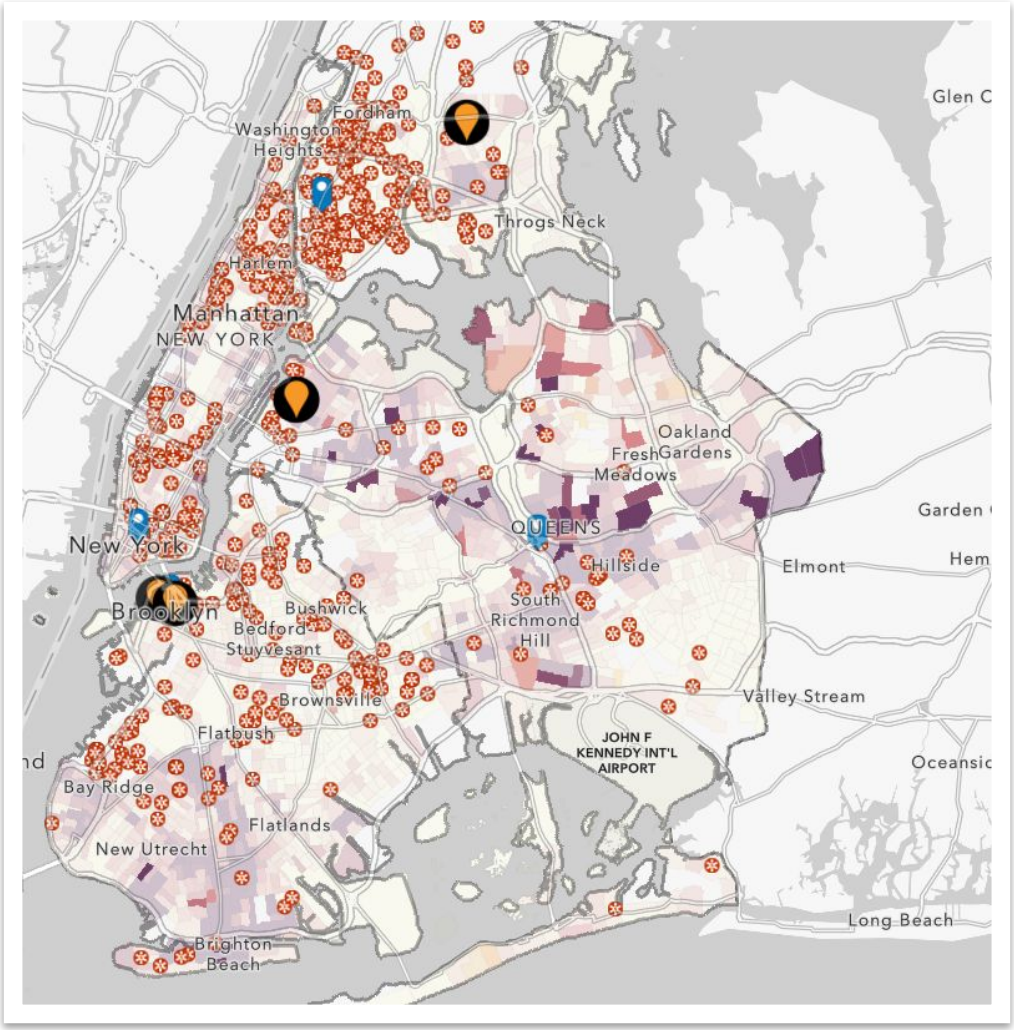


Stratify by Housing Status, Examples



Source: Common Ground Health (NY)

Stratify by Housing, Example



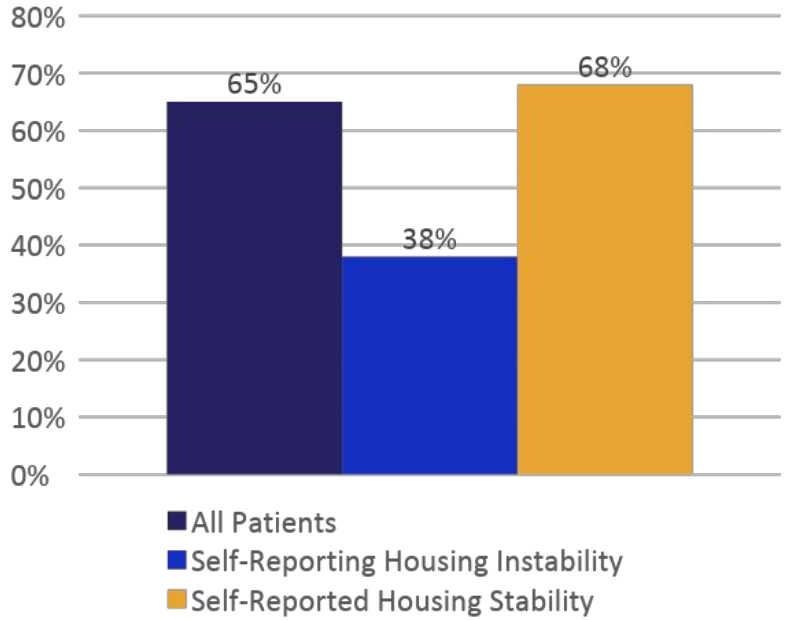
Source: Arab American Family Support Center (NY)

