BALTIMORE CITY HEALTH DEPARTMENT

CRISP

CRISP SDOH Screening & Community Connection

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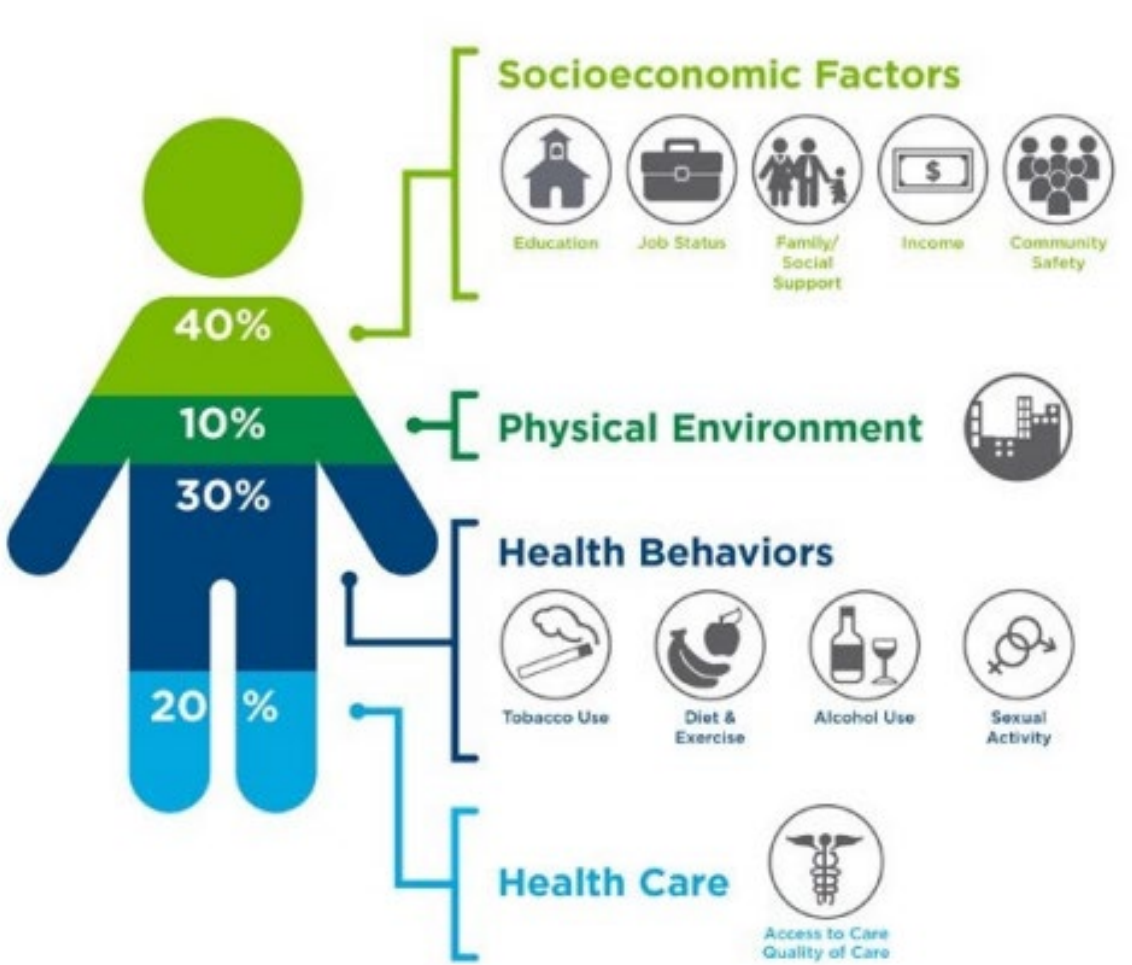
Agenda

- SDOH Screening Requirements
- CRISP Screening/Integration
- Population Level Reporting
- Community Benefits
  - Baltimore City Health Department & LHIC Overview
  - Why Social Needs Screening?
  - How: Public Health & Healthcare Collaboration

Social Determinants of Health

40-60% of health outcomes driven by patient's SDOH



Source: Institute for Clinical Systems Improvement Going Beyond Clinical Walls. Solving Complex Problems (October 2014). The Bridgespan Group

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CMS, NCQA & JCAHO SDOH Requirements

CMS SDOH Measures

CMS mandated that hospitals reporting to the Inpatient Quality Reporting (IQR) program submit 2 SDOH measures.

2024 (Required)

SDOH=Social **Drivers** of Health

SDOH-1 Measure: Reporting the number of patients 18+ who were admitted to your hospital and screened for SDOH

SDOH-2 Measure: Reporting the number of patients 18+ who were admitted to the hospital, screened for SDOH, and identified as having 1 or more social risk factors.

*Measure 2 will be separated into 5 rates for each of the domains

CMS Requirements of SDOH Screening

Recommend using the The AHC Health-Related Social Needs Screening Tool (cms.gov) (Not Required). However, must focus on the following 5 domains:

- Food Insecurity
- Housing Instability
- Transportation Needs
- Utility Difficulties
- Interpersonal Safety

NCQA & HEDIS

NCQA (National Committee for Quality Assurance) & HEDIS (Healthcare Effectiveness Data and Information Set)

-Measures set out to help healthcare providers and payers to understand their current performance.

Effective 2023 Measure: **Social Need Screening and Intervention (SNS-E)**:

- The SNS measure looks at six indicators, one each for screening and intervention across three social needs. It measures the percentage of members who, during the measurement period, were:

1) Screened via a **pre-specified instrument** at least once for unmet needs related to
  - Food.
  - Housing.
  - Transportation.

2) Members who **screen positive** receive a corresponding intervention.

Intervention indicators assess the percentage of members who screened positive and received a corresponding intervention within 30 days of the positive screen.

- Assessment.
- Assistance.
- Coordination.
- Counseling.
- Education.
- Evaluation of eligibility.
- Provision.
- Referral.

