Learning Collaborative (LC) 4: Addressing Resource and Referral Gaps through use of REALD Data

May 30, 2024

Social Determinants of Health (SDOH): Social Needs Screening & Referral Measure Technical Assistance (TA)

Oregon Health Authority

ORPRN Oregon Rural Practice-Based Research Network

OHSU

Welcome & Introductions

In the Zoom chat, please introduce yourself with the following:

- Your name & pronouns
- CCO affiliation

Please include your CCO in your Zoom name

Today's Agenda

- Review resource capacity planning Metric elements and explore the intersection with REALD data
- Understand the use of disaggregated REALD data
  - Guest speakers: OHA Equity and Inclusion Division REALD Team
  - Q&A with REALD team
- Breakout groups and discussion

Measure Requirements – Element 5

5. Establish written policies for using disaggregated race, ethnicity, language and disability (REALD) data to inform work on social needs screening and referrals (establish in MY 2023 and review in MY 2024 and 2025)

Intent: : CCOs use disaggregated REALD data to help understand and respond to members' needs in a culturally responsive way.

The element is met if the CCO has developed and distributed written policies for analyzing and using disaggregated race and ethnicity, disaggregated language, and disaggregated disability data to understand the populations served. The policies should describe how disaggregated REALD data is used to inform training, screening, and referral practices and to develop relationships with culturally specific CBOs and other resources to meet members' needs.

Examples of meeting this element: The CCO has established and distributed written policies, as outlined in Element 2, including protocols for analyzing and using disaggregated REALD data.

Measure Requirements – Element 14

14. Set up data systems to clean and use REALD data (set up by MY 2024 and maintain in MY 2025)

Intent: : CCOs set up data systems so they can effectively use REALD data received from OHA and other sources to inform processes for screening and referrals for social needs.

The element is met if the CCO uses disaggregated REALD data to understand the populations served by your CCO and identify resources to meet members' needs.

Examples of meeting this element: The CCO uses disaggregated REALD data to tailor training on how to provide culturally responsive screening and referrals and to work with community partners to address any gaps in culturally responsive services to meet members' social needs

Measure Requirements – Element 9

9. Assess the capacity of available resources and gap areas (MY 2023-2025)

Intent: CCOs understand capacity and gaps in available resources so they can connect members to culturally responsive community resources and they can prioritize investments in building capacity.

The element is met if the CCO conducts an inventory of CBO and other resources in the CCO service area that provide services to reduce or eliminate food insecurity, housing insecurity, and transportation needs and then compares the available resources with estimated unmet needs among CCO members.

Examples of meeting this element: The CCO creates an inventory of available resources by drawing on information sources such as

- The CCO's shared Community Health Assessments (CHAs),
- Data from a CIE, HIE or other resource or referral system or
- Consultation with organizations that support connections with community resources. The CCO compares that inventory with other data on needs. In the first year, this may be county-level or statewide data and subsequently, CCOs might use baseline data from the prior year. These data are compared with available resources to estimate the rate of unmet social needs among CCO members.

