VBP/VBC Domain – SDoH & Health Equity

DESCRIPTION

Health inequities related to race, ethnicity, disability, sexual orientation, gender identity, language, and geography have endured for reasons such as socioeconomic factors at the individual and community level, implicit and explicit biases, and structural racism (HCP-LAN, Advancing Health Equity through APMs). The awareness of disparate health outcomes during COVID has been a catalyst for the health care system to focus on addressing health disparities. HCP-LAN launched a Health Equity Advisory Team (HEAT) in 2021 to provide guidance on improving health equity through value-based pay models.

The Center for Medicare and Medicaid Services goals from its 2022 health equity strategy are to:

- Close the gap in health care access, quality, and outcomes.
- Promote culturally and linguistically appropriate services.
- Build on outreach efforts to enroll people eligible for Medicaid, Medicare, and the Marketplace.
- Expand and standardize the collection and use of health disparities data.
- Determine how CMS can support safety net providers.
- Ensure engagement with and accountability to the communities CMS serves.
- Incorporate screening for and promote access to health-related social needs.
- Ensure CMS programs serve as a catalyst to advance health equity.
- Promote the highest quality outcomes and safest care for all people.

Social Drivers of Health (SDoH) are the conditions in which people are born, grow, live, work, and age (About SDoH, Word Health Organization, 2018). They include food insecurity, housing, employment, education, income, transportation, neighborhood and physical environment, discrimination, stress, and social isolation. Many of these SDoH seem like they are outside the scope of work or control of health centers, but health centers are increasingly investing in identifying and addressing SDoH to improve health outcomes of the populations they serve. SDoH can have a 60% impact on health outcomes, while health care has a 10% impact (CHCS presentation, Addressing Social Determinants of Health: Connecting People with Complex Needs to Community Resources, Sept 2018). Further, physicians have known for a while that SDoH impact health outcomes - four of five clinicians said patients' social needs are as important to address as their medical conditions (Fenton. Health Care's Blind Side: The Overlooked Connection Between Social Needs and Good Health RWJF; 2011).

The SDoH & Health Equity domain addresses the health center's ability to collect SDoH and health equity data and address patient/population needs through direct interventions or through partnerships with community-based organizations (CBOs) and social service agencies. HC leadership will need to be committed to assessing and addressing social and health equity needs of the patients and populations they serve in order to address critical issues that impact patient health outcomes.

HCs also need to address SDoH in order to improve cost, quality, and access metrics important to VBP models, particularly as VBP models evolve to support the comprehensive needs of vulnerable populations and improve health equity. Fee-for-service payments are too inflexible to support cross sector collaboration important to implementing SDoH interventions. VBP models can provide financial flexibility and accountability to allow providers to more easily address SDoH and health disparities. And, there is relatively strong evidence that when health care organizations and CBOs work together on housing and nutrition interventions, they can reduce costs and generate a return on investment important to gain the support of payers (Duke Margolis Center for Health Policy, "How Are Payment Reforms Addressing SDoH?", Issue Brief, February 2021).

Addressing SDoH is important for improving health equity in populations that HCs serve, but HCs can't assume that addressing SDoH, like food insecurity and housing instability, will translate to improving health equity. HCs need to collect data and target interventions to specifically address health disparities. The LAN HEAT paper identified the need for the community to align around a common definition and shared understanding of health equity as a first step towards advancing VBP models to address health disparities that are prevalent in the population(s) being served.

As VBP models pivot to support the needs of vulnerable populations and improve health equity, HCs should be taking the lead in shaping these payment models to improve health outcomes for the patients and populations they serve. For example,

- Payment should support data, analytics, and care model changes that address the comprehensive needs of HC patients and improve health equity.
- Seeing patients with complex social and behavioral needs should not be a disadvantage in VBP models.
- VBP models should have adequate risk adjustment for behavioral and SDoH.
- Payment should support interdisciplinary teams, including community health workers, that address the comprehensive needs of vulnerable populations.
- Payment should support closed loop referrals to CBOs and social service agencies.

