ORPRN
Oregon Rural Practice-Based Research Network

OHSU

OREGON HEALTH AUTHORITY

March 18, 2025

Engaging Health Care Providers in Social Needs Screening and Referral

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

Zoom Meeting Tips

This event is being **recorded**

- It will be shared on the **OHA Transformation Center Webpage** after the event

For **live captioning**

- Click the **"cc"** button located at the bottom of your screen

For **zoom troubleshooting**

- Chat **Kristina Giordano**

Welcome & Introductions

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

- Your name & pronouns
- CCO
- What is your favorite thing about springtime?

★ **Please include your CCO or organization affiliation in your Zoom name**

Today's Agenda

- Learning objectives
- Metric specifications
- Discussion kick-off panel
  - Coquille Valley Hospital & Advanced Health
  - Providence Health and Services & Health Share of Oregon
- Q&A with panel
- Discussion: potential resource to help engage health care providers

Today's Objectives

- Explore examples of providers who have effectively integrated social needs screening and referral activities into their workflows.
- Identify common challenges providers face in conducting social needs screenings and explore solutions to address these barriers effectively.
- Discover practical approaches for providers to integrate social needs screening into their workflows, including leveraging data, payment arrangements, and team-based care models.
- Discuss tools and resources to streamline workflows, support provider adoption, and enhance the implementation of social needs screening.

★ **Participation is key! Please have your cameras on when speaking, especially in group discussion.**

Metric Specifications in Context

Providers are essential to meeting metric requirements by conducting social needs screenings and facilitating referrals.

- Supporting providers to create formal processes for:
  - Assessing whether OHA-approved or exempted screening tools are used (Metric element 7)
  - Establishing written procedures to refer members to services (Metric element 10)
  - Meeting Component 2 rates for a member in the sample who has seen a networked provider
- Preventing over-screening
  - Support a data-sharing approach within the CCO service area (Metric element 15)
- Understanding resource gaps
  - Assess capacity of referral resources and gap areas (Metric element 9)

Provider Engagement Panel:

Sarah Cornelison,
CCMA, CCHW
Patient Care Coordinator,
Coquille Valley Hospital

Amanda McCarthy,
Director of SDOH,
Advanced Health

Kate Wells for Rachel Smith,
Senior Program Manager,
Providence Health and Service

James Wilson,
Quality Improvement Manager,
Health Share of Oregon

Coquille Valley Hospital and Advanced Health

Providence

Providence Social Health Updates

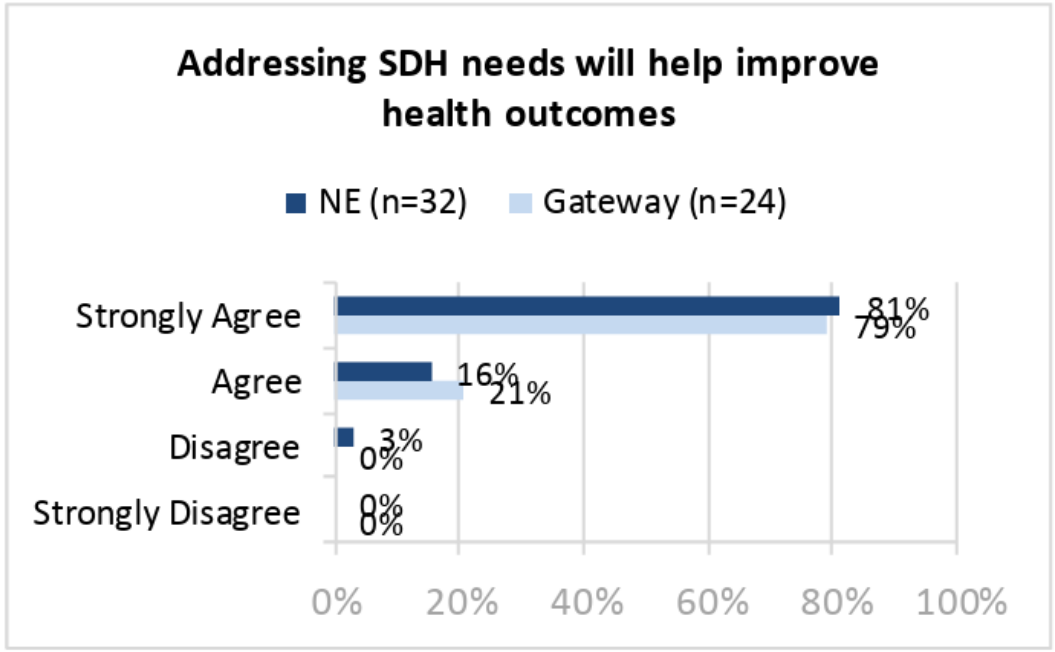
Rachel Smith, MPH
Providence Oregon, Population Health
rachel.smith@providence.org