Measure Requirements – Element 11

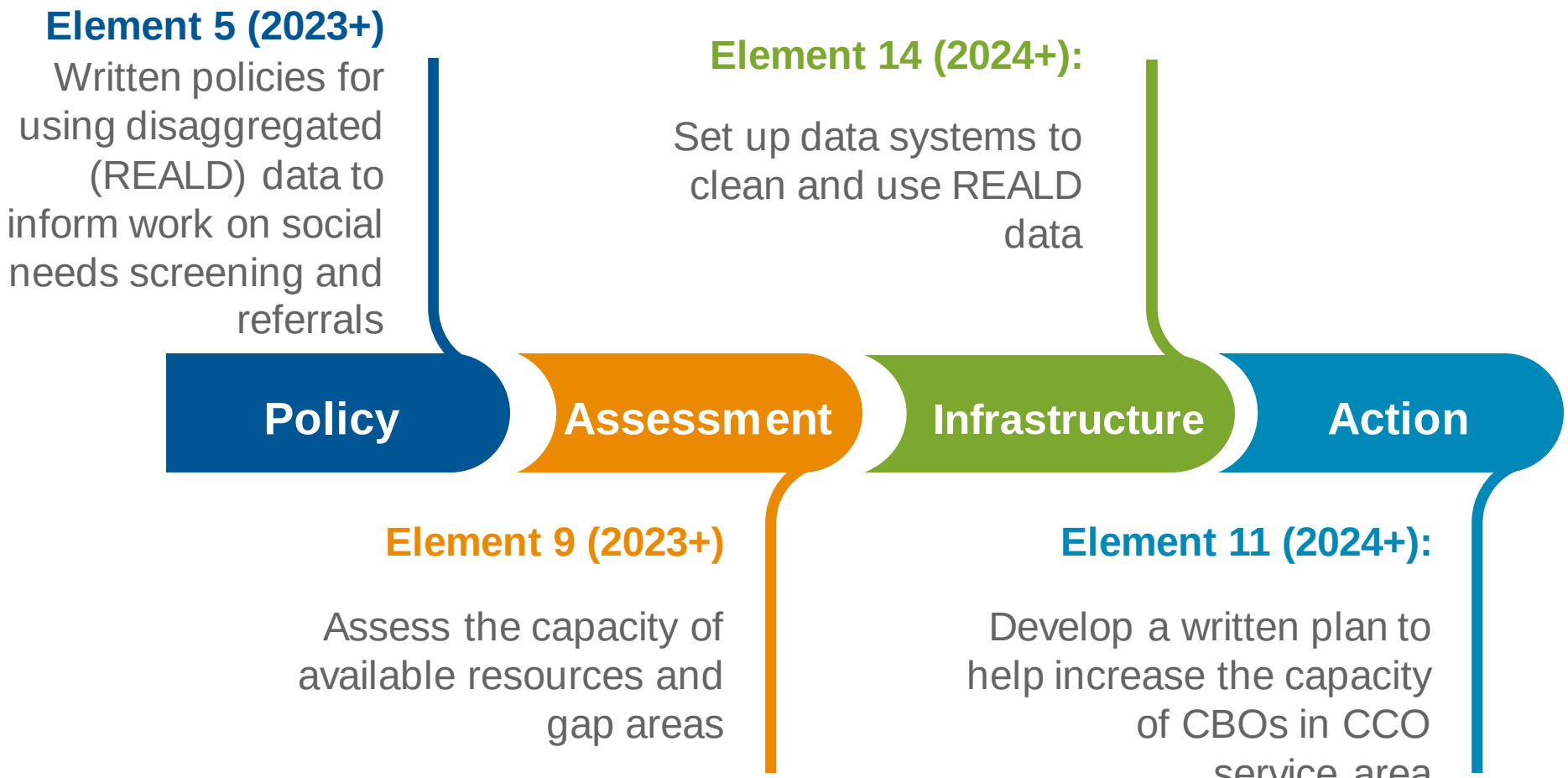
11. Develop a written plan to help increase the capacity of CBOs in CCO service area (establish in MY 2024 and review in MY 2025)

Intent: : CCOs make and implement plans to close gaps in available, culturally responsive resources to meet members' housing, food, and transportation needs.

The element is met if the CCO develops a written plan to meet members' unmet needs in the domains of food insecurity, housing insecurity, and transportation needs. The plan builds off the CCO's assessment of capacity and includes information about how the CCO will provide resources such as financial or staffing resources to increase CBO capacity. The plan aligns with related work such as the use of Health-Related Services funds and the Supporting Health for All through REinvestment (SHARE) Initiative.

Examples of meeting this element: The CCO publishes a detailed plan, incorporating the assessment of capacity among CBOs in the service delivery area, that outlines specific financial, infrastructure, and staffing strategies to help increase CBO capacity to meet members' housing, food, and transportation need.

REALD Intersection with Related Metric Elements



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OHA REALD Team Introductions

Aileen Duldulao, PhD, MSW
READ & SOGI Data Equity Measurement Methodologist

Colleen Rawson, MS
READ & SOGI Health Equity Analyst

Understanding & using disaggregated READ data

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Oregon Health Authority

What is REALD?

- REALD: **R**ace, **E**thnicity, **L**anguage, and **D**isability data standards
- Brought about by **communities** most impacted by health inequities
- Began with **House Bill 2134** (2013) – limited to OHA & ODHS
- Expanded with **House Bill 3159** (2021) – adds CCOs, providers & insurers
- Based upon local, state, and national data standards and best practices

What does health equity look like?

Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including Tribal governments to address:

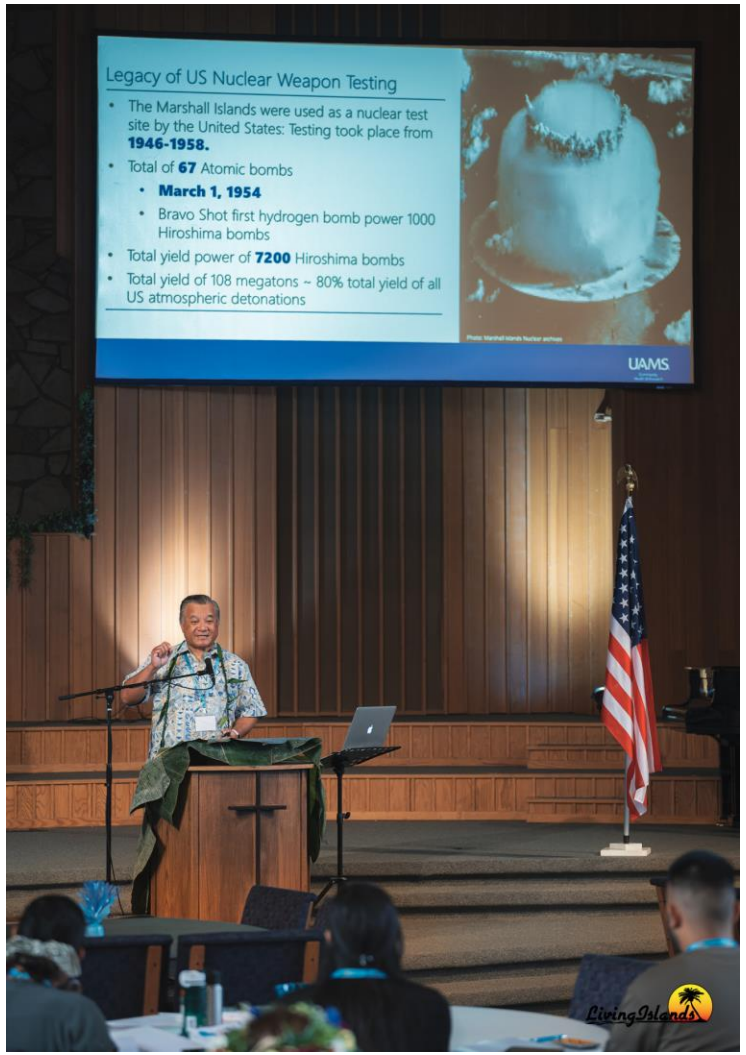
- The equitable distribution or redistribution of resources and power; and
- Recognizing, reconciling and rectifying historical and contemporary injustices.

Why does REALD matter?

What gets counted counts.

- Lack of granularity in race and ethnicity on a population level can mask important inequities in health and health care
- Quality data are essential for tracking how health outcomes and access to care differ across racial and ethnic groups