Capabilities in the SDoH & Health Equity domain include:

- Prioritizing SDoH and health equity as a key strategy that the HC will focus on.
- Collecting SDoH and health disparities information on the HC's patients and populations served.
- Developing a plan to address SDoH and health disparities.
- Implementing SDoH and health disparities interventions and developing an ROI connected to improved health outcomes and lower total cost of care.
- Referring patients to CBOs and social service agencies and tracking if patients access these services.

RATING YOUR HC LOW, MEDIUM, OR HIGH FOR THIS DOMAIN

Attributes of HCs that are rated low, medium, or high for capabilities in this domain.

1. Does your HC regularly use data to understand the socio-economic characteristics of the population in your service area? (from NACHC's Payment Reform Readiness Assessment Tool).
    a. Low – The HC has aggregate data on the insurance and socio-economic status of its own population. This data is examined infrequently, typically in preparation for UDS reporting.
    b. Medium – The HC has the workforce capacity to regularly examine both internal and external data regarding the insurance and socio-economic status of both its own patients and residents of the service area, including an analysis of trends over time.
    c. High – HC staff regularly applies socio-economic data regarding the needs of populations targeted by specific payment reform efforts.
2. Does your HC measure health equity in your patient population (e.g., health outcomes reported by race/ethnicity)?
    a. Low - These data are not routinely tracked.
    b. Medium - These data are tracked on an organization-wide basis.
    c. High - These data are routinely provided as feedback to care teams.
3. Social needs of patients are (from Delta Center's MAHP 2.0 Assessment):
    a. Low – not routinely addressed or sometimes assessed and documented to inform clinical care.
    b. Medium – systematically assessed and documented and addressed by referral to community resources as available.
    c. High – systematically assessed, documented, and addressed by established links to community resources or by in-house programs to fill community gaps.

4. The health center has developed a business case for linking reimbursement to utilization and social complexity of health center patients and health center cost structure (from Delta Center's MAHP 2.0 Assessment).
    a. Low – The health center is able to identify data on its cost, patient utilization rates, and enabling service needs for its overall patient population.
    b. Medium – The health center is able to identify data on its cost, patient utilization rates, and enabling service needs of specific group(s) of patients to be involved in payment reform.
    c. High – The health center has data comparing its patients to the patient population, and is able to demonstrate how its robust services lead to better outcomes/costs. The health center can clearly articulate how enabling services will contribute to achievement of clinical and cost goals of specific payment reform efforts.

If you are interested in your HC taking a more comprehensive VBP assessment, below are some options:

- Delta Center's MAHP 2.0 Assessment Tool https://deltacenter.jsi.com/resources/road-ahead-model-advancing-high-performance-primary-care-and-behavioral-health-under
- NACHC Payment Reform Readiness Assessment Tool https://www.nachc.org/resource/payment-reform-readiness-assessment-tool/

RESOURCES FOR CHCS TO IMPROVE THIS CAPABILITY

LPCA, HCCN and/or LPCACO programs/support:

- Expanding the Care Team: Including Community Health Workers to Address Social Care Needs https://www.youtube.com/watch?v=_tZs-lgN2xs
- GET PRAPARED: Leveraging the PRAPARE Tool for Improved Patient Outcomes" https://us02web.zoom.us/rec/component-page?action=viewdetailpage&sharelevel=meeting&useWhichPasswd=meeting&clusterId=us02&componentName=need-password&meetingId=rEekVa6YPAfBBx_TaENpsu6cWet7om2Yr5JAe5Gm2bwHv7rzk0s-Ayaah059GGiN.B2YYaP6qTQvIJu2C&originRequestUrl=https%3A%2F%2Fus02web.zoom.us%2Frec%2Fshare%2F7xbdSHmggjN6zmW5CrXTI9TbABFkogbBm_7cq8AgIsEqxioNT6Gy7MrhEiYVDjBV.7wYnx9mmni04cyXF
- LPCA ASSIST and Social Determinants of Health https://lpca.net/wp-content/uploads/LPCA-Assist-and-SDOH_findhelp-5.25.2023.pdf
- Social Drivers of Health (SDOH) & Azara Care Connect https://lpca.net/wp-content/uploads/SDOH-and-ACC_Azara-Healthcare-5.25.2023.pdf
- Athena EMR User Group Session 1 (PRAPARE) https://lpca.net/wp-content/uploads/PRAPARE-SDOH-athenahealth.pdf
- NextGen EHR User Group Session 1 (PRAPARE) https://lpca.net/wp-content/uploads/LPCA-PRAPARE-Presentation-3.30.23.pdf
- PRAPARE Screening Example https://lpca.net/wp-content/uploads/Prapare.pdf
- Greenway Intergy EHR User Group Session 1 PRAPARE" https://lpca.net/wp-content/uploads/PRAPARE-presentation-3.15.2023.pdf
- LPCA Coding SDOH and Crosswalking to UDS 10.5.2023.pdf

