Café Connect: Data Coordination Between Social Services and CCOs

Social Determinants of Health (SDOH) Social Needs Screening & Referral Measure

March 18, 2023

ORPRN
Oregon Rural Practice-Based Research Network

Agenda

- Introductions & Context (5 mins)
- Liz Buck & Diana Crumley, Center for Health Care Strategies (25 mins)
- Q&A with Center for Health Care Strategies (10 mins)
- Breakout Group Discussion (15 mins)
- Next Steps & Upcoming Technical Assistance Opportunities (5 mins)

Context

- State social services, such as the Supplemental Nutrition Assistance Program (SNAP) and Oregon Housing and Community Services, have extensive data on populations that intersect with the Medicaid member population.

- Coordinating data between Coordinated Care Organizations (CCOs) that manage Medicaid and state agencies that provide social resources can:
  - Improve care coordination
  - Reduce over-screening
  - Reduce duplication of services
  - Identify individuals who do not access healthcare settings
  - Enhance targeted interventions
  - Improve outcomes

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Center for Health Care Strategies
Better care where it's needed most

Learnings from Other States: Implementing Cross-Sector Data Sharing Efforts

Data Coordination Between Social Services and CCOs

March 18, 2024

Diana Crumley

Liz Buck

Center for Health Care Strategies

Dedicated to strengthening the U.S. health care system to ensure better, more equitable outcomes, particularly for people served by Medicaid.

Together with our partners, our work advances:

Effective models for prevention and care delivery that harness the field's best thinking and practices to meet critical needs.

Efficient solutions for policies and programs that extend the finite resources available to improve the delivery of vital services and ensure that payment is tied to value.

Equitable outcomes for people that improve the overall well-being of populations facing the greatest needs and health disparities.

Social Needs Screening & Referral: Trends

- State Trends: Oregon, Rhode Island, and Massachusetts created social needs screening measures, pre-dating federal activity.
- National Trends:
  - → New measures, including:
    - *Screening for Social Drivers of Health / Screen Positive Rate* (CMS)
    - *Social Needs Screening and Intervention (SNS-E)* (HEDIS® 2023)
  - → New requirements and codes, including:
    - Special Needs Plan (SNP) health risk assessment
    - Joint Commission Standards
    - New CMS Innovation Center Models
    - SDOH Risk Assessment & Community Health Integration (Medicare HCPCS codes)
  - → Growing interest in community care hubs

National Resource: Gravity Project

- *Identify, improve, and create data classes and elements that support interoperability for quality measures, billing, and other health equity needs*
- *Develop CPT and HCPCS to support documentation of social care services to support policy requirements, and enable sustainable CBO partnerships*
- *Define and incorporate standards for documenting critical health equity demographic elements (race and ethnicity, gender, sex for clinical use, pronouns, sexual orientation, language)*
- *Define methodology techniques for tailoring the information shared between health systems and CBOs to maximize CBO needs, while ensuring control for the individual about which information is shared with whom*

Slides include excerpts from Gravity Project's Strategic Goals, available here: Project Information - Gravity Project - Confluence (hl7.org); *See also Social Care Co-Design Final Report*, in partnership with HealthBegins. Available at: https://confluence.hl7.org/display/GRAV/Social+Care+Voice+Engagement?preview=/175606815/220699508/FINAL-Co-Design-Report-Gravity-Project-and-Civitas-Networks-for-Health.pdf

Center for Health Care Strategies

National Resource: Civitas Networks for Health

- Members: All-Payer Claims Databases, Health Information Exchanges, Regional Health Improvement Collaboratives, Quality Improvement Organizations, & Health Data Utilities
- *Recent Presentation: Community-Led Health Data Utility (HDU) in Oregon*
  - → Comagine Health and Reliance eHealth Collaborative (members)
  - → Project Access Now (Carly Hood-Ronick)

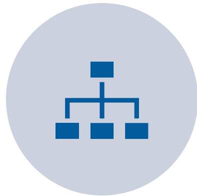
For more information on the Oregon model, see here: https://www.civitasforhealth.org/oregon-health-data-utility/

Case Studies & Examples

Liz Buck, Senior Program Officer

Center for Health Care Strategies

Components of Effective Cross-Sector Data Sharing



Buy-in and support at all levels of organization

Governance structures that involve key stakeholders including members of the community

Shared vision across stakeholders

Guided by the specific data uses of the community and partners

Includes agreements between parties and consent among people who have data

Includes a commitment to involving community members as a key mechanism of advancing health equity

Case Study: #1- Connecticut

Strong history of supportive housing in the state.

→

Corporation for Supportive Housing supported Connecticut in initial match between Homeless Management Information System and Medicaid for a reentry program.

→

Engagement of providers and key stakeholders in release of information was key. Memorandum of Understanding between agencies was also critical.

↓

In Connecticut, HMIS and Medicaid data went to New York University to complete the match, matched names then went to the state's HMIS.

→

Top 10% of individuals with highest use were identified for supportive housing

→

Connecticut launches Housing Engagement and Support Services. CHESS provides supportive housing benefits under Medicaid, coordinated with Medicaid services and non-Medicaid housing subsidies.