REALD – COFA community example



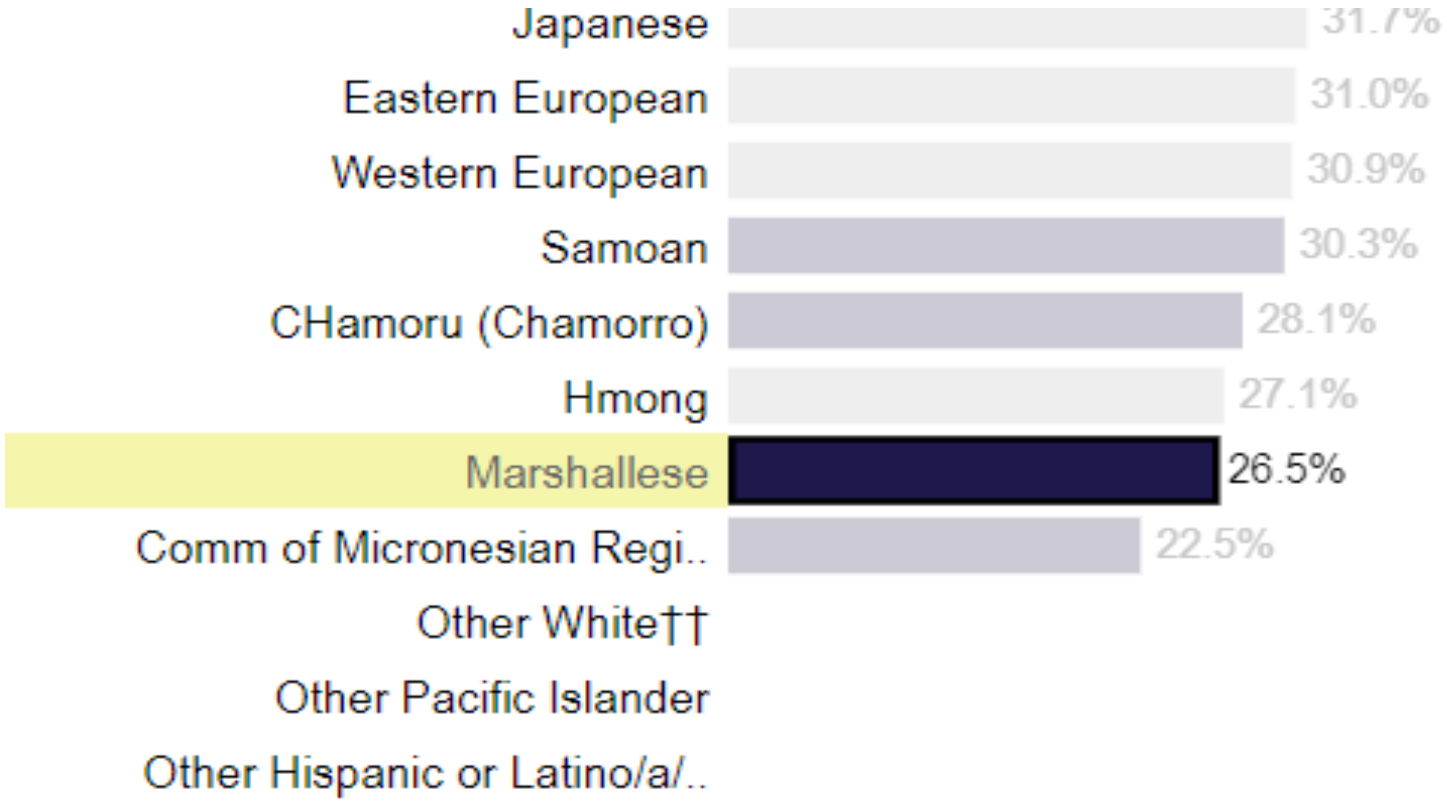
- Oregon is one of the first states to collect and publish data on Pacific Islanders from countries affected by the Compact of Free Association (COFA) treaty
- The treaty is the result of U.S. military occupation, atomic nuclear testing and ballistic military exercises that contaminated much of the environment and impacted the health of generations
- A drafting error in 1996 stripped these communities of their promised Medicaid coverage, which was not reinstalled until the end of 2020

Linking REALD data to SDOH

CCO performance statewide by disaggregate race and ethnicity groups

In 2022, the gap in CCO performance statewide was 23.0 percentage points

Key finding among American Indian members



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Basic principles of cleaning and using REALD data

- Most granular categories possible
    - **Disaggregated**: broken down by detailed (granular) sub-categories
- If you do have to aggregate, use intermediate aggregation (not federal OMB)
    - **Intermediate aggregation**: different ways to aggregate racial/ethnic categories based on context of the analysis
- Using **"alone or in combination" (AOIC)**: reporting the maximum number of people that report a racial or ethnic identity (i.e., number of all races reported will exceed total population reported)

Takeaways

- REALD plays an important role in health equity work
- It is a starting point to understanding the gaps in access to services. Community partnerships and meaningful engagement contextualize this data
- Understand that REALD categories do not show the whole picture and are not meant to measure identity or culture

READ TA for CCOs

- Past READ & SOGI Data Analytic Institute in October 2023 with representation from all CCOs – materials available from colleagues
- Bi-monthly data files to CCOs from the READ & SOGI repository

Q&A for REALD team

Next Steps (Breakout Groups)

You will be randomly assigned to a breakout room. In your breakout rooms, you will have **15 minutes** to discuss:

- Identify concrete steps for incorporating REALD-informed practices into their organizations.
- Identify any guidance needed on developing action plans for implementation.

★ **Please designate one colleague from your breakout group to take notes & share at least 1 take away with the large group.**

Breakout Group Share-Out

Next Steps

★ Check out the latest release of the **SDOH Metric FAQ**

Upcoming Metric TA Opportunities

- **Value Sets Round Table Session 1**
  - June 14, 2024, 10 a.m. PST – Registration Link
- **Value Sets Roundtable Session 2**
  - June 18, 2024, 3 p.m. PST – Registration Link

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