Social Determinants of Health:
Social Needs Screening & Referral Measure

Technical Assistance Webinar 1
November 8, 2022

Oregon Health Authority

Measure Technical Assistance

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Agenda

- Background & Timeline
- Measure Overview
- Partnership/Impact Web
- Grounding and Breakout Session
- Reflections & Next Steps

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.

Health-related social needs: An individual's social and economic barriers to health.

[Definitions per OAR 410-141-3735]

Background – Social Needs Screening

- 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).
- **Nearly half** of the Medicaid population in Oregon has one or more social needs, and communities of color are disproportionately affected (Oregon ACoordinated Care Organizationuntable Health Communities, May 2020).
- The COVID-19 pandemic has caused an **increase** in social needs among Medicaid members (Oregon ACoordinated Care Organizationuntable Health Communities, May 2020).

Benefits of social needs screening:

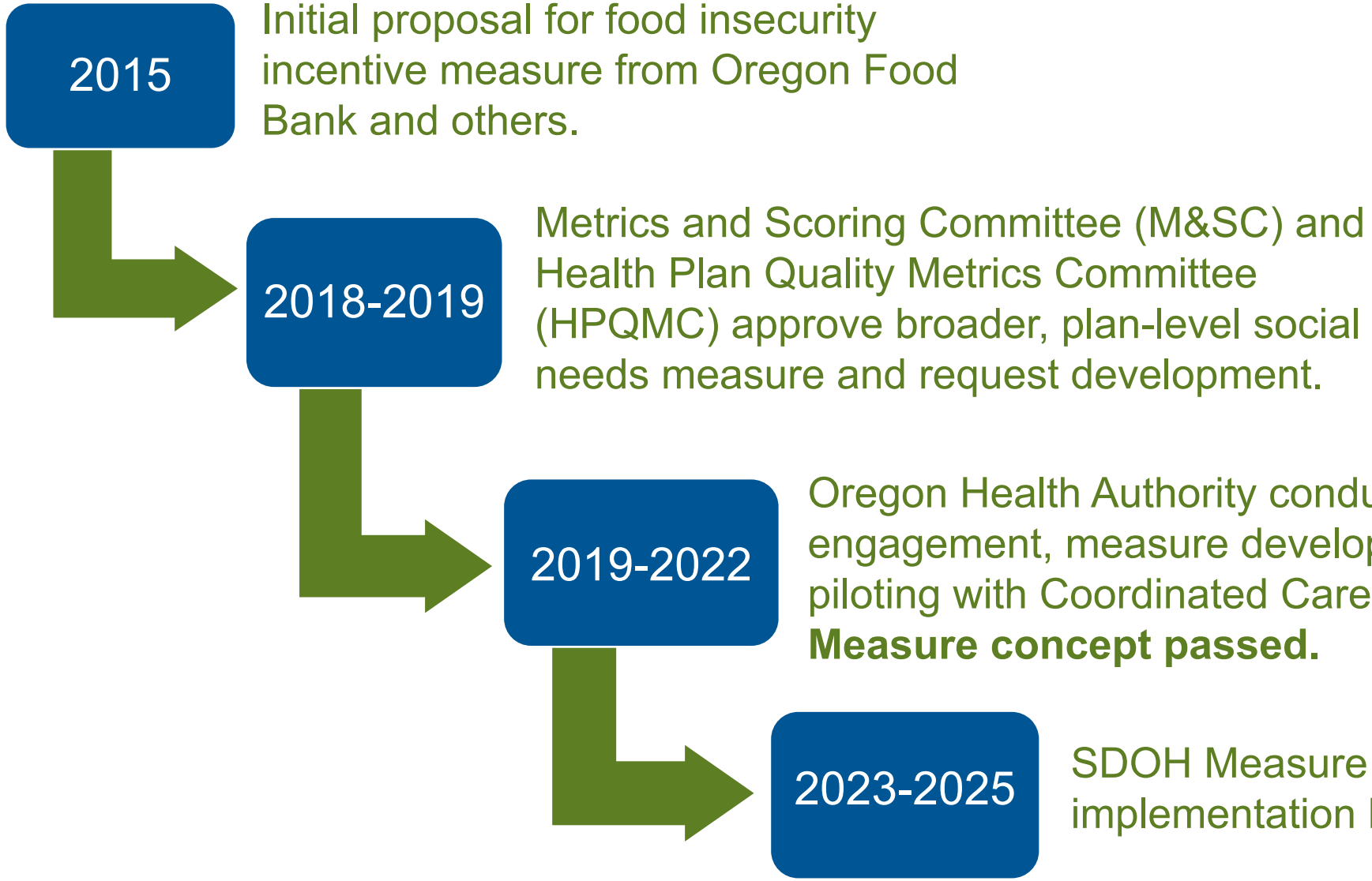
➔ **Collaboration** across sectors to provide wrap-around care

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

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

Office of Health Policy. (2022, April). *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 ACoordinated Care Organizationuntable Health Communities study, May 2020.
Social Determinants of Health Measurement Work Group Final Report, February 2021.