Housing Status w/in QI Efforts

Example, clinical quality measure, individuals without housing

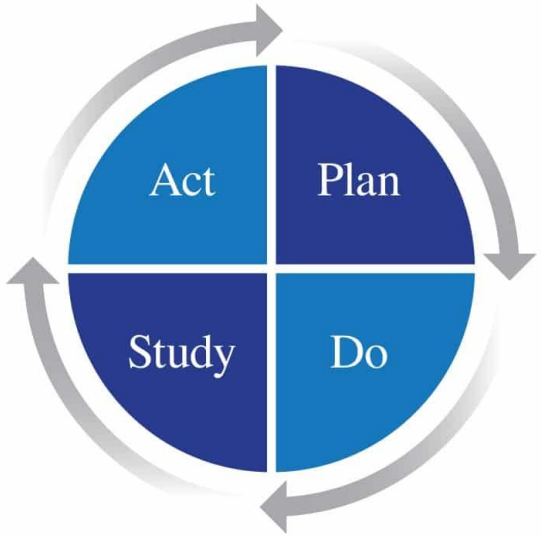
Potential Improvement Pilots to Try:

1. Introduction to CHW/navigator at time of appointment for follow-up care
2. Use on-site pharmacy for prescription fulfillment or on-site lab for lab work during visit
3. Initiate pre-medical provider visit with LCSWs



Housing Status w/in QI Efforts

Example, clinical quality measure, individuals without housing



Plan: Stratify your quality measure data by housing status

Do: Implement a specific, single workflow change

Study: Review changes in quality measure over the following weeks (***ensure you're looking at right denominator)***

Act: Revise and rollout any high-value, high-impact strategies

Care Models to Address Housing

- Street Medicine Teams (unhoused)
- Community Health Workers / Promotoras (all populations)
- Shelter-Based Teams and/or Telehealth Kiosks (unhoused)
- Supportive Housing Partnerships (housed)
- Pop-Up Clinics / Mobile Clinics (all populations)
- HC-Embedded Service Partnerships (all populations)

Care Models to Address Housing *Key Considerations*

- Appropriateness to the population
- Staffing capacity
- Sustainability (operational and financial)
- Regulatory considerations
- Pathways to supportive / social services
- Patient and staff safety
- Alignment of partnership priorities / capacity

Closing Comment

Your health center is sitting on a mountain of data that can inform both (a) immediate patient care and (b) continuous quality improvement and program design.

Do not forget the latter!

Contact Information

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Vice President

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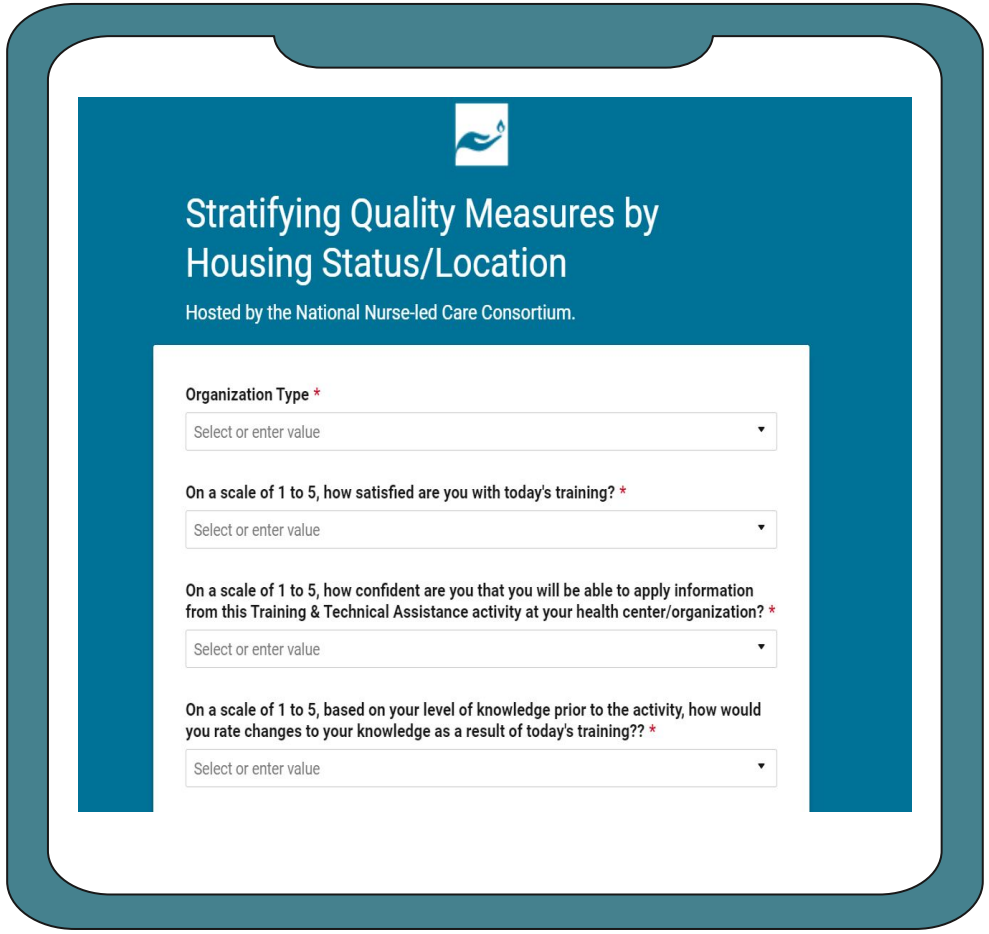
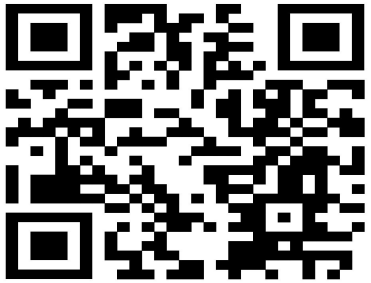
Questions?