JCAHO Standards

JCAHO (Joint Commission on Accreditation of Healthcare Organizations)

- Effective January 1, 2023, new requirements to reduce health care disparities will apply to ambulatory care, behavioral health care and human services, critical access hospitals and hospital accreditation programs.
  - Requirement: 1)Assess the patient's health-related social needs (HRSN) and 2)Provides information about community resources and support services.
  - Examples of patient's health related social needs may include the following:
    - Access to transportation
    - Difficulty paying for prescriptions or medical bills
    - Education and literacy
    - Food Insecurity
    - Housing Insecurity

*Needs may be identified for a representative sample or for the entire population

r3_disparities_july2022-6-20-2022.pdf (jointcommission.org)

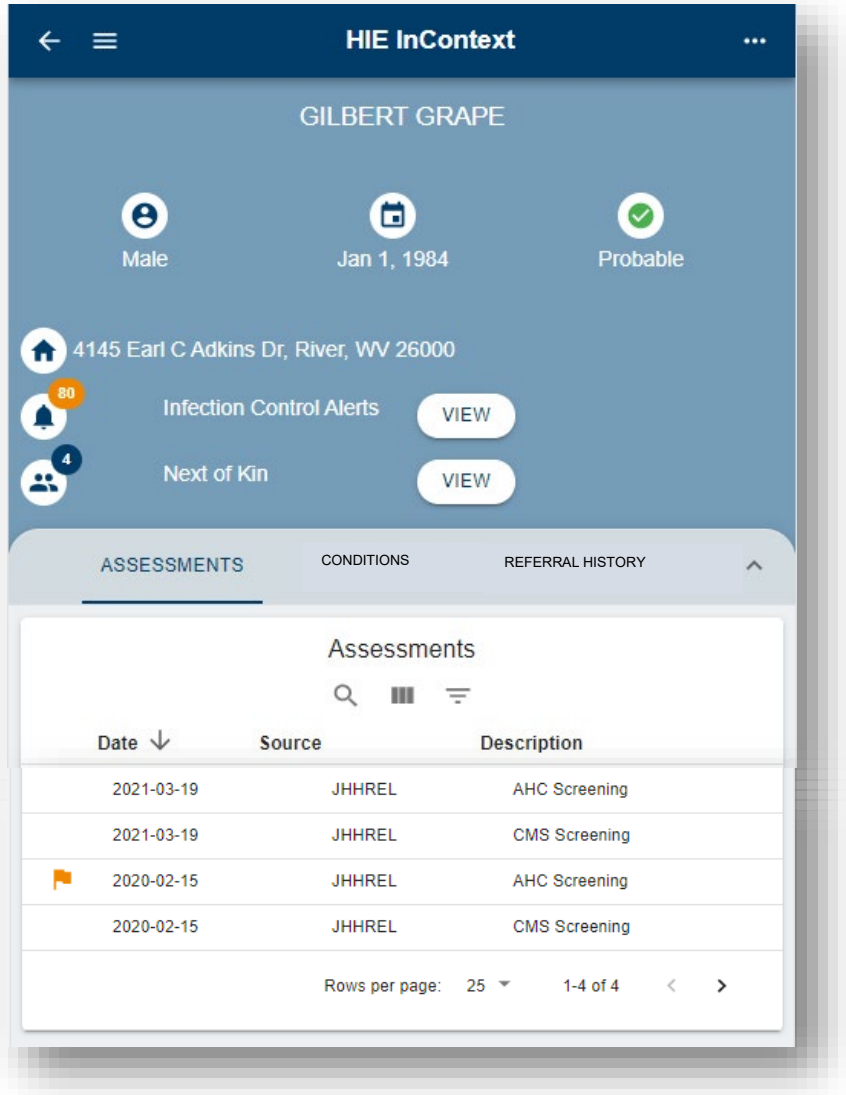
CRISP Process

Identifying Social Needs

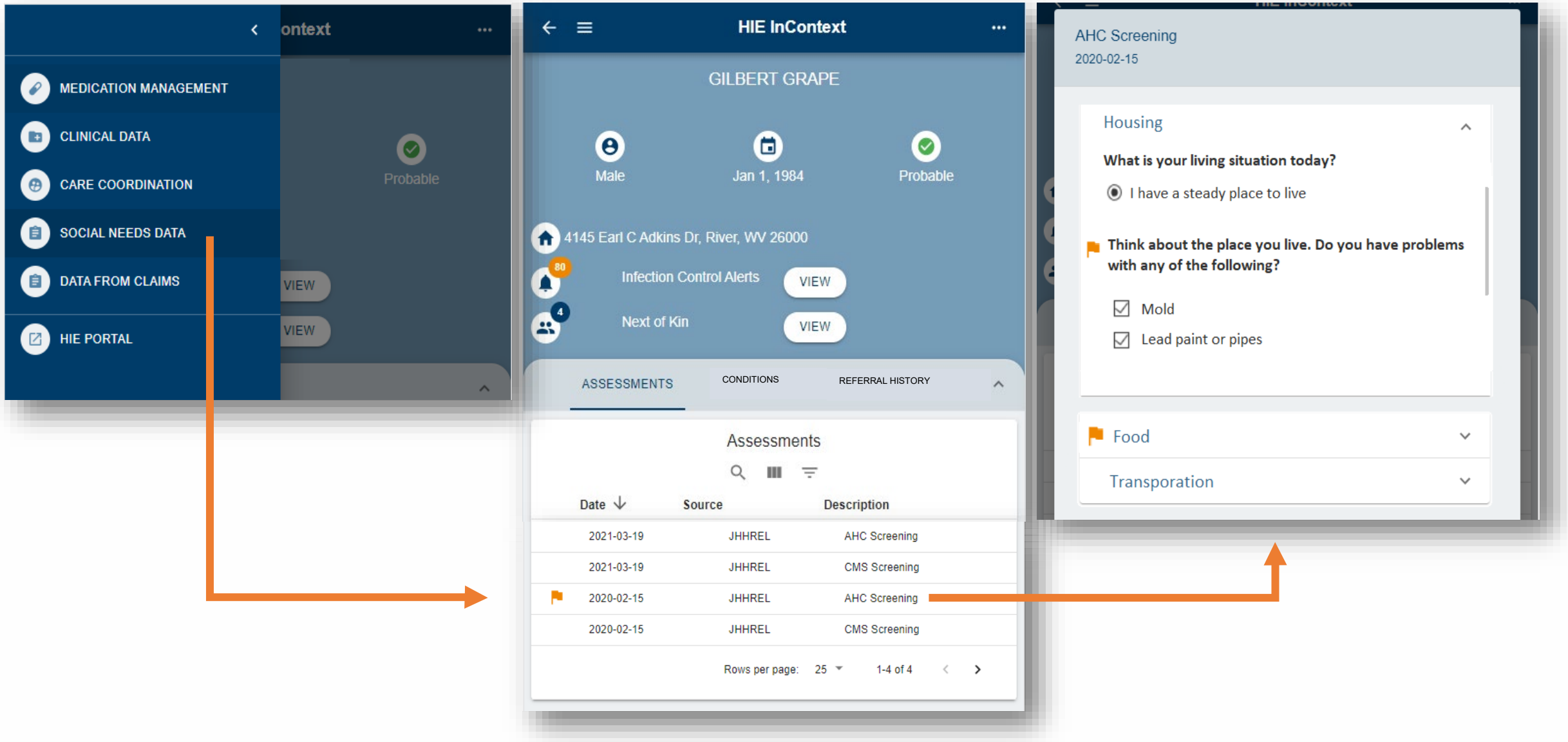
Problem: Social needs data are siloed and care teams have an incomplete picture of a person's needs when trying to achieve optimal health.