Other partners that can help CHCs improve this capability:

- PRAPARE team, SDoH assessment and implementation
- Association of Asian Pacific Community Health Organizations (AAPCHO), research and implementation tools
- Hostetler Group, strategies to align VBP models with CHC health equity efforts
- Integrated Work, justice, equity, diversity, and inclusion (JEDI) trainings
- https://www.findhelp.org/

Links to resources for this capability:

SDoH, Health Equity Links

- https://www.lpcaassist.net/
- SDoH screening and implementation tools/resources, PRAPARE https://prapare.org/
- Justice, equity, diversity, and inclusion trainings/resources, Integrated Work https://integratedwork.com/consulting/jedi/
- CMS 2022 Health Equity Plan https://www.cms.gov/files/document/health-equity-fact-sheet.pdf
- Health Equity Resources, CDC https://www.cdc.gov/nccdphp/dnpao/health-equity/health-equity-resources.html
- Health Equity Resources, CHAMPS http://champsonline.org/tools-products/quality-improvement-resources/health-equity-resources
- PCMH Health Equity Initiative https://www.oregon.gov/oha/HPA/dsi-pcpch/Documents/PCPCH%20Program%20Health%20Equity%20Initiative%20Community%20Feedback%20and%20Next%20Steps%20Report%20December%202021.pdf
- Toolkit to Advance Racial Health Equity for Primary Care, CHCF https://www.chcf.org/publication/toolkit-racial-equity-primary-care-improvement/
- Health Equity Curricular Toolkit, AAFP https://www.aafp.org/family-physician/patient-care/the-everyone-project/health-equity-tools.html
- Health Equity Resources, IHI https://www.ihi.org/Topics/Health-Equity/Pages/default.aspx
- Behavioral Health Equity Resources, SAMHSA https://www.samhsa.gov/behavioral-health-equity/resources
- Duke Margolis Center for Health Policy, paper on payment reform addressing SDoH https://healthpolicy.duke.edu/publications/how-are-payment-reforms-addressing-social-determinants-health-policy-implications-and
- HCP-LAN paper on pivoting VBP models to improve health equity http://hcp-lan.org/workproducts/APM-Guidance/Advancing-Health-Equity-Through-APMs.pdf
- The Gravity Project: working to create data standards related to SDoH: https://thegravityproject.net/
- Healthy People 2030 SDoH Page (also has articles and resources): https://health.gov/healthypeople/priority-areas/social-determinants-health
- Data Sources:
    - CDC Data Set Directory: https://www.cdc.gov/dhdsp/docs/data_set_directory.pdf
    - City Health Dashboard – an online data mapping tool put together by NYU Langone Health: https://www.cityhealthdashboard.com/
    - County Health Rankings – by RWJF: https://www.countyhealthrankings.org/explore-health-rankings
    - US Health MAP by Institute for Health Metrics and Evaluation (IHME) – out of the University of Washington: https://vizhub.healthdata.org/subnational/usa
    - County Explorer by the National Association of Counties: https://ce.naco.org/
    - CDC Quick Maps: https://www.cdc.gov/dhdsp/maps/quick-maps/index.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fdhdsp%2Fmaps%2Fnational_maps%2Findex.htm
    - Community Commons: https://www.communitycommons.org/