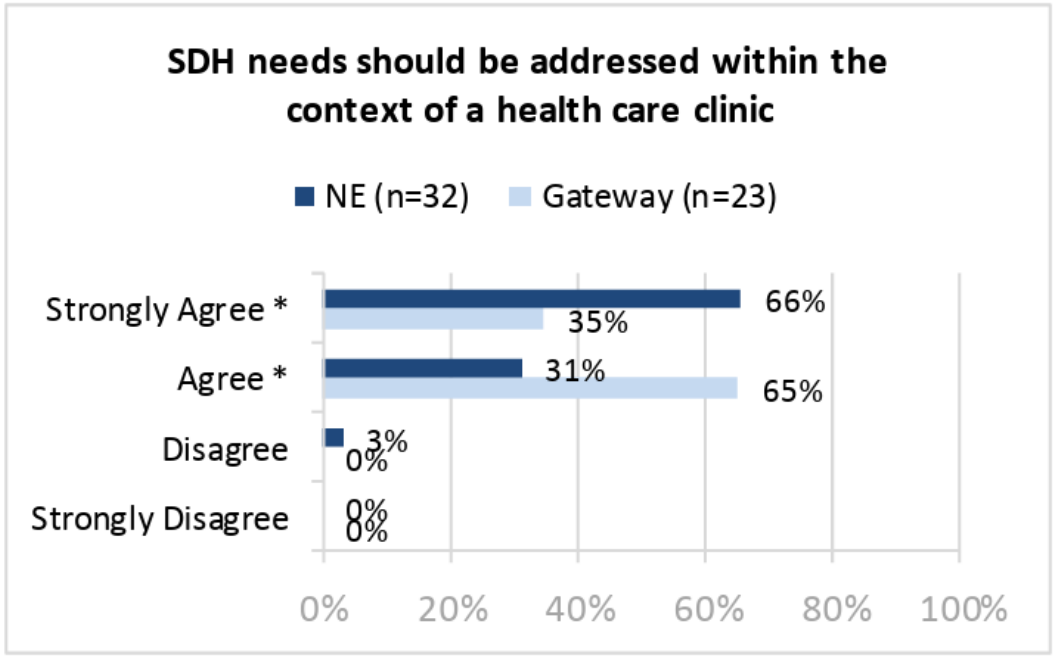
Providence Keys to Success

- Get provider buy-in early – in both understanding why we are doing this (beyond a requirement) and in workflow design
- Tie this to our mission and values as an organization
- Give teams autonomy to align SDOH workflows to existing workflows within their clinics
- Identify pain points and develop mitigation plans from the start
- Empower clinical teams to able to monitor their own progress
- Demonstrate impact

Step 1: Building the Case with Clinical Teams

- In 2015, when we started our SDOH screening journey, we surveyed staff to understand what they knew about the impact of unmet social needs
- 70% of staff were at least moderately aware of SDOH needs and nearly 100% felt it was their clinic's responsibility to help address these needs





* Indicates a statistically significant difference between the clinics ($p < 0.05$).