Goal: Capture all relevant social needs data and share it with appropriate members of the care team.

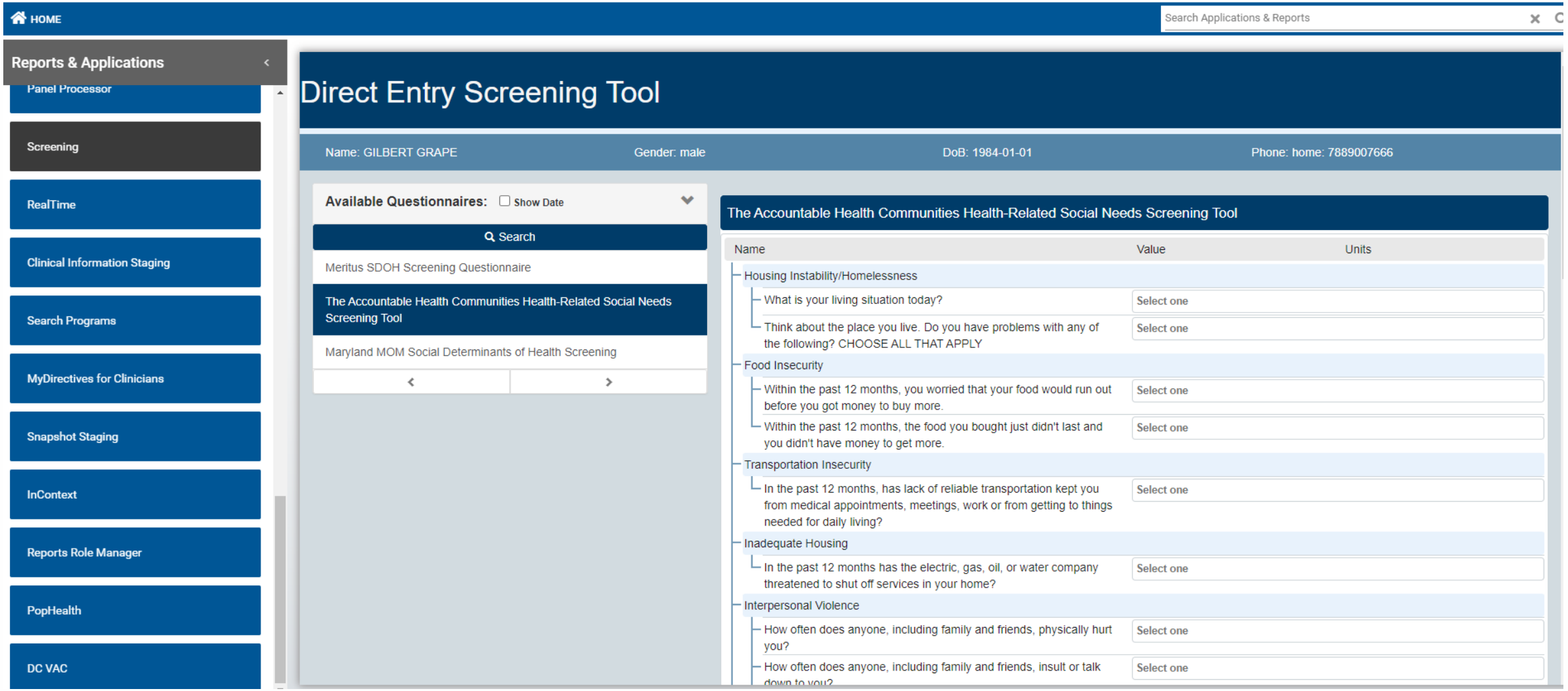
- Social needs assessments from various sources.
- SDOH conditions (Z-codes)



Displaying Social Needs Data at the Point of Care



Direct Entry Screening Tool



Onboarding Screening/Assessment

- Each question is mapped to an SDOH category based on the gravity project/CMS Requirements:
  - **Food Insecurity**
  - **Housing Instability**/Homelessness
  - Inadequate Housing
  - **Transportation Needs**
  - Financial Insecurity
  - Demographics (Unemployment/Education/Veterans)
  - Social Isolation
  - Stress
  - Neighborhood Safety
  - **Interpersonal Safety**
  - Behavioral Health
  - **Utility Difficulties**
  - Other
- Each answer to a question will be connected to if a need is identified or not. If a need is identified it will trigger the orange flag.

