Social Determinants of Health (SDOH): Social Needs Screening & Referral Measure Café Connect Orientation

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Oregon Health Authority

Measure Contacts

Technical Assistance Team

- Anne King, MBA (she/her)
  kinga@ohsu.edu
- Kate Wells, MPH (she/her)
  katemcwells@gmail.com
- Claire Londagin, MPH (she/her)
  londagin@ohsu.edu
- Kristina Giordano (she/her)
  giordank@ohsu.edu

Oregon Health Authority Team

- Rachel Burdon, MPH (she/her)
  Rachel.E.Burdon@oha.oregon.gov
- Katie Howard, MPH (she/they)
  Katie.Howard@oha.oregon.gov

Upcoming Technical Assistance (TA) Opportunities

Learning Collaboratives (LCs)

Audience: CCO Measure Leads

- Share strategies and learn from one another
- Topics will center high priority needs and metric must-pass elements

Upcoming Topic: (Sept 28)
Grounding LC – **Register Here**

Café Connect Event Series

Audience: CCOs, CBOs, & providers

- Hear from experts in the field
- Opportunity for CCOs, CBOs, and providers to engage in dialogue

Upcoming Topic: (Oct 24)
Health and Social Care Integration: Sustainable Partnerships – **Register Here**

Bi-Monthly Office Hours

Audience: CCO Measure Leads

- Talk through questions with TA providers and other CCOs
- Structured resources on a specific topic area

Upcoming Topic: (Oct 27)
Developing formal agreements with CBOs – **Register Here**

Individualized Technical Assistance

- One-on-one technical assistance is available to all CCO staff responsible for metric implementation
- Support tailored to the needs of individual CCOs
- Contact **Claire Londagin** (londagin@ohsu.edu) for individualized TA

Agenda

- Social Needs Screening Background
- Measure Overview & Requirements
- Opportunities for Collaboration Between Coordinated Care Organizations (CCOs), Community Based Organizations (CBOs), & providers
- Questions
- Additional Resources

Background – Definitions

Social Determinants of Health: The social, economic and environmental conditions in which people are born, grow, work, live and age, and are shaped by the social determinants of equity. These conditions significantly impact length and quality of life and contribute to health inequities.

Social Determinants of Equity: Systemic or structural factors that shape the distribution of the social determinants of health in communities.

[Definitions per OAR 410-141-3735]

Background – Definitions

Social Determinants of Health:

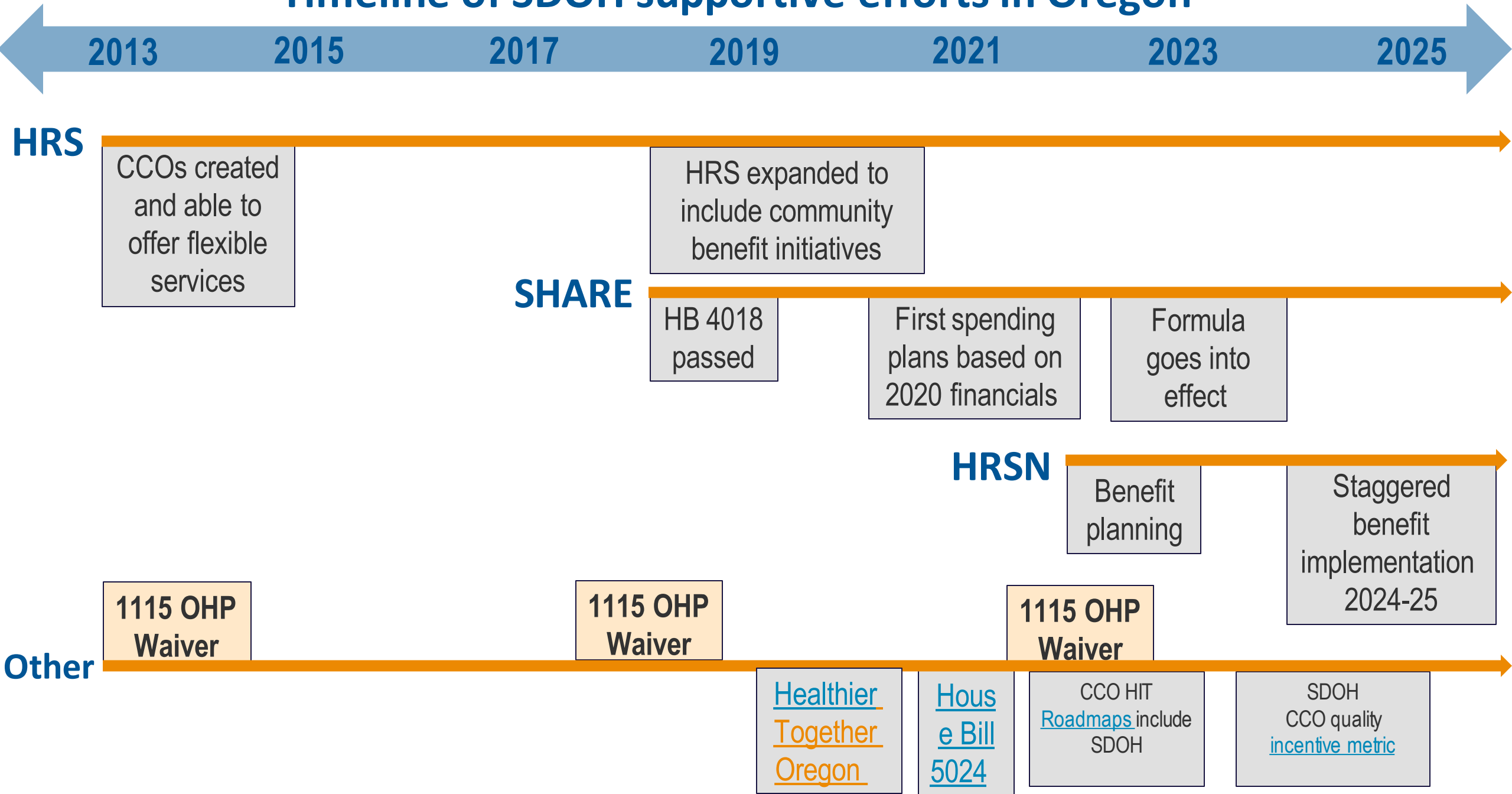
a. Nonmedical factors that influence health outcomes;

b. The conditions in which individuals are born, grow, work, live and age; and

c. The forces and systems that shape the conditions of daily life, such as economic policies and systems, development agendas, social norms, social policies, racism, climate change and political systems.

[Definition per Senate Bill 966]

Timeline of SDOH supportive efforts in Oregon



Social Needs Screening Background

- There is growing evidence to support that social determinants can be **more impactful** than clinical care or lifestyle choices on a person's health (Office of Health Policy, April 2022).
- 73% of the 18,003 Medicaid members screened by the Oregon Accountable Health Communities project reported a food, housing, transportation, utilities and/or safety need. (Accountable Health Communities, 2022)
- The COVID-19 pandemic has caused an **increase** in social needs among Medicaid members (Oregon Accountable Health Communities, May 2022).

Benefits of Social Needs Screening:

➔ **Collaboration** across sectors to provide wrap-around care

➔ **Connection** of patients to needed services, improved individual health

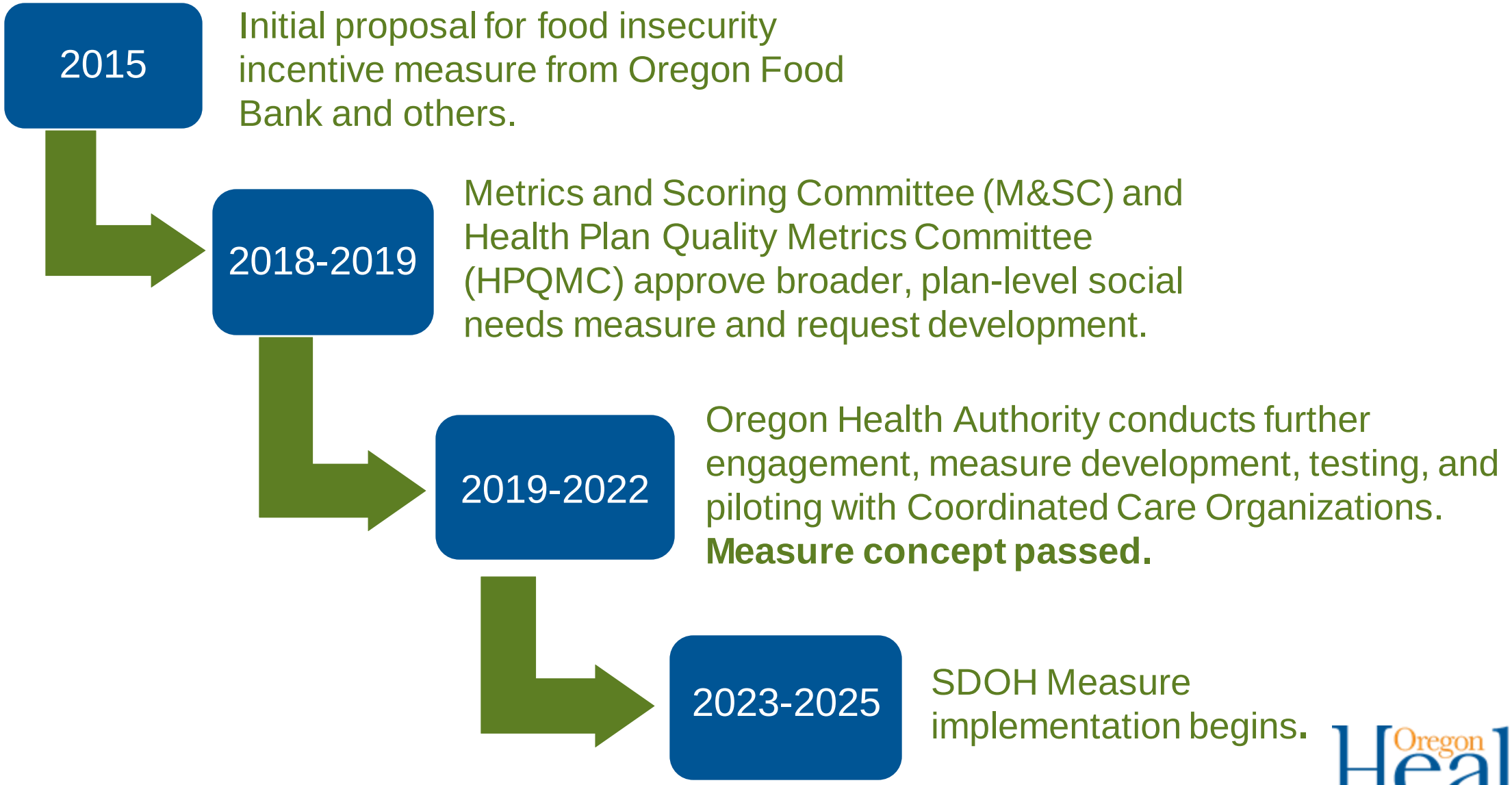
➔ **Collection** of both patient and population-level data to inform broader community solutions

Source: Office of Health Policy. (2022). *Addressing the Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts*. (HP-2022-12). U.S. Department of Health & Human Services. Office of the Assistant Secretary for Planning and Evaluation. https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf

Oregon Accountable Health Communities study. (2022)

Social Determinants of Health Measurement Work Group Final Report, February 2021.

Measure Timeline



Measure Overview

The **Social Determinants of Health: Social Needs Screening & Referral Measure** aims to acknowledge and address Oregon Health Plan members' social needs over the course of three years.