Measure Timeline



Measure Development – Community Engagement

Effort	Purpose	Participants	Timeline
Social Determinants of Health Measurement work group	Identify and recommend social needs screening measure concept to Metrics and Scoring Committee & Health Plan Quality Metrics Committee	Invited stakeholder applicants with expertise from health and social service sectors	Appointed March 2020; convened October–December 2020
Environmental scan	Collect information about ongoing social needs screening efforts in Oregon	Consultants Nancy Goff and Oregon Rural Practice-based Research Network; key stakeholder interviewees; Coordinated Care Organizations; Health Share of Oregon Coordinated Care Organization health system partners	March–April 2020
Oregon Health Authority social needs screening coordination meetings	Advise measure development, share social needs screening practices and approaches	Relevant Oregon Health Authority program staff	May–June 2020
Expanded planning team	Develop 3-5 social needs screening measure concepts for the work group's consideration	Oregon Health Authority; Oregon Department of Human Services; National Committee for Quality Assurance; Bailit Health; Health Information Technology Commons; Oregon Community Health Information Network; other technical experts	May–September 2020
Oregon Health Authority leadership, advisory committees, Coordinated Care Organization community advisory councils	Advise on high-level measure concepts	Several groups were engaged for feedback, including the Medicaid Advisory Committee, Public Health Advisory Board and the Health Equity Committee	September–October 2020

Reference: Social Determinants of Health Measurement Work Group Final Report

Measure Development – Guiding Principles

EQUITY

- Centers equity and trauma-informed practice
- Focused on improved health and well-being for all Oregonians
- Acknowledges limitations and potential harms (especially to patients/members)

FEASIBILITY

- Is feasible, especially for the health system to report or collect data on

ALIGNMENT

- Aligns with broader agency social determinants of health goals (and Medicaid 1115 demonstration waiver)
- Driven by a shared definition of and framework for addressing social determinants of health
- Lays the foundation to spur meaningful and sustainable collective action
- Considers alignment with Oregon Health Authority's and partners' other current social needs screening practices

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 - Measurement Years 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 - Measurement Years 2024 - 2026: Measures the percentage of Coordinated Care Organizations members screened and, as appropriate, referred to services.

*Oregon Medicaid Policy changes can be found here: https://www.oregon.gov/oha/HSD/Medicaid-Policy/Pages/Changes.aspx

Must-Pass Elements by Measurement Year

Elements of work to be aCoordinated Care Organizationmplished	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 aCoordinated Care Organizationmplished	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 (Community-based Organization) 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

2023 Measure Implementation Activities

Potential Impact on Providers

Screening Practices

2023 Coordinated Care Organization implementation activities that may impact providers:

- Distribute written policies, protocols and best practices to partners for
  - Assess members' unmet social needs
  - Use disaggregated Race, Ethnicity, Language and Disability (REALD) data
- Collaborate with partners to develop protocols to prevent over-screening
- Conduct a systematic assessment of all provider organizations and Community-based Organizations to assess:
  - If and/or where screenings are done
  - Screening tools and questions used
  - Languages available for screening