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Population Reporting

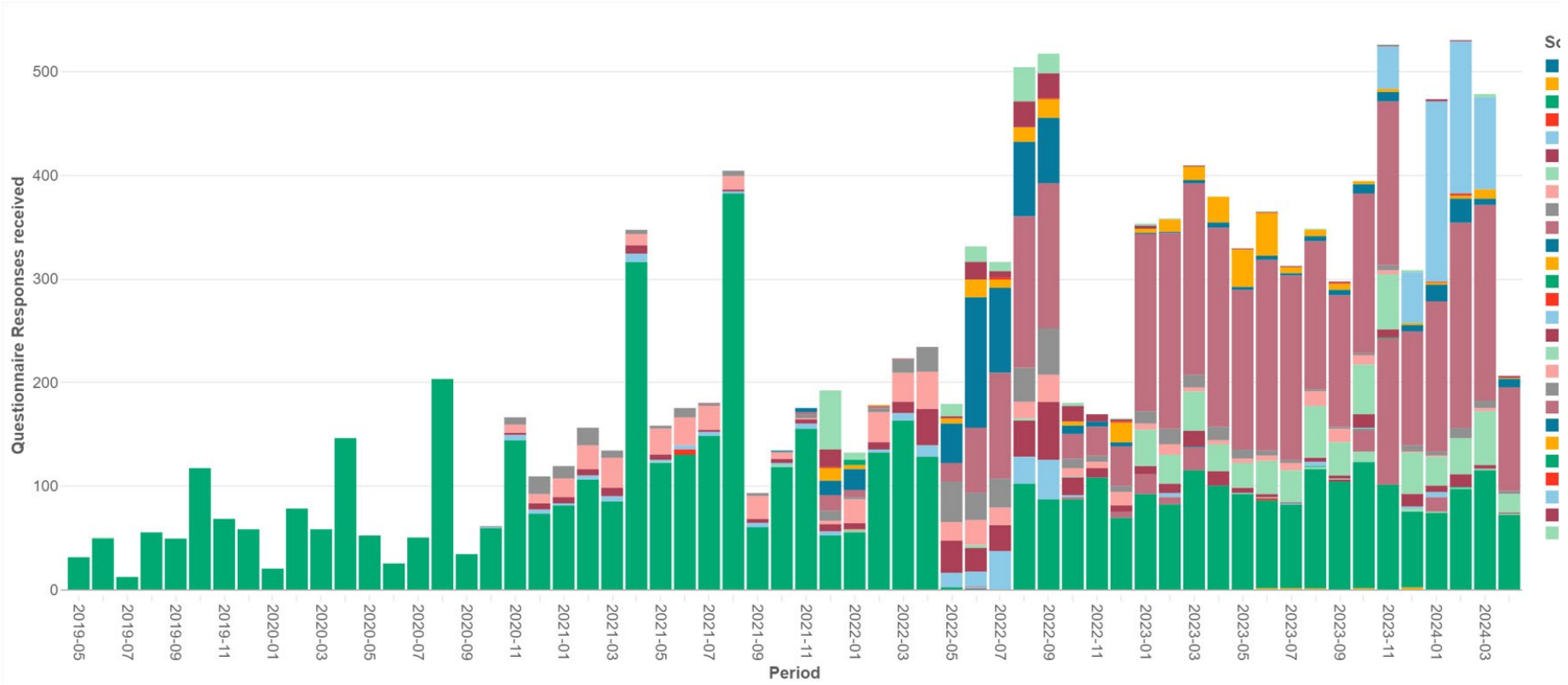
Key Metrics - Assessments

16
Sites Sending

4
Sites in Onboarding Pipeline

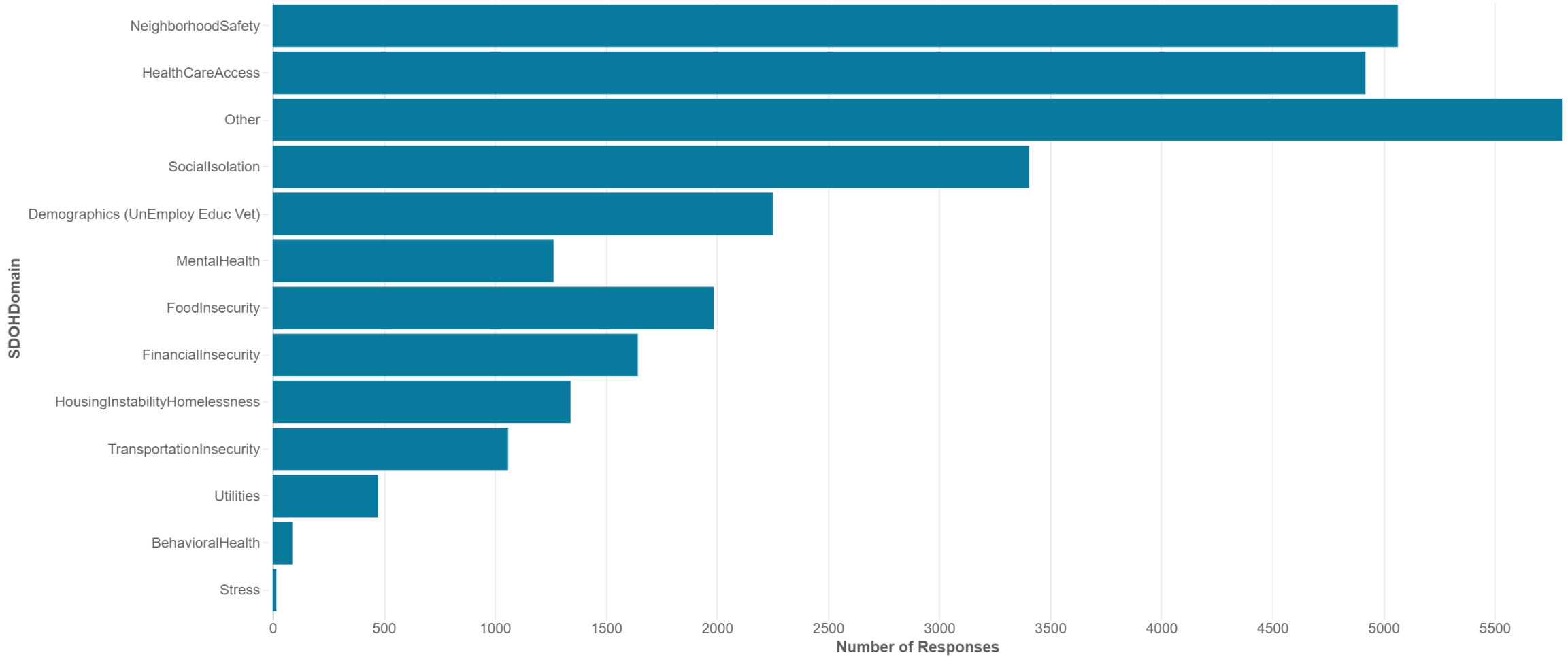
12
Active Questionnaires

450+
Received per month: current rate

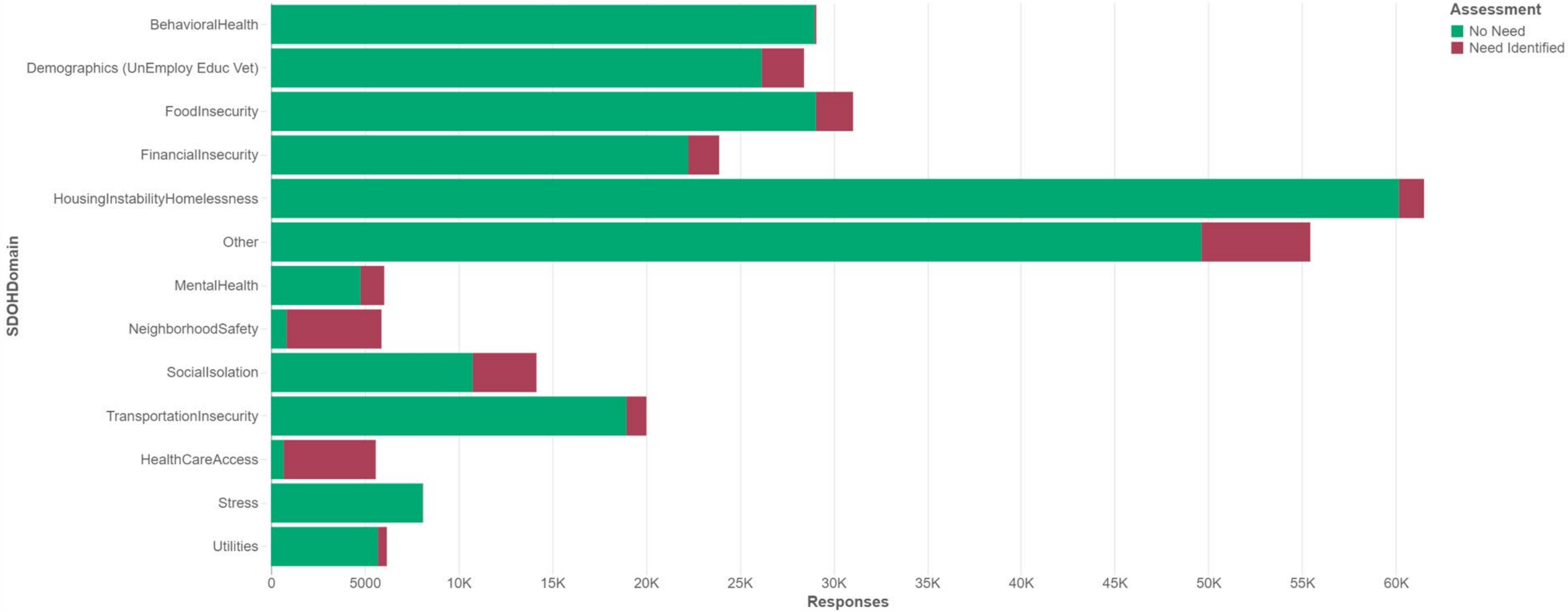


Population Level Reporting

Identified Needs



Population Level Reporting



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Community Benefits

Baltimore City Health Department

Local Health Improvement Coalition (LHIC)

Elise Bowman, Director of Strategic Partnerships

Agenda

- Baltimore City Health Department & LHIC Overview
- Why Social Needs Screening?
- How: Public Health & Healthcare Collaboration

Baltimore City Health Department (BCHD)

Vision

An equitable, just and well Baltimore where everyone has the opportunity to be healthy and to thrive.

Mission

To protect health, eliminate disparities, and enhance the wellbeing of everyone in our community through education, coordination, advocacy, and direct service delivery.

Data-Driven

Integrity

Innovation

Collaborative

Empowerment

Local Health Improvement Coalition (LHIC)

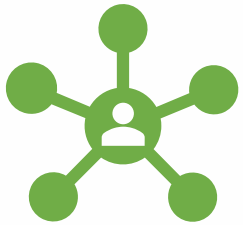
- Identify and address Baltimore City's most pressing health priorities through the Community Health Needs Assessment and Community Health Improvement Plan
- Foster shared leadership among healthcare, government, community organizations and community members
- Support a diversity of perspectives, collaboration and pooling of resources

Brandon M. Scott
Mayor, Baltimore City
Ihuoma Emenuga, MD, MPH, MBA
Commissioner of Health, Baltimore City

LHIC Priorities

The LHIC is currently working to **improve health** through shared leadership, collaboration, and pooling of community resources and insights.