Sources: National Human Services Data Consortium, *Connecticut's HMIS Journey and Lessons Learned* and National Academy for State Health Policy, *Q&A: How Connecticut Matched Its Medicaid and Homelessness Data to Improve Health through Housing*

Case Study #2: Learning and Action in Policy and Partnerships Initiative

- *Arizona Housing Coalition:* Integrated HMIS and Medicaid data and engaged people experiencing homelessness to improve systems

- *D.C Primary Care Association* Developed a community resource inventory that facilitates coordination of care between social service agencies and health care organizations

BRIEF • August 2022

A Community-Centered Approach to Data Sharing and Policy Change: Lessons for Advancing Health Equity

By Liz Buck and Alissa Beers, Center for Health Care Strategies, and Waldo Mikels-Carrasco, Data Across Sectors for Health

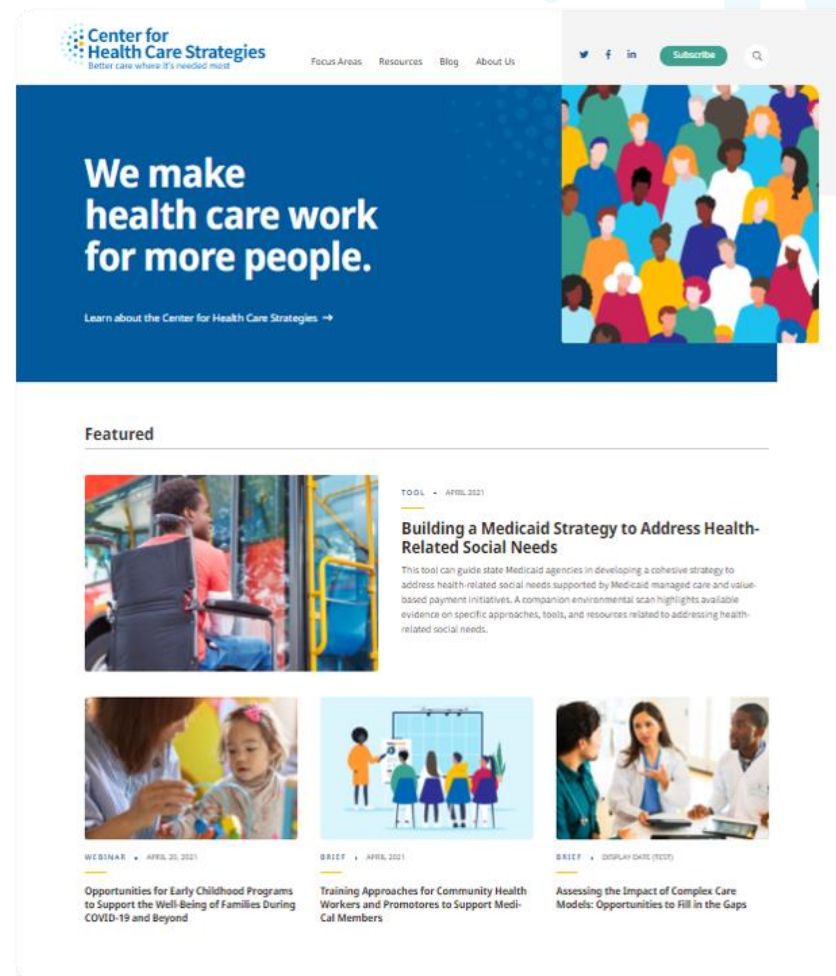
Source: CHCS and DASH, "A Community-Centered Approach to Data Sharing and Policy Change: Lessons for Advancing Health Equity."

Key Learnings and Considerations

- Goal is to make data usable and ensure its valuable for *all* users– including community- based organizations and community members.
- Important to have feedback loops to identify implementation challenges.
- Community perspectives can inform a more accurate picture of what the data means and is critical to advancing health equity.

Visit CHCS.org to…

- **Download practical resources** to improve health care for people served by Medicaid.
- **Learn about cutting-edge efforts** from peers across the nation to enhance policy, financing, and care delivery.
- **Subscribe to CHCS e-mail updates**, to learn about new resources, webinars, and more.
- **Follow us on LinkedIn or Twitter** @CHCShealth.



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Questions

Breakout Discussion

You will be randomly assigned to a breakout room. You will have 15 minutes to discuss:

- What have you learned from CHCS's presentation that you can use to improve your approach to data coordination?
- How will you ensure the inclusion of community perspectives in your data coordination approaches?

Updates to Spring Technical Assistance Offering!

- The topics of some events have changed, and **two events have been cancelled and repurposed.**

- **New Event: Coding & Value-set Roundtables**

  Audience: CCO Staff engaged in measure implementation

  - Friday June 14, 10am
  - Tuesday June 18, 2pm

Updated SDOH Metric Technical Assistance Event List

Next Steps

★ Review New Guidance Documents

- **2025 draft measure specifications** – out for public comment & **due back by April 15** to Metrics.Questions@odhsoha.oregon.gov.
- March Update of **SDOH Metric FAQ** **- coming soon**
- **2024 Learning Collaborative Playbook – coming soon**

Upcoming Metric TA Opportunities

- **Office Hour** – Aligning SDOH Metric with the 1115 Waiver & Other Initiatives
  - April 12, 2024, 10 a.m. PST – Registration Link
- **Learning Collaborative** – Addressing Referral Resources & Gaps through use of REALD
  - April 25, 2024, 3 p.m. PST – Registration Link
- **Café Connect** – Optimizing Data Sharing Systems
  - May 23, 2024, 1 p.m. PST – Registration Link

Oregon Health Authority

Measure Contacts

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2023-2024 SDOH Metric TA Structure

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: (May 23)
Optimizing Data Sharing Systems– 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: (April 12)
Aligning SDOH Metric with the 1115 Waiver and other SDOH Initiatives – Register Here

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: (April 25)
Addressing Referral Resources & Gaps Through REALD– 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