Social needs this measure addresses:

- Food insecurity
- Housing insecurity
- Transportation needs

Component 1 - Measure Year 2023 – 2025:
Assesses Coordinated Care Organizations' plans for implementation of social needs screening and referral in an equitable, trauma-informed manner; ensures groundwork is laid for data sharing and reporting.

Component 2 – Measure Year 2025 - 2026:
Assesses Coordinated Care Organizations' plans for implementation of social needs screening and referral in an equitable, trauma-informed manner; ensures groundwork is laid for data sharing and reporting.

Must-Pass Elements by Measurement Year

Elements of work to be accomplished	2023	2024	2025
A. Screening practices			
Collaborate with members on processes and policies	Must pass	Must pass	Must pass
Establish written policies on training	Must pass	Must pass	Must pass
Assess whether/where members are screened	Must pass	Must pass	Must pass
Assess training of staff who conduct screening		Must pass	Must pass
Establish written policies to use Race, Ethnicity, Language and Disability (REALD) data to inform appropriate screening and referrals	Must pass	Must pass	Must pass
Identify screening tools or screening questions in use	Must pass	Must pass	Must pass
Assess whether Oregon Health Authority-approved screening tools are used		Must pass	Must pass
Establish written protocols to prevent over-screening	Must pass	Must pass	Must pass

Must-Pass Elements by Measurement Year

Elements of work to be accomplished	2023	2024	2025
B. Referral practices and resources			
Assess capacity of referral resources and gap areas	Must pass	Must pass	Must pass
Establish written procedures to refer members to services		Must pass	Must pass
Develop written plan to help increase community-based organization (CBO) capacity in Coordinated Care Organization service area		Must pass	Must pass
Enter into agreement with at least one community-based organization that provides services in each of the 3 domains	Must pass	Must pass	Must pass
C. Data collection and sharing			
Conduct environmental scan of data systems used in your service area	Must pass	Must pass	Must pass
Set up data systems to clean and use REALD data		Must pass	Must pass
Support a data-sharing approach within the Coordinated Care Organization service area		Must pass	Must pass