Value Case for SDOH within Providence

Supports value-based care and population health

- SDOHs impact as much as 70% of a person's well being and health care utilization
- Proactively attending to SDOH needs allows us to get upstream and prevent unnecessary illness and utilization of health care services

Addressing SDOH helps address health equity

- Communities of color experience a disproportionate burden of SDOH needs
- Offering SDOH screening across our care continuum will allow us to identify and address these inequities and disparities and improve overall health
- Ensures we can reduce bias and stigma

Mission Alignment

- Recognizing the importance of SDOH, the Sisters of Providence opened an orphanage and food pantries before building a hospital. Understanding the importance of SDOH needs is part of the fabric of who we are and critically important to creating health for all

Step 2: Build Champions from the Start

Our workflows were designed with frontline staff from a variety of roles, which informed our design in key ways:

A one size fits all workflow would not work

- Each clinic needed to align this work to their existing workflows
- Screening only certain populations (based on a disease diagnosis or insurance type) felt inequitable and often harder to operationalize than universal screening

Step 2: Build Champions from the Start (con't)

Clinic staff were very hesitant to screen if there was nothing to do about an identified need

- This was the #1 reason clinics were hesitant to do this work
- We focused on designing interventions that were effective and scalable at the same time (and sometimes even before) as building out screening workflows

Epic workflows were not efficient

- We worked together to identify what the limitations were and advocated for change

Clinics need to have access to their own data; chart scrubbing was burdensome

Mitigating challenges

Pain point: Resource availability

- Strengthened relationships with community-based organizations
- Incorporated education on the social safety net, clarifying that solutions are not always immediate.
- Created staff scripts to set expectations without overpromising outcomes.

Pain Point: Epic was not designed with social needs in mind

- Added AHC housing questions to Epic's SDOH fields in 2018 to address unmet needs.
- Created a "community partner" template for non-HIPAA entities to streamline referral access in Epic.
- SDOH screening isn't shown in the patient Snapshot, making it hard to track – **still working on this.**

Empower with Data: Example Clinic Dashboard

SDOH PMG Clinic Screening Overview

Patients seen in a PMG primary care clinic within past 12 months. Updated 3/3/2025.

Screening rates include patients asked one of Housing, Food, Utilities, Transportation question in any Epic encounter within the same time period.

PMG Clinics	Geopod	Age Band	Date	Domain	Encounter Type	Language	Financial Class	Payor	Race	Ethnicity	Zip Code
PMG ASHLAND INTERN...	(All)	(All)	(All)	(All)	(Multiple values)	(All)	(All)	(All)	(All)	(All)	(All)