Diabetes



Care Coordination

Social Determinants of Health

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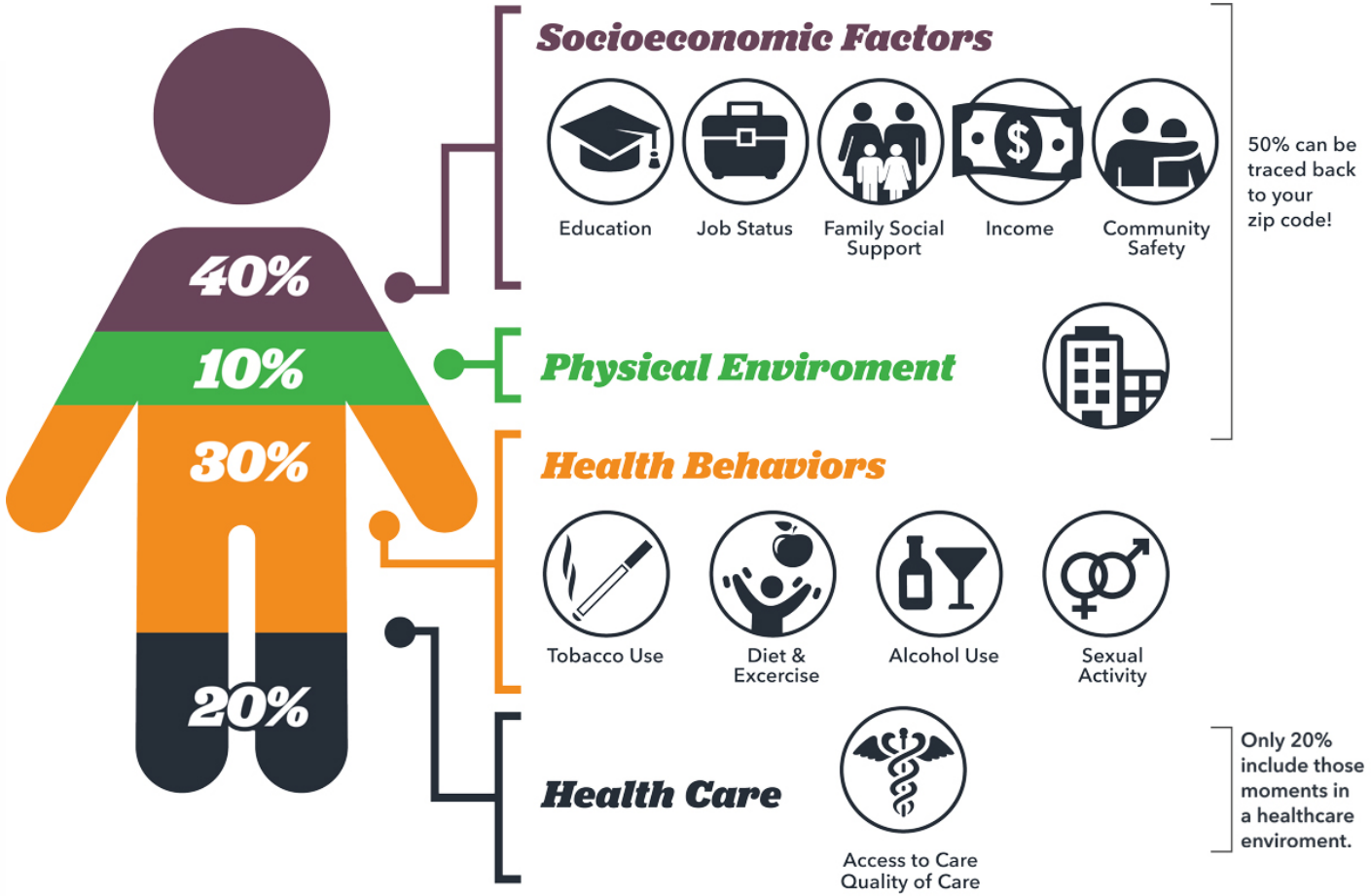
Why Social Needs Screening: Community Needs Assessment: Snapshot of Baltimore City

The "Why"

1. Addressing Health requires **whole person** approach
2. Wellness/ Health requires **individual, community, and system** interventions
3. No ONE institution, system, entity is ENOUGH.



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

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Community Health Needs Assessment (CHNA)

Identifies **key health needs** and barriers to health through **systematic** data collection and analysis

Occurs every 3-5 years

Collaborative process between city and hospitals

Engages diverse voices

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Community Survey Results:

Top perceived health needs in their communities

44% Addiction or substance use

43% Diabetes or high blood sugar

43% High blood pressure

40% Mental health

27% Overweight/obesity

27% Chronic pain and arthritis

***Respondents were asked to identify top 5, so values sum to more than 100%

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Key Leader Survey Results:

Top perceived health needs of the city

67% Mental health/suicide

64% Housing

61% Food security

55% Gun violence prevention

52% Substance use/alcohol use

52% Access to care

***Respondents were asked to identify top 5, so values sum to more than 100%

Community Survey Results:

Top perceived social needs for their communities

27% Can't afford healthy food

23% Gun violence

23% No or limited access to health insurance

23% Lack of job opportunities

22% Poor neighborhood safety

22% Housing problems/ homelessness

***Respondents were asked to identify top 5, so values sum to more than 100%

Key Leader Survey Results:
Top perceived social needs of the city

79% Access to affordable housing

73% Reducing crime/violence

70% Access to healthy foods

58% Access to jobs/employment

42% Affordable childcare

***Respondents were asked to identify top 5, so values sum to more than 100%

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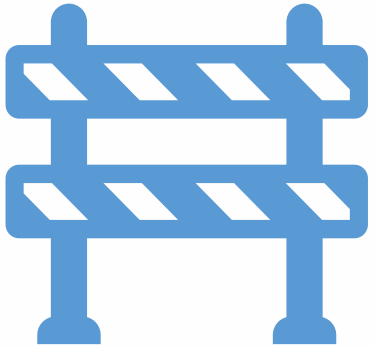
Community Survey Results:

Top perceived barriers to health care access in the community



57% Cost – too expensive or can't pay

41% Don't have health insurance

30% Lack of transportation

28% Long wait times or unavailability of appointments

26% Not able to take time off work or afraid of losing job

***Respondents were able to submit more than one response, so values sum to more than 100%

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Focus Groups: Key Findings

Housing & Homelessness

Healthcare: Access

Healthcare: Quality

Education

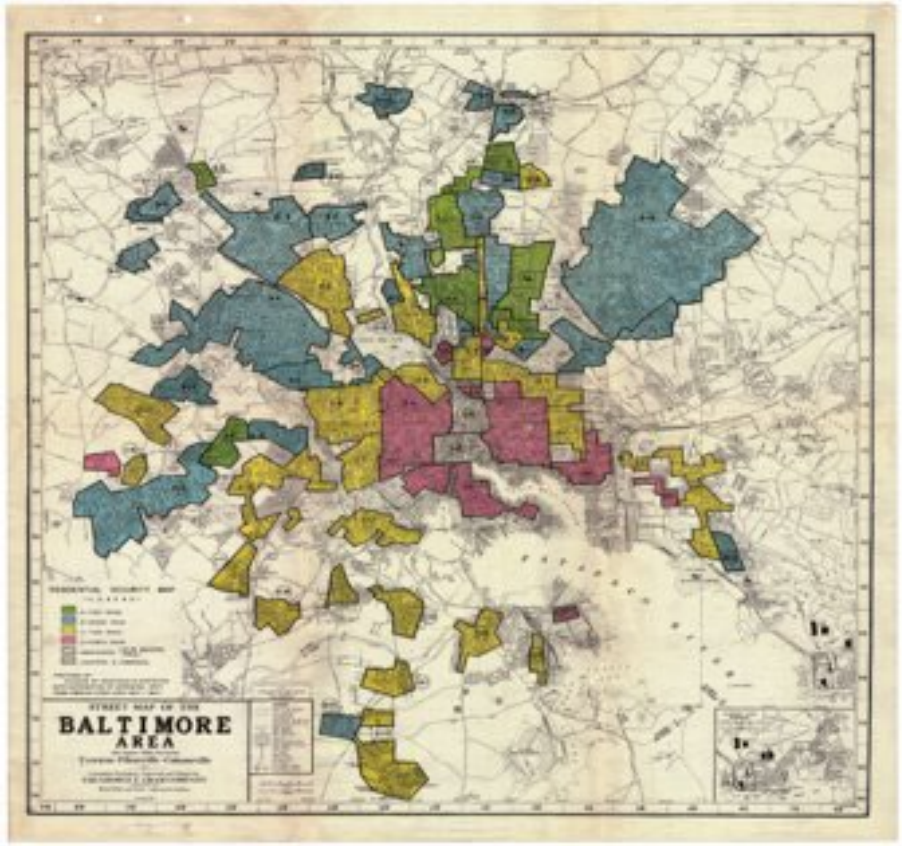
Food Insecurity

Mental Health

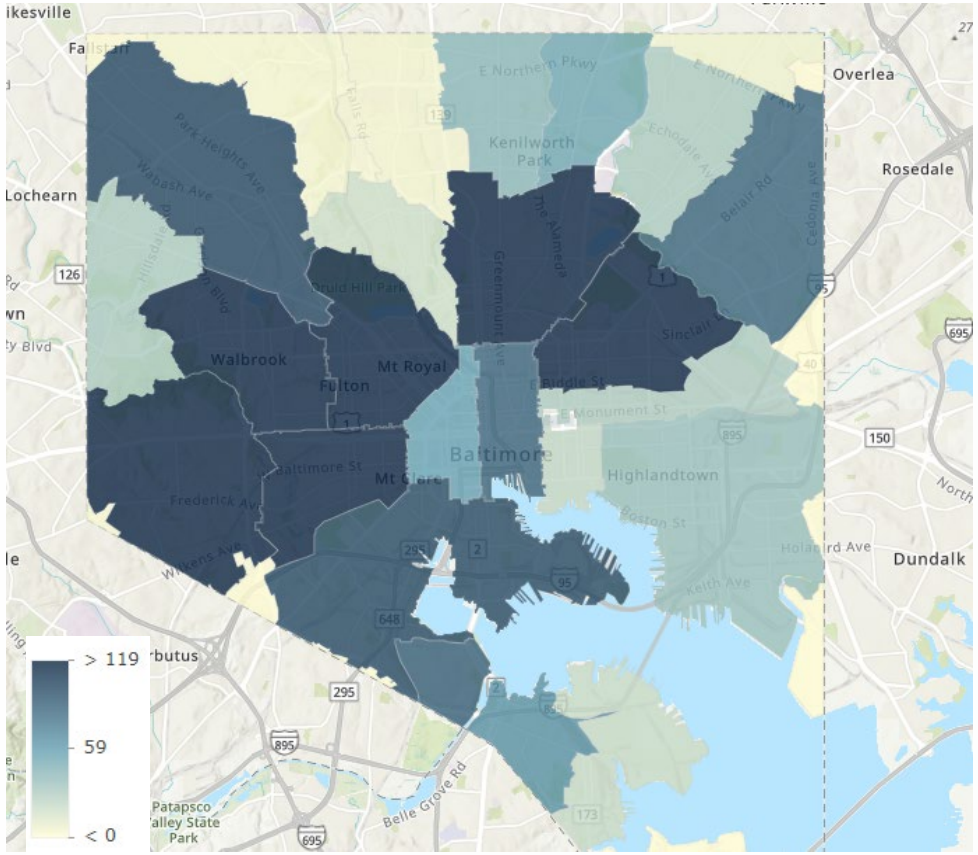
Transportation & Transit

Safety

Baltimore City has a history of racist policies that continue to impact the communities we serve



Baltimore City AHC beneficiaries by CSA, Oct. 2018 – Oct. 2020



[Link to map]

Upstream, Downstream and Midstream Intervention

Social needs screening can **improve the data on social determinants** of health and therefore **support policy makers, public health, and service delivery leaders** to target resources and services more effectively to the communities most in need.

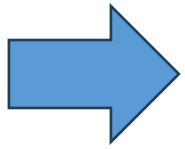
Social Needs Screening **is critical junction** between individual health and systems solutions.

Graphic adapted from de Beaumont Foundation and Trust for America's Health. (January 2019) "Social Determinants and Social Needs: Moving Beyond Midstream"

https://www.healthyhighpoint.org/our-focus/our-upstream-approach/

Shared Problems Require Shared Solutions

Social Needs Screening



- NO Shared Language + Standards
- Lack of Infrastructure
- CBO Capacity
- Funding
- Duplicate Work

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HOW:

Public and Private Collaboration

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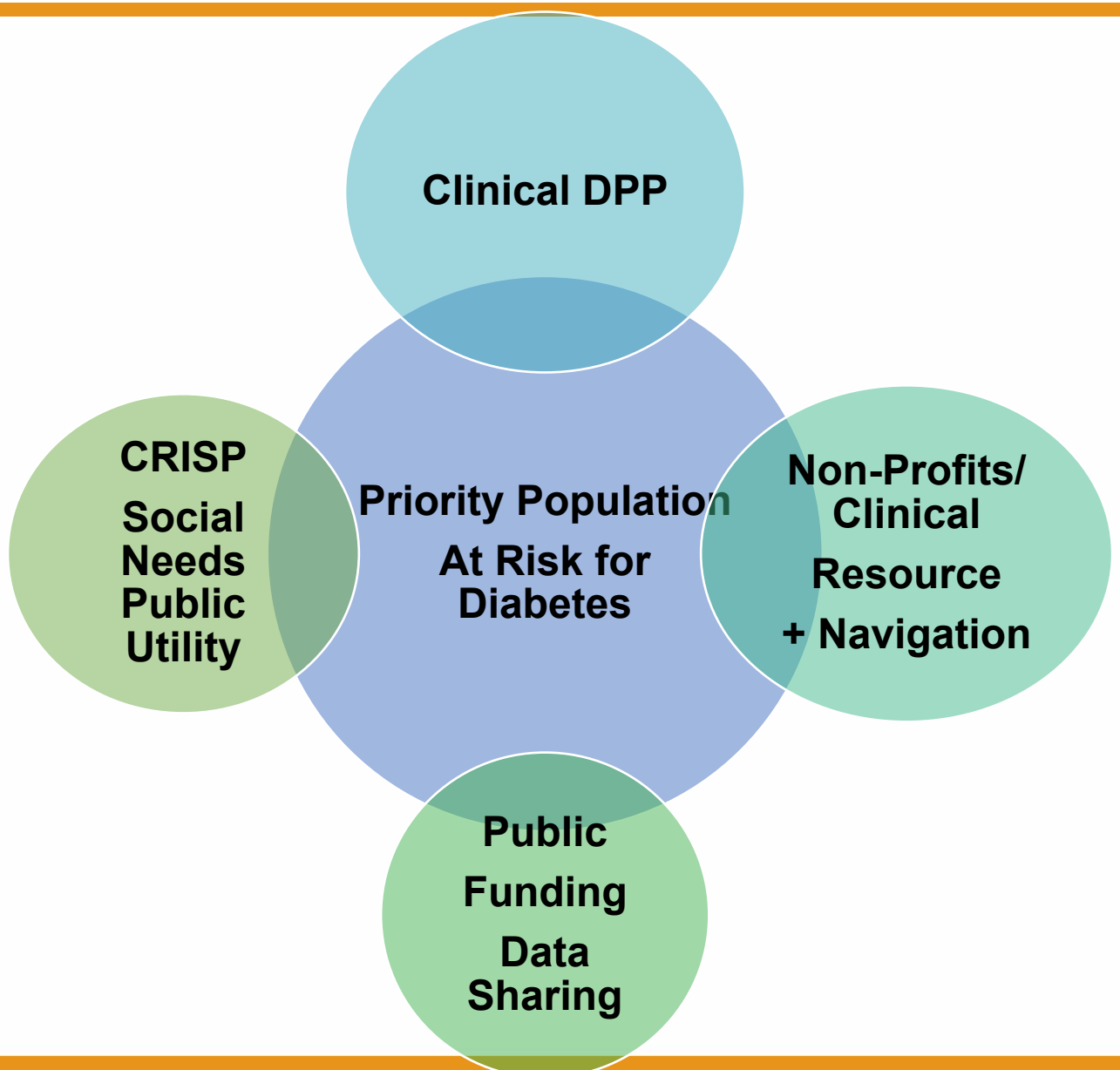
Improving Health Equity for Populations At Risk for Diabetes



Community Health Improvement Plan (CHIP)

Multi-year **community-driven plan** to improve the health of our community. The LHIC will begin the CHIP process in May 2024

Organize & Engage Partners

Develop & Implement Strategies for Action

Establish Accountability

How to Get Involved

Ways to Get Involved

- ✓ Become a member of the BCHD LHIC
- ✓ Participate in the CHIP
- ✓ Attend an LHIC Quarterly Meeting

Ready to Join the LHIC?

Thank you!

Elise Bowman
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Michelle Nnorom
Michelle.Nnorom@crisphealth.org

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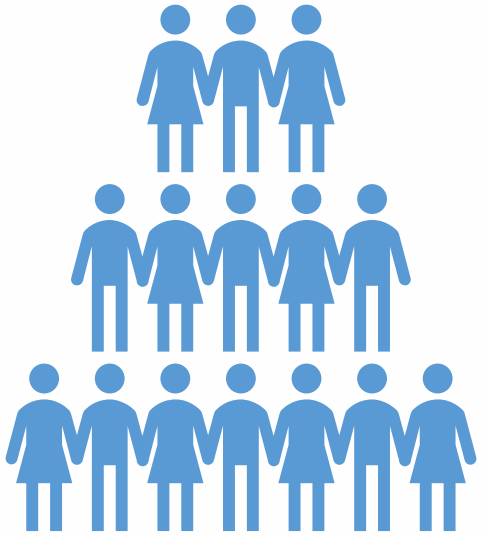
Appendix

Community Survey Results: Respondents



2,282 respondents

72% identified as women

48% Black or African American

18% Hispanic/Latinx

38% ages 60+

33% ages 40-59

29% ages 18-39

Key Leader Survey

Online tool in English

Conducted Sept–Nov 2023

33 respondents

- 48% non-profit organization
- 18% healthcare provider
- 12% faith-based organization
- 9% community development corporation
- 9% other
- 3% local government

**Percentages do not sum to 100% due to rounding

Onboarding Process: SDOH Screening

Organization sends CRISP assessment/screening questions (including all possible responses)

Organization/CRISP work together to ensure all questions are categorized and pinpoints need identified answers

CRISP builds the screening tool and then sends **organization** .CSV file to prep

Organization/CRISP test data through SFTP site

GO LIVE

Technical Process

1. Screening is mapped and built on the CRISP side
2. CRISP will send csv specs to organization to ensure file ingestion
3. SFTP site will be set-up (if needed)
4. Test csv files sent from organization to CRISP
5. Optional: Screening added to Direct Entry Screening Tool in CRISP
6. Optional: Upload of all previously completed screenings
7. Daily/Weekly auto-sending of screenings to CRISP