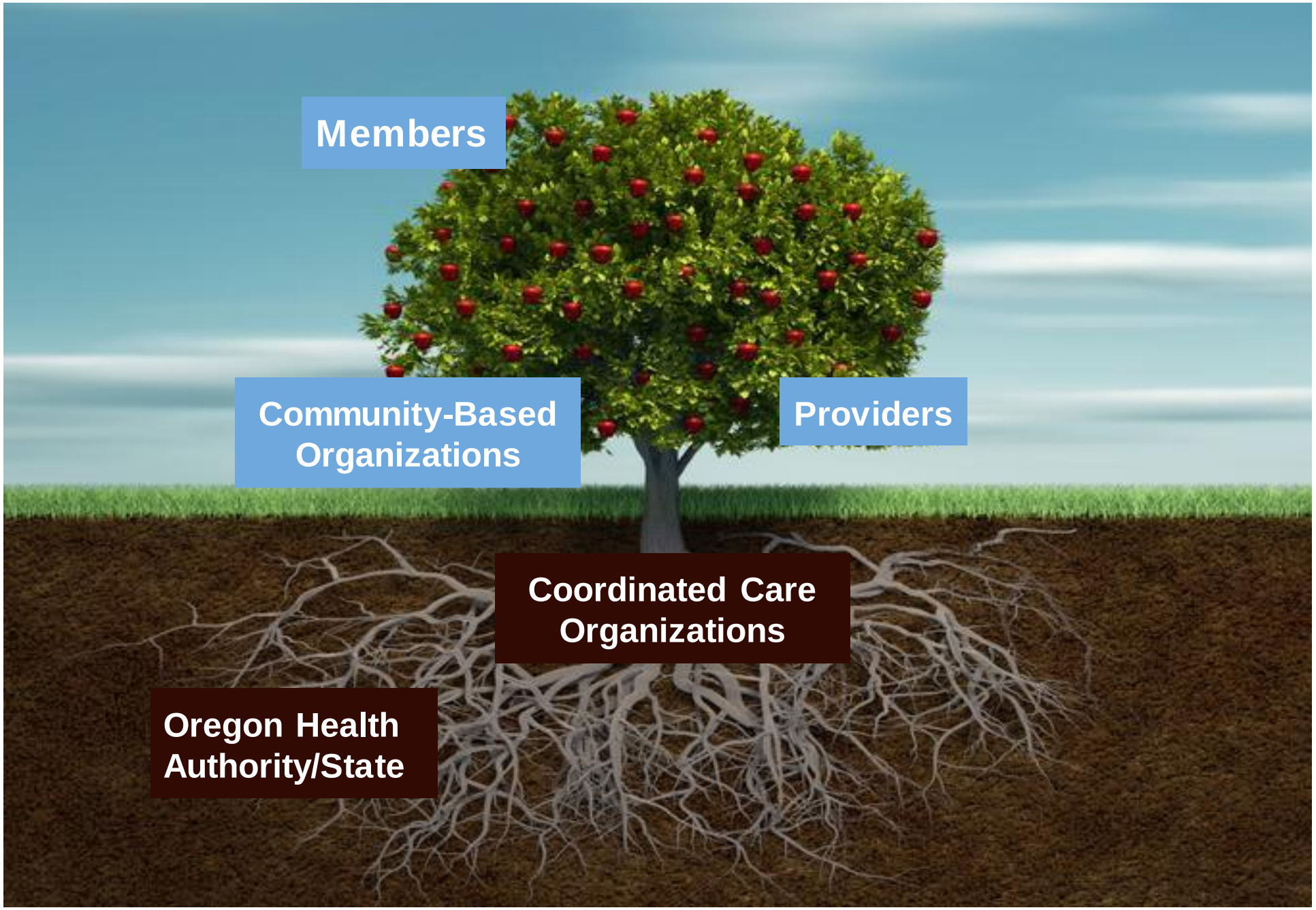
2022-2023 Technical Assistance in Review

- Past technical assistance events can be viewed on the **OHA Transformation Center Webpage**
- Have a question? **Check out the FAQ!** This resource will be updated quarterly.
- Walk through measure requirements and brainstorm next steps with the **CCO Learning Collaborative Playbook.**

- **All SDOH Metric Resources can be found on the** OHA Transformation Center Webpage

2023 & 2024 Measure Implementation Activities

Opportunities for Collaboration Between CCOs, CBOs & providers


Members
Community-Based Organizations
Providers
Coordinated Care Organizations
Oregon Health Authority/State

How CBOs and Clinical Providers Can Partner with CCOs

- Collaborate on **protocols and procedures** to:
  - Assess individuals' unmet social needs
  - Prevent over-screening
  - Refer individuals to services

- Support the **systematic assessment** of:
  - Social needs screening tools and questions
  - Languages available for screening tools
  - Where screenings are occurring
  - Training provided to those who conduct screening
  - Data collection and exchange practices

- Participate in the **inventory of services and resources** for food, housing, and transportation in each CCO service area
- Collaborate on written **plans to increase CBO capacity** in each CCO service area
- Maintain or form new **contracts (CCOs and CBOs)** to provide services in each of the three domains
- Participate in development of processes for using **REALD** data in screening and referral practices

Questions?

Coordinated Care & SDOH Metric Resources

To learn more about Coordinated Care in Oregon:

- Overview and key elements of Oregon's Coordinated Care model
- Map of Coordinated Care Organization (CCO) service areas in Oregon
- Overview of how Coordinated Care Organizations (CCOs) are measured for quality and outcomes
- 2023 CCO Incentive Measures

- **SDOH Metric Resources can be found on the** OHA Transformation Center Webpage

Evaluation

Thank you!

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