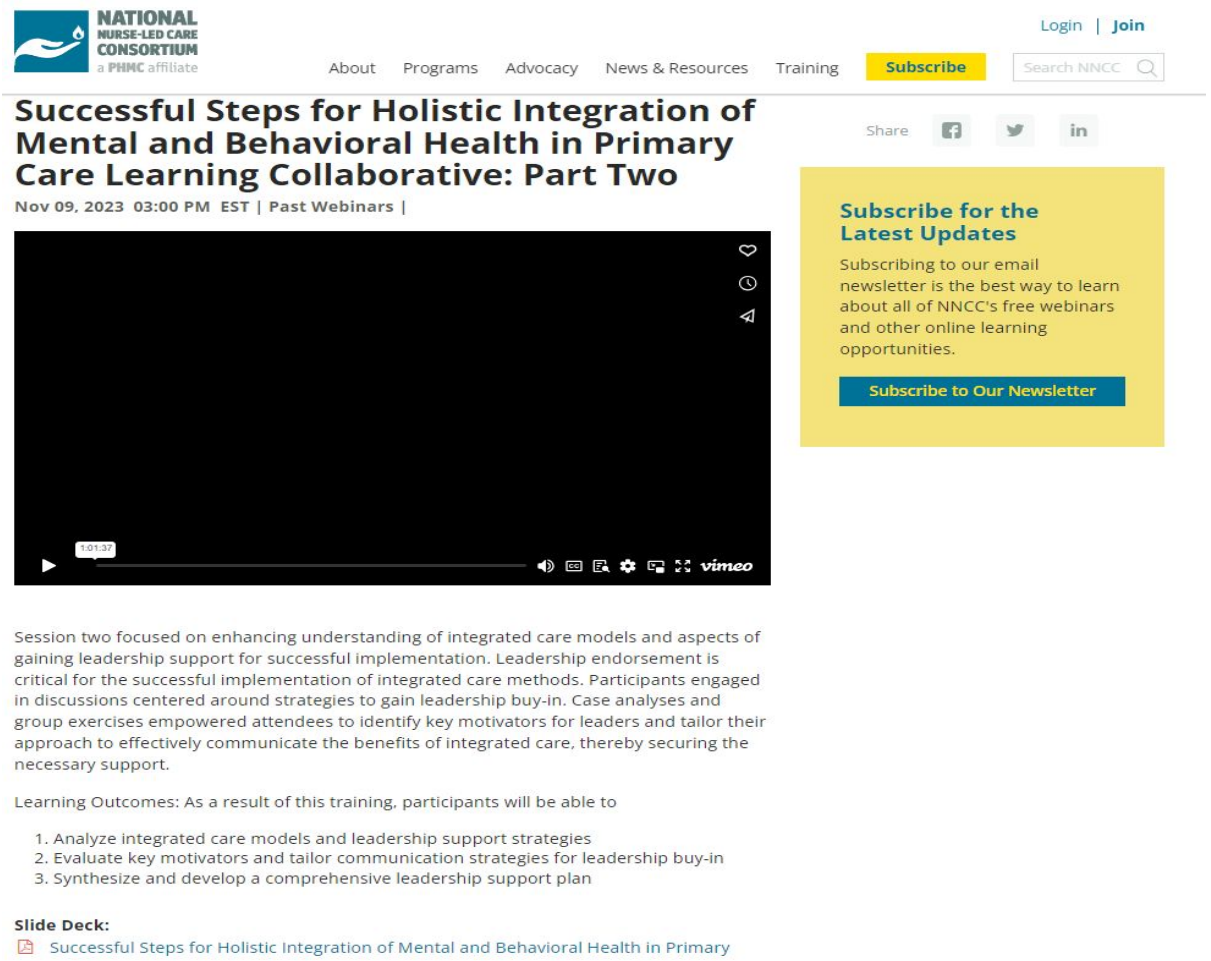
Evaluation Survey



Access T/TA Resources

HEALTH CENTER RESOURCE CLEARINGHOUSE





Thank You!

If you have any further questions or concerns please reach out to Fatima Smith fasmith@phmc.org or Matt Beierschmitt at mbeierschmitt@phmc.org