Overview

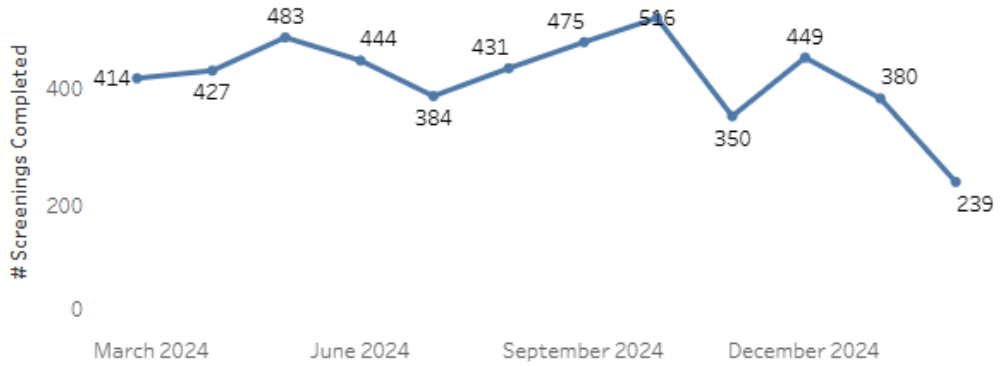
2,340
Patients Screened

91%
% Screened

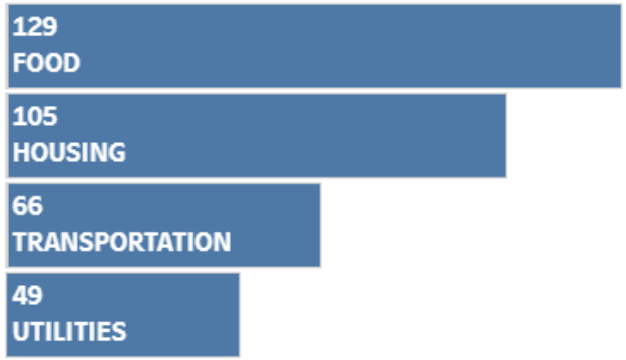
2.10
Average Screens Per Patient

239
Screened Positive

Number of Screenings Completed By Month



Patients By Need



Top 10 Clinics With the Highest % of Patients Screened

		# Patients Seen	# Patients Screened	% Screened	Average Screens Per Patient	# Screened Positive	% Screened Positive
1	PMG ASHLAND INTERNAL MEDICINE	2,567	2,340	91%	2.10	239	10%

Visit Providers Metrics

				# Patients Screened	# Screened Positive	% Screened Positive
1	JUL	Physician	PMG ASHLAND INTERNAL MEDICINE	763	99.0	13%
2	WA	Physician	PMG ASHLAND INTERNAL MEDICINE	715	45.0	6%
3	KUH	Physician	PMG ASHLAND INTERNAL MEDICINE	693	52.0	8%
4	RIC	Physician Assista..	PMG ASHLAND INTERNAL MEDICINE	621	47.0	8%

Demonstrate the Impact

- Working hard to keep the impact of SDOH screening work in front of staff
- Using data to inform new interventions – like opening food pantries at clinics with the highest rates of food insecurity

Demonstrate the Impact

Patient Story

The Community Resource Desk Resource Specialist received a referral from Sabrina's PCP after she screened positive during her clinic visit. Sabrina shared that she had a PGE (utilities) shut off notice. The Specialist worked with Sabrina to submit an energy assistance application to Community Action of Washington County, who were able to help her cover her overdue bills.

Sabrina was excited that she was able to get assistance and will no longer have her lights and heat shut off. The Specialist also supported her in signing up for the PGE bill discount program to avoid this stress in the future.

> "We are so very grateful for the services we received. Having the food we need is so important and your help we receive is just so appreciated!!! Thank you so much!!!!!"

Providence

Panel Q&A

Rachel Smith, Providence Health and Services
James Wilson, Health Share of Oregon

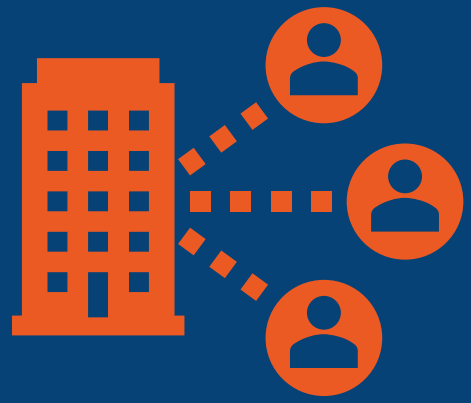
Sarah Cornelison, Coquille Valley Hospital
Amanda McCarthy, Advanced Health

Resource needs:
Provider strategy and buy-in

Ideas for Tools to Engage Providers

Potential topics that can be covered in a brief resource document:

- Include list of OHA approved tools
- Share list of resources in community
- What the CCO needs for reporting
- Resources available from the CCO



Break-out Discussion: Resource Needs

Breakout Discussion

Questions:

- What part of engaging providers in SDOH screening and referral has your CCO found most challenging?
- What does your CCO use as an educational resource to engage providers (FAQ, buy-in/context document, etc.)?
- If a resource existed, what would your CCO find as important topics to cover?

Next Steps

- ★ New FAQ Responses in the January FAQ Release
- ★ Final 2025 Measure Specifications Released

Upcoming Metric TA Opportunities

- Webinar: Non-medical Transportation; Systems, Barriers, Opportunities
  - April 22, 2025 – Registration Link
- For 1:1 technical assistance inquiries, reach out to **Claire Londagin at londagin@ohsu.edu**

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