Referral Practices & Resources

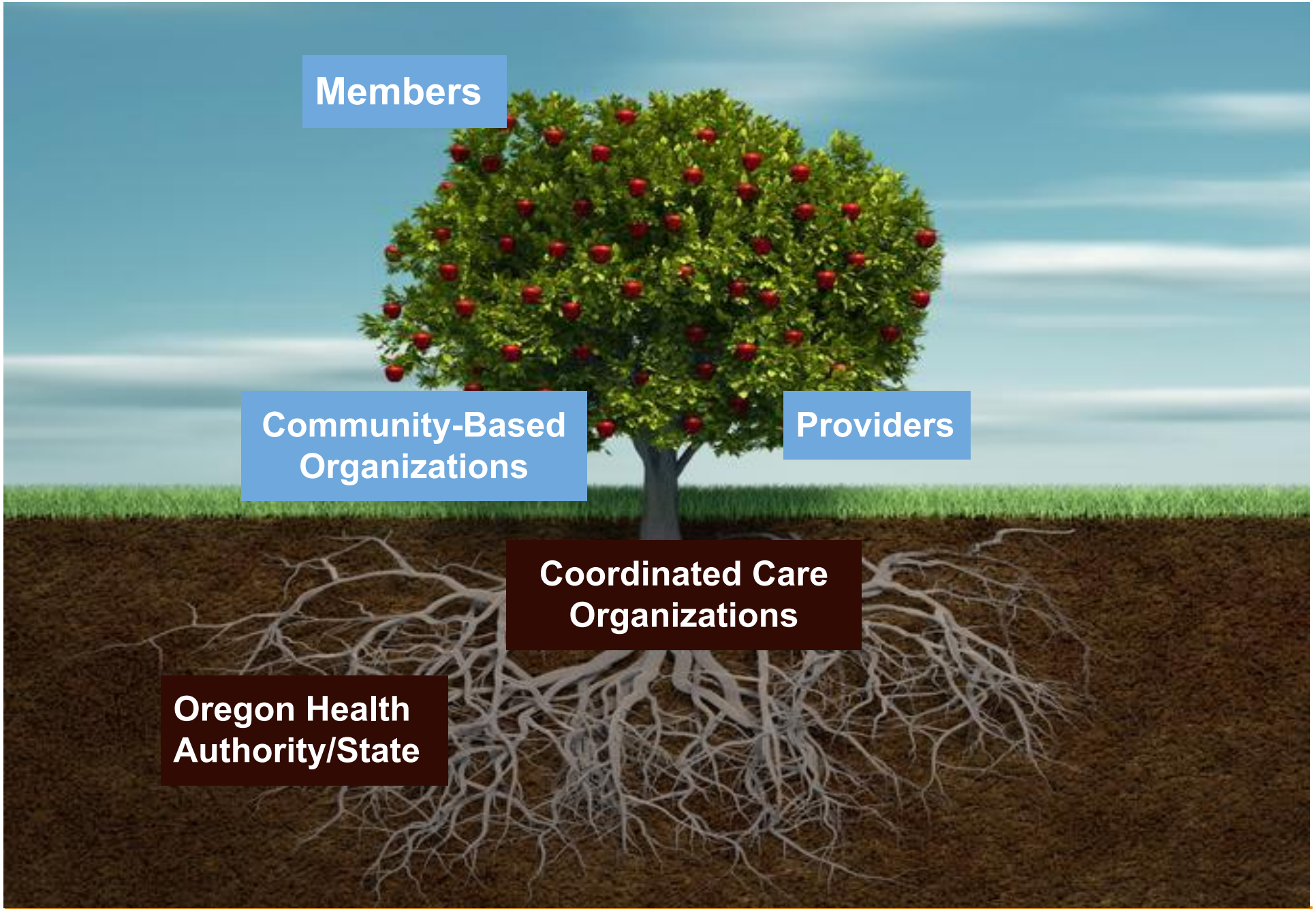
2023 Coordinated Care Organization implementation activities that may impact providers:

- Conduct an inventory of Community-Based Organizations and other resources in the Coordinated Care Organization service area that provide services to reduce or eliminate food insecurity, housing insecurity, and transportation needs
- Enter into new or maintain current contracts with community based organization Community-Based Organizations that provide services in the three domains

Data Collection & Sharing

2023 Coordinated Care Organization implementation activities that may impact providers:

- ➔ Conduct a systematic assessment of how any social needs screening and referral data is captured and/or exchanged by all provider organizations and Community-Based Organizations


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

Questions?

Poll Everywhere Activity

Join by Web

1. Go to **PollEv.com**
2. Enter **OREGONRURAL811**
3. Respond to Activity

Join by Text

1. Text **OREGONRURAL811** to **37607**
2. Text in your message

Intro to Breakout Groups

Activity:

- 5 questions
- 4-5 minutes per question
- ★ Designate speaker to share key points with large group

Guidelines:

- Please be brief and specific so everyone has the opportunity to speak
- Use raise hand icon or chat to comment
- A garden plot will be documented where ideas live and grow

Breakout Group Discussion

- What Social Determinants of Health Measure communication materials or guidance documents would be helpful? What support does your organization need?
- What has worked well for you when developing policies and processes related to health-related social needs screening?
- What has helped you in sharing information about patient social needs across sectors (healthcare, government, community sectors, etc.)?
- What data collection and sharing methods do you currently use?
  - How are you thinking about using Community Information Exchange for this?
- What has your organization put in place to prevent over-screening, including screenings not related to health-related social needs?

Breakout Session Debrief

What are the key takeaways from your breakout group conversations?

Evaluation

Next Steps: 2023 Webinars and Learning Collaboratives

Screening, Referral, Data Webinars: 60-90 minute presentations for Coordinated Care Organizations to learn more about the measure specifications

Statewide Webinars: 60-90 minute presentations for Coordinated Care Organizations, Community-based Organizations and clinical providers to learn more about the measure specifications

Learning Collaboratives: 60-90 minute interactive sessions for Coordinated Care Organizations, Community-based Organizations and clinical providers to strategize and collaborate on measure implementation

January	February	March	April	May	June
- Screening Practices Webinar	- Screening Practices Learning Collaborative - Statewide Measure Webinar	- Referral Practices & Resources Webinar	- Referral Practices & Resources Learning Collaborative - Statewide Measure Webinar	- Data Collection & Sharing Webinar	- Data Collection & Sharing Learning Collaborative
← One-on-One Technical Assistance →					

Learn more about Coordinated Care in Oregon:

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

Learn more about the Social Determinants of Health: Social Needs Screening & Referral Measure:

- Measure overview
- Measure specifications
- Educational webinar slides (March 2022)
- Educational webinar recording (March 2022)
- Social Determinants of Health Measurement Workgroup

Thank You!

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